Rickleton Medical Centre

Quality Report

Rickleton Medical Centre
Office Row
Rickleton
Washington
NE38 9EH
Tel: 0191 4150576
Website: rickletonmedicalcentre.nhs.uk

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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.

Contents

Summary of findings

Overall summary

The practice is based in the Rickleton area of Washington. It is a small practice with 2046 patients. The practice had not previously been inspected by the Care Quality Commission (CQC) and the provider declared full compliance when it was registered in April 2013. The practice does not have any branch surgeries.

Before the inspection we looked at a wide range of information we held about the practice, as well as information the practice sent to us. We asked other organisations, such as the Sunderland Clinical Commissioning Group (CCG) and the local Healthwatch organisation, to share with us what they knew about the practice. We held a listening event where members of the public could tell us about their experiences of GP services within Sunderland. Prior to our visit we also asked patients to complete CQC comment cards telling us about their experiences of the service they had received.

We carried out an announced inspection on 01 September 2014. We also had telephone contact with the practice on 02 September 2014. During the inspection we spoke with patients and staff. We also received 45 CQC comment cards completed by patients. Feedback from patients was very positive. They told us they were satisfied with the care and treatment they received. Patients also reported they felt involved in all decisions concerning their care or treatment, and felt safe using the practice. Patients told us they were treated with respect and dignity at all times. Throughout the inspection we observed patients being treated with compassion and care.

The practice had planned its services to meet the needs of the different types of patients it served. Care and treatment was provided in line with current published guidelines and best practice. The practice had a good leadership team who supported staff to engage positively with patients, learn lessons following significant events and near misses, and undertake learning to develop their professional skills and competences. Medicines were handled safely. Systems were in place to protect and safeguard patients against the risk of harm or abuse. The practice was clean and hygienic throughout.

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

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 had demonstrated that it was safe over time. Staff understood and fulfilled their responsibilities with regards to raising concerns, recording safety incidents and reporting them both internally and externally. The practice management team took action to ensure that lessons were learned and shared these with the team to support improvement. There was evidence of good medicines management. Safe recruitment practices were evident and there were enough staff to keep patients safe. Good infection control arrangements were in place and the practice was clean and hygienic. Risks to patients were assessed and well managed.

Are services effective?

Data showed patient outcomes were in line when compared to other practices in the local CCG area. Practice staff followed guidance produced by the National Institute for Health and Care Excellence (NICE) when providing care and treatments to patients. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance. Staff had received training appropriate to their roles and further training needs had been identified. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support effective working between the practice and members of the multidisciplinary team. Staff had access to the information they needed to deliver effective care and treatment.

Are services caring?

Data showed patient outcomes were either in line with, or better than average, when compared to other practices in the local CCG area. Patients said they were treated with compassion and they were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to health information and advice when needed, and they received support to manage their own health and illness. Staff demonstrated they understood the support patients needed to cope with their care and treatment

Are services responsive to people's needs?

Services had been planned so they met the needs of older patients, and those with long-term conditions. Initiatives were also in place to meet the needs of other key population groups. Patients were able to access appointments in a timely way. They reported good access to the practice and told us urgent same day appointments were

Summary of findings

always available. The practice had taken steps to reduce emergency admissions for patients with complex healthcare conditions, and older patients had been given a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to any issues raised.

Are services well-led?

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for, and also felt well supported. The practice had a range of policies and procedures covering the activities of the practice. Systems were in place to monitor, and where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

Summary of findings

What people who use the service say

During the inspection we had contact with five patients. We received 45 CQC comment cards completed by patients. The feedback we received indicated patients were satisfied with the care and treatment they received. Patients told us they received a good service which was caring and met their needs. They said they were treated with dignity and respect, and felt their privacy was promoted. We received positive feedback about the practice's appointment system and patients told us they found it easy to get through to the practice on the telephone. Patients said they were able to obtain an appointment within a reasonable amount of time. None of the patients we spoke to, or received feedback from, expressed concerns about how the practice operated.

Of the patients who responded to the National GP Patient Survey:

- 100% said they found it easy to get through to the practice by telephone;
- 94% said receptionists at the practice were helpful;
- 99% said the last appointment they got was convenient;
- 92% described their experience of making an appointment as good;
- 99% said they would recommend the surgery to someone new to the area.

Information obtained from the 2013 in-practice survey showed similar high levels of satisfaction with the practice and the care and treatment it provided. For example:

- 98% of patients reported that the arrangements for providing or arranging their care and treatment were good;
- 98% of patients said they had confidence the practice GP was honest and trustworthy;
- 100% of patients reported they would be happy to see the same GP again.

Areas for improvement

Action the service SHOULD take to improve

The practice should:

- Take further action to develop an active Patient Participation Group (PPG).

Rickleton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP and the team included a Practice Manager and an Expert by Experience. An Expert by Experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Rickleton Medical Centre

The practice is based in the Rickleton area of Sunderland. The practice is registered with the Care Quality Commission to provide the following regulated activities: treatment of disease, disorder and injury; diagnostics and screening procedures; surgical procedures. Dr Olagoke Aiyegbayo operates as a single-handed GP and employs a practice manager to oversee the day-to-day running of the practice. The practice also has a practice nurse, a healthcare assistant and three reception staff.

The practice is part of NHS Sunderland Clinical Commissioning Group (CCG). Sunderland has some of the worst areas of deprivation in England. Over 40% of the population live within an area classified as one of the most deprived in the country. The practice is responsible for providing primary care services to approximately 2046 patients. The practice has a higher percentage of the practice population in the over 18 age year group and a lower level of deprivation than the England average.

When the practice is closed patients access out-of-hours care via a branch of Primecare which is based in the Sunderland area. An 'extended hours' service is available one day a week for patients who are unable to attend the practice during its usual opening hours.

Why we carried out this inspection

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

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How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the service. We carried out an announced visit on 01 September 2014. During our visit we spoke with a range of staff including: the GP operating the practice; the practice manager; the practice nurse; staff who worked in the reception team. We also spoke with five patients on the day of our visit. We reviewed 45 comment cards where patients had shared their views and experiences of the service with us. We observed how people were being cared for.

Are services safe?

Our findings

Safe patient care

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how this practice operated. During this inspection, neither the patients we spoke to, nor those who returned CQC comment cards, raised any concerns about safety at the practice.

The information we collected as part of our preparation for this inspection showed that the practice performed as 'similar to expected' regarding safety issues when compared to other practices in the Sunderland CCG area. We also found that the CQC had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The local CCG told us they had no concerns about how this practice operated with regards to safety.

Other information we reviewed about the performance of the practice indicated it was an outlier for NSAID (Non-steroidal anti-inflammatory drugs) prescribing. The practice was unaware of this and told us their prescribing rates for this type of medicine was within agreed perimeters. They provided us with an audit indicating they were not an outlier for NSAID prescribing. The audit also confirmed that no further action was required.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we were told that following a medicines error, a significant event review was held to look at what lessons needed to be learnt to prevent a reoccurrence. As part of the review, mentor support was given to the member of staff concerned to help them with their continuing professional development.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice had a significant event reporting policy which provided guidance on how significant events should be dealt with. The GP demonstrated a good understanding of what constituted a significant event, and all of the staff we spoke with were knowledgeable about the significant event reporting process.

We looked in more detail at the records the practice had kept about the 15 significant events that had occurred during the previous 12 months. These showed members of the team had self-reported significant events and that these events were discussed within practice team meetings. Staff told us appropriate follow-up action had taken place after each significant event and lessons had been learned through the process of discussion and reflection.

The sample of staff meeting minutes we looked at provided an overview of what action had been taken to prevent similar significant events re-occurring. We saw that following a recent significant event, the GP had contacted the patient concerned to discuss the incident and had made them aware of the potential consequences. However, we also found the records kept of the significant events that had occurred did not always contain sufficient analysis of what lessons had been learnt and why, and how they might be used to improve patient outcomes. For example, the guidance produced by the Royal College of General Practitioners suggests the account of a significant event should include, amongst other things, what changes have been agreed for the reporter and the team. The college also recommends the process should include a review of the changes carried out and their effect upon patient care. We found the practice was not recording the outcome of their significant event reporting process as well as they could.

Safeguarding

The practice had a range of policies, procedures and systems in place to help keep patients safe. These included, for example, children and vulnerable adults safeguarding policies and procedures. Both of these policies were thorough and comprehensive. The staff we spoke with had received training in safeguarding vulnerable patients to a level that was appropriate to their role within the practice.

Are services safe?

The GP acted as the safeguarding lead for the practice. They met regularly with other primary healthcare professionals to consider any current safeguarding issues, and to identify any action they needed to take and who should do this. The staff we spoke with knew who the practice safeguarding lead was. Systems were in place to identify vulnerable patients at risk of harm or abuse. This included, for example, placing flags on the medical records of at risk children, and adults with memory problems. (Placing flags on medical records helps to alert practice staff to potential and actual risks to a patient's health and wellbeing.)

The practice had also devised a chaperone policy which provided staff with guidance on the role of a chaperone, when they might be needed and who should perform this role. The practice website and brochure included information about its approach to providing a chaperone. The staff we spoke with were clear about how to carry out the chaperone role, and confirmed they had received the training they needed to do this.

We saw evidence that the practice had identified all potential risks relating to the practice and had taken action to minimise these. For example, the practice had assessed the risks associated with an epidemic. The assessment had identified where epidemic alerts might come from, what impact responding to an epidemic might have on the day-to-day functioning of the practice, and what action would be necessary to manage the practice response.

Monitoring safety and responding to risk

The practice had a process for identifying and responding to new risks. This included, for example, carrying out Significant Event Audits to review any concerning events that had occurred at the practice.

The practice had devised its own health and safety policy setting out the steps it would take to protect staff and patients from the risk of harm or accidents. Safety certificates confirmed that electrical, gas and medical equipment was safe to use. Arrangements had been made to protect patients and staff from harm in the event of a fire. This included carrying out appropriate fire equipment checks.

Medicines management

Arrangements had been made which helped to ensure the safe management of medicines. The latest QOF information (2012/2013) available to us indicated that the practice had exceeded the 80% standard for carrying out a medicine review and recording this in the notes of all patients prescribed repeat medicines, during the preceding 15 months.

We found the practice had put arrangements in place which ensured that the cold chain was maintained for the storage of vaccines and other medicines requiring refrigeration. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature.) A policy was in place which provided staff with guidance about what to do if refrigerator temperatures were not within the required range.

The practice also had arrangements in place to monitor the expiry dates of emergency medicines and medical gases. We found all emergency medicines were in date and an effective ordering and checking regime was in place.

Patients were able to re-order repeat prescriptions using a variety of ways. This included ordering at the practice, by telephone and in writing. The web site provided patients with helpful advice about ordering repeat prescriptions, including advising patients to allow 48 hours before visiting to obtain their repeat prescription. QOF information (2012/13) confirmed the number of hours from a patient requesting a prescription to its availability for collection by them was 48 hours or less.

Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. The receptionist handled requests for repeat prescriptions competently. They spent time talking with these patients to identify what they needed. They also checked the patients' electronic records to make sure the prescriptions requested were on repeat. A member of staff who dealt with prescriptions told us repeat prescription requests were sent through to the GP for checking and authorisation.

The QOF information (2012/2013) available to us indicated that a prescribing adviser had met with practice staff at least annually, and that the practice had taken steps to

comply with the guidance they received regarding prescribing medicines. The GP attended the local CCG medicines optimisation meetings which provided them with access to best practice on prescribing medicines.

Cleanliness and infection control

We found arrangements had been made to ensure the practice was clean and hygienic. The practice employed its own cleaning staff and provided them with a cleaning schedule setting out what needed to be done and when. The cleaning cupboard was clean and tidy, and was suitably stocked. We saw personal protective clothing was available to cleaning staff. The practice cleaner had completed infection control training to help make them aware of current infection control standards. Although cleaning staff did not sign an accountability sheet to confirm required cleaning tasks had been completed, the practice manager undertook a daily visual inspection of the premises to check the required standards were being maintained. We found the practice was clean throughout, and none of the patients we spoke to raised any concerns about levels of cleanliness.

Protective paper covers for consultation couches, personal protective equipment and materials, and bins for clinical and sharps waste, were available in the clinical rooms we visited. One of the sharps bins had not been dated. Plastic curtains were available for the examination couches in the clinical rooms and were washed annually. Spillage and biohazard kits were available to enable staff to deal safely with spills of bodily fluids. The staff we spoke with were aware of their location. Arrangements had been made to dispose of clinical waste weekly. Appropriate documentation was in place. Cupboards in the clinical rooms were well organised and all products were within date.

Infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. The practice had a designated infection control lead and staff had completed infection control training relevant to their roles and responsibilities. Staff we spoke with said they were clear about their infection control responsibilities and confirmed they would raise any concerns directly with the practice manager. The practice manager told us the last external infection control audit had been carried out some years ago, and that a regular in-practice infection control audit was not carried out. Although we identified no concerns during the inspection, carrying out a regular in-practice audit will help ensure compliance with best practice standards.

A Legionella risk assessment had been carried out following which a decision was made that no further action needed to be taken. However, details of the outcome of the risk assessment that had been carried out had not been recorded.

Staffing and recruitment

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. The practice had one male GP, a practice manager, a practice nurse, and a team of receptionists. The practice manager told us current staffing levels were sufficient to meet the needs of the patient population. However, the practice recognised that patients did not have access to a female GP. The GP told us that as soon as the practice list reached a certain size, steps would be taken to recruit a female GP. They also told us locum cover was always provided by the same female GP.

Locum cover was provided when the practice GP took leave. We received positive feedback from some patients about the quality of locum cover. Cover was not provided for the practice nurse when they took leave. The practice manager told us chronic disease clinics and appointments, and other work carried out by the practice nurse, were planned ahead to enable commitments to be met without the need to bring in a locum nurse. The healthcare assistant had been trained to take bloods, carry out blood pressure and weight checks. A member of the reception staff had been trained to carry out electrocardiograms. We were told these services continued to be provided in the absence of the practice nurse.

The practice had put arrangements in place to help ensure that only suitable staff were appointed. We looked at the records of two staff that had been appointed during the previous eighteen months. Written references, full employment history details in the form of a Curriculum Vitae and Disclosure and Barring Service checks had been obtained. Practice staff carried NHS Smart cards which contained an identification photograph. We were told staff's identities had been verified under the NHS Employment Check Standards process. The practice had obtained confirmation that the practice nurse was

registered with their professional body the Nursing and Midwifery Council (NMC), and was fit to practise. We checked the General Medical Register and confirmed the GP was licensed to practice.

Dealing with Emergencies

The practice had access to equipment and medicines for managing emergencies. This included an adult defibrillator which is used to resuscitate patients who have stopped breathing. Staff knew how to access it and checks were completed to make sure it was kept in good working order. However, there was no evidence the practice had assessed whether they needed to obtain a set of purpose-made paediatric pads for use with children aged between one and eight years of age. Staff told us they were clear about the action to take in the event of a medical emergency. All relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training during the previous 12 months.

The practice had a business continuity plan which included an assessment of potential risks that could affect the day-to-day running of the practice. This provided information about contingency arrangements that staff would be expected to follow in the event of a foreseeable emergency.

Equipment

The practice had a range of equipment in place. This included medicine refrigerators, an electrocardiogram (ECG) machine, sharps boxes (for the safe disposal of needles), and fire prevention equipment. We saw regular checks of the equipment took place to ensure it was maintained in satisfactory working condition. For example, there was regular testing of all electrical equipment. Certificates were also available confirming that other equipment such as scales, blood pressure equipment and nebulisers were safe and fit for purpose. Key staff had recently undertaken fire warden training to help them protect patients and staff in the event of a fire. Fire equipment had recently been tested and serviced, and the practice had a designated fire safety officer who was responsible for ensuring fire safety within the building. Records were available confirming required fire safety checks had been carried out, including a recent fire evacuation drill.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

As part of our planning we looked at information from the General Practice High Level Indicators tool. The practice was highlighted as being an outlier for the prescribing of a medicine used to help lower a patient's cholesterol levels. (An outlier is an observation that something lies outside of what might usually be expected and may indicate some sort of problem.) We were told the practice had carried out an audit of their prescribing practice in relation to this medicine. This showed that, following an investigation on a case by case basis, the prescribing of this medicine was appropriate, and in line with prescribing guidance.

We found the GP had taken steps which helped to ensure that the care and treatment they provided was evidence based and informed by relevant quality standards, such as those provided by the NICE. For example, we found they followed good practice guidance in relation to the provision of contraceptive advice for young people. The practice GP had devised an in-practice checklist to help ensure that good practice was followed when dealing with requests for contraception. The GP was also involved in the local CCG Medicine Optimisation Team. (Medicines optimisation is about ensuring that the right patients are prescribed the right medicine at the right time to help achieve improved outcomes). The local CCG had recently revised and updated its guidelines on Vitamin D deficiency management and treatment. The practice GP told us they were involved in the preparation of these guidelines and demonstrated a good level of knowledge in how to apply these guidelines in their day-to-day practice.

Arrangements had been made to meet the needs of new patients wishing to register with the practice. The practice offered new patients a personal health check. This included a health assessment by the practice nurse and, where appropriate, a referral to the GP. We were told the assessment covered areas such as past medical and family histories and a measurement of any risk factors. Where abnormal tests results were received, we were told these were forwarded to the GP for action where required.

The GP and nurse were able to perform appropriate skilled examinations and arranged timely investigations where they thought this would help with the management of a condition or provide a more accurate diagnosis. We were told about a recent consultation where the GP felt concerned enough about a patient's presenting condition to urgently refer them for further assessment and diagnosis, even though they did not meet the criteria for an urgent cancer referral. Letters of support, written by hospital consultants as part of the GP's appraisal documentation, complimented them on the appropriateness of their management of the patient case and subsequent referrals for additional assessment and diagnosis.

The practice had taken steps to meet the needs of its patients. For example, chronic disease clinic appointments were offered to patients with long-term conditions. There was also a call/recall system in place which helped ensure patients received notification of when they next needed to attend the practice. Further information about how the practice meets the needs of its various population groups can be found towards the end of this report.

Arrangements were in place to ensure informed consent was obtained for the care and treatment provided to patients. Written guidance was available for staff about how they should seek informed consent from patients, including children, who might find it difficult to provide valid consent. The GP told us they had recently had to assess the capacity of a patient with a learning disability to make decisions about the care and treatment they needed. It was clear that the GP had not only assessed the needs of their patient and their capacity to make a decision about how their needs should be met, but had also involved family members and care supporters in the decision making process. The GP was aware of relevant legislation and good practice. We found they were able to apply these when assessing whether a patient had the capacity to make key decisions about how their care and treatment needs should be met.

The practice had a complete register of all patients in need of palliative/supportive care. A register was also in place identifying the carers of patients with palliative care conditions. The QOF information we looked at confirmed the practice held regular, at least every three months, multidisciplinary case review meetings where all patients on the palliative care register were discussed. The practice manager told us the GP always contacted patients who had received a cancer diagnosis even when he was not actively involved in their care and treatment. The GP told us that

Are services effective?
(for example, treatment is effective)

patients on the palliative care register were now reviewed bi-monthly, and regular visits were carried out to check how they were coping with any care and treatment they were receiving.

Management, monitoring and improving outcomes for people

The latest available QOF information (2012/13) showed the practice had, for the most part, achieved good outcomes for its patients. The information showed the practice had not only produced registers which identified patients suffering from a range of chronic diseases, such as asthma and coronary heart disease, but had also delivered healthcare interventions in line with nationally accepted clinical guidelines.

The practice had put systems in place to help it develop, monitor and improve the quality of the care and treatment provided to patients. For example, the 2012/13 QOF information showed the practice had:

- Met internally to review data on secondary care outpatient referrals;
- Participated in an external peer review with a group of local practices to compare its data on A&E attendances and agree an improvement plan;
- Developed and implemented three care pathways for the management and treatment of patients, in order to avoid emergency admissions into hospital.

The practice had undertaken clinical audits relating to prescribing and medicines management. (Clinical audit is one way that GPs can measure and improve the quality of the clinical care they provide to patients). For example, an asthma audit for children aged 5 to 12 years of age had recently been carried out. This confirmed that all children on the register who were using steroid inhalers, had had their annual asthma health checks and growth rates checked. The practice had also looked at the arrangements in place for ensuring the safe transfer of prescribing responsibility for certain types of medicines from hospital consultants to the practice GP. However, we found no evidence of non-prescribing clinical audits or of formal peer review. Carrying out audits in other clinical areas, and participating in effective peer review processes, will help confirm that the current quality of care is consistent with best practice.

Staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. The GP and practice nurse were registered with their respective regulatory bodies, i.e. the General Medical Council and the Nursing and Midwifery Council. We were able to confirm that clinical staff had completed training relevant to their roles and responsibilities. The GP had made arrangements to participate in an annual appraisal process. They had an agreed appraiser who was responsible for confirming they had complied with re-validation requirements. The GP also attended Sunderland CCG learning events and completed on-line learning to help support his continuing professional development.

Arrangements were in place to provide staff with opportunities for continued learning, including protected time, provision of appraisals and attendance at practice and clinical meetings. The practice had an appropriate induction programme which new staff were expected to complete. A completed induction record was in place for a recently appointed member of staff. We looked at a sample of other records which confirmed staff received an induction and support to enable them to learn about their new role and responsibilities.

We were told practice staffing levels were subject to constant review to ensure they remained relevant and appropriate. It was clearly evident the GP was dedicated to his patients and committed to providing a personal approach that a single-handed practice enabled and required. The feedback we received showed that patients were very happy with the practice and the care and treatment they received. Locum cover was provided when the GP took leave. Feedback received as part of the GPs appraisal arrangements confirmed patients were satisfied with the quality of locum cover provided during their absence.

Working with other services

The practice had made arrangements to promote multidisciplinary working with other services. For example, the practice had an allocated midwife, social worker and health visitor. The GP told us this arrangement promoted multidisciplinary working, and supported the sharing of key information amongst practice professionals.

Out-of-hours care was not provided by the practice. Information on the practice website told patients how to

Are services effective?

(for example, treatment is effective)

access emergency out-of-hours care and treatment. The practice provided out-of-hours and emergency care services, for example the local ambulance service, with access to care plan information for patients who had palliative care or complex health needs. This enabled these services to access important information about these patients in the event of an emergency.

Arrangements had been made which helped to ensure that incoming information, such as blood test results and hospital discharge letters, were dealt with promptly. For example, we were told incoming information was forwarded to the relevant member of staff to enable an appropriate practice response to be made.

Health, promotion and prevention

Arrangements had been made to support people to live healthier lives. Staff demonstrated a commitment to achieving the best possible outcomes for their patients. Health promotion work was carried out by the practice nurse. The training records for the practice nurse showed they had the skills, knowledge and competencies required to carry out health promotion and preventive care and treatment. The practice provided a range of clinic appointments, and other specialist services. Information was available at the practice about health promotion. Free dual testing kits for sexually transmitted diseases were available in the reception area. The practice website included a symptom checker which provided feedback about the best course of action. The website also contained other helpful information such as details of how patients could access local health and social care services. New patients were offered a health assessment on registering with the practice. This included a review of their current health and lifestyle.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice performed as 'better than expected', or 'tending towards better than expected', when compared to other practices in the Sunderland CCG area, with regards to some of the responses from the National GP Patient survey. In other areas of the survey, the practice performed as 'similar to expected.'

When we checked the NHS Choices website, we found that no negative patient comments had been registered. The five patients we interviewed all said they received good quality care and treatment. This was also the feedback we received from the 45 patients who completed CQC comment cards. Without exception, patients praised the GP and his team and only made positive comments.

Patients were treated with kindness, dignity and respect, and their privacy was promoted. For example, privacy curtains were available in the GP and practice nurse consultation rooms. We were told a room could be provided if patients told the receptionist they needed to speak confidentially about a private matter.

Patients we spoke with said they were treated with dignity, and their privacy was respected. Of the patients who responded to the National GP Patient Survey, 81% were satisfied with the level of privacy when speaking to receptionists at the surgery. However, 12% said that other patients could overhear what they said and they were not happy with this. (7% of patients did not respond to the survey question.)

Reception and management staff were observed to be courteous and spoke respectfully to patients at all times. They listened to patients and responded appropriately. Of the patients who participated in the National GP Patient Survey (2013), 94% said they found receptionists at the practice 'helpful'.

Arrangements were in place to offer patients the option of having a chaperone present during their consultation. The practice had a chaperone policy and we confirmed staff had received training in this area. Although information about how to access a chaperone was available in the reception area, the clinical rooms we visited did not have information on display advising patients they could request a chaperone.

Arrangements had been made to provide patients with the support they needed to cope emotionally with their care and treatment. Of those patients who responded to the National Patient GP Survey:

- 99% of patients had confidence and trust in the practice GP.
- 99% of patients said they were given enough time to discuss what they wanted at their appointment;
- 99% of patients said the practice GP was good at listening to them;
- 98% of patients said the Practice GP was good at treating them with care and concern;

Some of the patients we spoke with said they had been referred to various support groups and had been provided with printed information about their particular healthcare conditions. Information about a range of support groups was available on the practice website.

Involvement in decisions and consent

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the National GP Patient Survey, 95% of patients said the GP was good at explaining tests and treatments and 87% said they were good at involving them in decisions about their care. Percentage scores for the practice nurse were slightly lower. Of the patients we spoke with during the inspection, all said they had been involved in decisions about their care and treatment, and that staff had taken time to explain things in an understandable manner. None of the patients who returned CQC comment cards expressed any concerns about their involvement in making decisions about their care and treatment.

The practice had a consent policy which provided staff with guidance about the approach to be followed when seeking patients' consent to care and treatment. The consent policy included a patient consent form which staff were expected to use when obtaining written consent. The GP was clear about when implied consent was sufficient to carry out routine care and treatment contacts with patients. They also understood when expressed consent was required and for what types of clinical interventions.

Are services caring?

The GP spoke knowledgeably about obtaining consent from children and had devised an aide-memoire to ensure he covered of all the necessary points. We looked at the use of best-interest decision-making for patients without capacity to consent. We found the GP had an understanding of what to do in the event that a patient lacked capacity to make a decision about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the diverse needs of the population it served and took action to provide what patients needed. We looked at how the practice met the needs of older patients and patients with long-term conditions. The practice had taken steps to identify patients who would benefit from more support to help them avoid an unplanned hospital admission due to the complexity of their healthcare needs. Older patients had been informed that the GP would act as their named doctor to help improve the continuity of the care they received. Patients with long-term conditions were offered relevant screening tests and health and promotion advice to help them manage their healthcare needs. Practice staff had received training which helped them to meet the needs of older patients and patients with long-term conditions.

Reasonable adjustments had been made which helped patients with disabilities, and patients whose first language was not English to access the practice. For example, some of the consultation rooms and the reception area were on the ground floor. A wheelchair accessible ledge was provided at the reception desk. A disabled toilet was available. A loop system was in place to help patients with hearing needs. An intercom system was in operation at the front entrance that enabled patients with mobility needs to contact reception staff for help and support. Access to an interpreter service was available for use by patients whose first language was not English. We were told this service had been available for the past seven years but that the practice did not use it that regularly as they had very few patients who required this service. The GP told us that recently a small number of Polish families had registered with the practice. He confirmed discussion was underway to look at how their language needs might be addressed.

The practice did not have an active PPG. We were told that some years ago, the practice had taken steps to set up a PPG but this had not worked, and since then no further action had been taken. PPGs are an effective way for patients and the practice to work together to improve the services the practice provides.

Access to the service

The practice opened between 08:30am and 6:00pm each week day. Extended hours appointments were offered between 6:30pm and 7:30pm each Wednesday. Information about opening hours was clearly displayed, both within the practice and on its website. The practice offered patients different ways of accessing appointments. These included accessing appointments by visiting the practice, contacting the practice by telephone and making appointments on-line. Appointments were bookable up to two months in advance.

We were told that following a capacity and demand audit in 2013, a number of changes were made to how the practice responded to same day requests for urgent care. These included: introducing telephone consultations for each surgery session; prioritising by the GP to help ensure patients requesting an emergency appointment or a home visit had their needs assessed promptly; providing patients with access to a small number of appointments that could be booked on-line for each surgery session. The practice charter, contained within the practice brochure, stated that all patients would be seen within 48 hours of their request. We checked the practice appointment system and found that routine appointments were available on the day of our visit for both the GP and nurse.

Of the patients who participated in the National GP Patient Survey: 100% said they found it 'easy' to get through on the telephone to someone at the practice; 97% said the practice opened at times that were convenient to them; 95% said they usually waited 15 minutes or less after their appointment time to be seen and that they didn't normally have to wait too long to be seen. We talked to five patients about their experience of using the practice. None raised concerns about access to appointments.

The practice's brochure provided information about, for example, the range of services offered and how patients could obtain medical support outside of surgery hours. Health promotion literature, and information about services provided at the practice, was also available in the reception area. The practice website provided patients with information about opening hours, how to obtain repeat prescriptions, and what to do in an emergency.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns and complaints

There was a system in place for handling complaints and concerns. The practice had a detailed complaints procedure which provided information about how patients could make complaints and how any complaints received would be handled. Information about to make a complaint was also included in the practice brochure. The practice had a designated responsible person who handled all complaints. The practice had received two formal complaints during the last 12 months. Records of these complaints indicated the practice had taken action to address the concerns raised and that complaints were handled appropriately. A comments book and a suggestion box were available in the reception area. We checked and found none had been received recently.

Are services well-led?

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

Our findings

Leadership and culture

Information we looked at before we carried out the inspection indicated the practice performed similarly to other practices in the local CCG area in relation to the well-led domain. For example, the information indicated all non-clinical team members had an annual appraisal, and the practice nurse had a personal learning plan which had been reviewed at their last annual appraisal.

The latest QOF information available to us showed the practice had performed well with regards to practice management. For example, the practice had:

- A protocol for the identification of patients who were carers and a mechanism for referring them for a social services assessment;
- Systems in place to ensure the regular and appropriate inspection, calibration, maintenance and replacement of equipment.

The GP and their practice manager demonstrated a clear commitment to their patients and meeting their needs. This commitment was reflected in the positive feedback we received from patients who were very satisfied with the care and treatment they received. Leadership presence was notable. The practice manager made them self available to the team and patients throughout the working day. Practice staff worked well together as a team. They were clear about, and competent in carrying out their roles and responsibilities. Staff enjoyed their work and had developed a good rapport with the patients who used the practice.

The GP demonstrated a willingness to work with other professionals to achieve better outcomes for patients. For example, regular clinical meetings took place and involved other community based professionals such as the health visitor and midwife. The practice manager was able to clearly explain the benefits of multi-disciplinary working and the positive impact it had on the provision of care and treatment to patients.

Arrangements were in place which helped the GP and the practice manager to maintain an overview of how the practice operated. For example, the practice had development plans in place covering both the short term and long term development of the practice. Development plans help practice decision-makers reach a clear and shared understanding of the direction the practice is moving. They also help to focus attention on the steps that need to be taken to achieve agreed goals.

Governance arrangements

The service was well-managed and staff listened, learned and took appropriate action to make improvements. There was a clear focus on promoting and achieving clinical excellence in the quality of care they delivered to patients. Staff were committed to achieving the best possible outcomes for patients. The GP and his practice manager promoted an open culture, actively sought feedback from staff and promoted their engagement in helping to improve the services provided to patients. Staff told us they felt valued and said there was a 'real sense of teamwork' in the practice. The staff we spoke with were clear about which leadership roles and responsibilities were held by the GP and practice manager. They told us they were satisfied with the way in which the practice was led and managed.

Patient experience and involvement

The practice did not have an active PPG. We were told that steps had been taken to set up a practice group, but that this had been unsuccessful. We were told the local CCG had set up a locality patient group but this had been dissolved due to poor attendance. The practice website included information about the locality group and a copy of the last set of meeting minutes. However, the website did not include any information about how patients could become involved in a PPG. Supporting and enabling the development of a PPG helps patients to contribute to the continuous improvement of services, ensuring that practices are more responsive to their needs and wishes.

The website included a 'Patient Opinion' page which encouraged patients to share their recent experiences of using NHS services. This enabled the relevant health services to respond to the anonymous feedback practice patients provided.

Of those patients who responded to the National GP Patient Survey:

- 99% of patients reported that they had confidence in the practice GP;
- 99% of patients said the practice GP was good and giving them enough time;

Are services well-led?

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

- 99% of patients said the practice GP was good at listening to them.

Patients provided similar feedback regarding their contact with the practice nurse. For example, 97% said the practice nurse was good at giving them enough time and 91% said they were good at listening to them.

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

The practice recognised the importance of the views of patients and those close to them, and it was clear that they placed considerable emphasis on listening to patients on a day-today basis. Patients were encouraged to send any comments or suggestions they had via the practice website. The practice had also carried out its own in-practice patient survey. The feedback received was very positive about the care and treatment provided at the practice. All of the additional comments made by patients were positive. Patients did not identify any concerns.

We looked at 45 comment cards that patients had completed prior to the inspection and spoke with five patients on the day of the inspection. Patients told us they were satisfied with the care and treatment they received from the practice. Patients spoke highly of the practice team and felt they were well looked after. No concerns were raised by any of the patients we received feedback from during this inspection.

Management lead through learning & improvement

The practice had put systems in place which enabled learning and supported staff to improve their performance. All staff whose records we looked at had received an annual appraisal. However, a training and development plan was not in place for each of these staff. The GP and practice nurse undertook continuing professional development in line with their registration. The GP had made arrangements to satisfy the GMC's revalidation requirements. (Re-validation is a process in which GPs have to provide evidence of their continuing fitness to practice.) The practice nurse had completed five training courses in the last eight months. We found evidence that new staff had received an induction to help them carry out their role and responsibilities. Other staff had also completed training relevant to their role.

Staff we spoke with were clear about their duties and responsibilities, and knew who they were accountable to and for what. We observed good team work and saw that staff worked well together to address any concerns and to meet patients' needs.

Identification and management of risk

Systems had been put in place to identify and minimise any risks to the delivery of patient care and treatment. A business contingency plan had been devised to help ensure that patient care could continue in the event of a foreseeable emergency. The staff we spoke to knew how to report any concerns and felt confident about reporting significant events. The practice notified the local CCG of any concerning incidents via an agreed reporting system. The practice had a process in place for reviewing and learning from significant events, and staff we spoke to felt the approach used by the practice helped them to learn from any errors. A member of the reception team was able to describe how they reported a significant event, and spoke confidently about the improvements that had subsequently been made.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice planned and delivered services aimed at meeting the needs of older people. We were told the practice had taken steps to implement a proactive care programme aimed at preventing unplanned admissions of older people into hospital. This included using a specialist risk assessment tool to help identify the most vulnerable patients who were at risk of unplanned hospital admission due to the complexity of their healthcare conditions and needs.

The practice had produced a register of patients who they considered might be at risk of an unplanned emergency admission into hospital. The practice manager said the GP had made a decision to provide additional care and support to all of the patients identified on the list, rather than just to 2% of the patient population as required. We were told the practice had begun writing to each patient to make them aware they were on the list. We looked at the letter sent out by the practice. It provided a good level of information about how the practice would provide the extra support, who would do this and what information would be shared with other professionals involved in their care. We were told the care plan template attached to the letter would be used to record details of their needs, and how those needs would be met and coordinated by the practice. The practice had also written to each patient aged 75 years and over, confirming the practice GP would act as their named doctor and care coordinator. Providing a named GP helps improve continuity of care and the coordination of services for patients. We were told a discussion was presently taking place about other undiagnosed patients who they considered might benefit from a dementia risk assessment because of their age, health and circumstances.

We were told that, where the practice had been made aware of a patient's discharge from hospital, action would be taken to invite them in for a review of their medicines within 72 hours of their returning home. We found the practice had a safe system in place which helped to ensure they made a prompt response to any hospital discharge letters they received.

The practice had taken steps to ensure its staff had the knowledge, skills and competence to respond to the needs of older people. We saw evidence confirming the practice nurse had undertaken training which helped them to meet the needs of older people with a range of complex conditions. For example, they had completed training in: smoking cessation; diabetic management; ear irrigation; practical electrocardiography; sexual health; prescribing drugs and administering vaccinations and immunisations. The nurse had also completed a diploma in the care of patients with chronic obstructive pulmonary disease. Information relevant to the needs of older people was available in the reception waiting area and on the practice web site.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We were told the practice nurse was responsible for the delivery of chronic disease management. The practice offered patients access to a variety of clinics and services. This included daily clinics of varying appointment lengths for patients with long-term conditions such as dementia, diabetes and asthma. We were told the practice used the 'Two-Visit' approach to working with patients with long-term conditions. This involved patients undergoing relevant screening tests before attending a second visit to discuss results. The length of appointments with the practice nurse varied depending on the type of consultation taking place. We were told the second visit focused on setting achievable personal goals and action plans with the patient, and encouraging and promoting their capacity to manage their own health. The practice had seven patients with a diagnosis of dementia and all had a care plan, and had been referred to a local memory clinic.

The practice made use of information technology to help them with their patient 'call and recall' system. We were told regular QOF checks were carried out to identify which patients on each of the chronic disease registers were due for a health review. We were told the system worked well.

We were told the practice had taken steps to implement a proactive care programme aimed at preventing unplanned admissions of patients with long-term conditions into hospital.

The practice had taken steps to improve medicine safety for patients with long-term conditions by putting arrangements in place to respond promptly to incoming hospital discharge letters, and other letters and notifications.

The practice had taken steps to ensure its staff had the knowledge, skills and competence to respond to the needs of patients with long-term conditions. We have included more details about the training completed by the practice nurse in the Older Persons Population Group section above.

The practice had made arrangements to support and enable multi-disciplinary working. For example, 'Special Patient Notes' (SPN) had been prepared for patients with complex health and social care needs that were nearing the end of their life. We were told information about the needs of this group of patients had been entered onto a clinical patient management system which could be accessed by out-of-hours primary care and emergency services professionals.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of mothers, babies, children and young people. The latest QOF information we had access to showed the practice had obtained the maximum number of points for the additional services they provided. These included: the provision of ante-natal care; screening and child development checks at intervals consistent with national guidelines and contraceptive advice to young people.

Women who might be pregnant could have a pregnancy test carried out by the practice. We were told that once the results had been received, the patient would be given an appointment with the GP to discuss the outcome. On confirmation of pregnancy, we were told a referral would be made to the community midwifery service. Women received a one hour appointment at a local health centre led by the midwife attached to the practice. We were told this appointment was used by the community midwife to ask questions about the patient's general health, family and social history and previous pregnancies. The midwife also assessed whether there were any potential risk factors associated with the pregnancy. If concerns were identified, we were told the midwife would make a referral to the GP if they thought medicines might need to be prescribed, or to a specialist consultant or midwife if a pregnancy was thought to be high-risk.

Arrangements were in place to support women to access both ante-natal and pre-natal care. Clinical staff, including the community based midwife, signposted women to local support groups.

A pamphlet provided by Sunderland Children's Centre was available in the reception area. This provided advice on the activities and support groups taking place within the local area, such as, for example: a teenage ante-natal clinic, Young Parent Plus, Bosom Buddies (breastfeeding advice) and Baby Days which offered useful information and advice for new mothers.

The practice manager told us women were provided with an individualised ante-natal and post-natal care plan. These included details of the healthcare professionals involved in their care, and information about the support they would receive after giving birth as well as what to do in the event of an emergency. Pregnant women who smoked were automatically referred to a smoking cessation service at their first booked appointment.

The practice provided mothers and new babies with access to a weekly baby clinic where vaccinations and immunisations were administered by the practice nurse between 11:00am and 12:30am.

Free Chlamydia and Gonorrhoea testing kits were available in the waiting room along with health information about these conditions. The provision of this service helped young people to test for these conditions in the comfort of their own home, and encouraged them to seek advice and help at the practice. The practice had adopted the C Card initiative within the practice. (The C Card is a nationwide initiative carried out a local level, which is targeted at reducing teenage pregnancies.) This meant young people registered with the practice were able to access free condoms.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice had taken action to plan its services to meet the needs of the working age population, including those that had recently retired. 97% of respondents to the National GP Survey said they were satisfied with the practice's opening times and 92% described their experience of making an appointment as good. The practice's opening hours were from 08:30am to 6:00pm. Extended hours were provided each Wednesday up to 7:30pm in line with the number of patients registered with the practice.

Patients were able to access appointments either by telephone, calling in at the reception desk or on-line via the practice web site. The practice website provided patients with access to a YouTube video informing them how to book new appointments, order repeat prescriptions and change address details. It also provided working age patients with helpful information about health and social care services operating within the local area. A link was provided which enabled patients to access a range of information leaflets written by an expert team of GPs.

Patients were also able to access a symptom checker to help them assess their own health and wellbeing. (The symptom checker is a tool which provides patients with feedback about their best course of action based on the symptoms they have entered.)

Information about how to access carer support groups was available on the practice website, and in the reception area. This included support to access multi-media information about carers such as Facebook and Twitter. The practice ran carer initiative schemes which identified patients who acted as carers, and ensured they were provided with an opportunity to undergo an annual health check. We were told the carer initiative scheme helped to ensure that the practice's carers' register was up to date.

Patients were able to access further services within the practice such as midwife appointments and counselling services. Providing these additional services makes it easier for working patients to access them. Patients were also able to benefit from using 'Choose and Book', which is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a clinic or hospital.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice planned and delivered services aimed at meeting the needs of vulnerable patients who might it difficult to access primary care.

We looked at the most up-to-date QOF (2012/13) information we had access to for this practice. We saw that the percentage of patients with learning disabilities on the practice list was 0.25% (five patients.) The practice was able to produce a register of patients aged 18 years and over with learning disabilities. An alert flag had been placed on each patient's medical records to ensure that all staff would know about their learning disabilities. We were told that some of the patients with learning disabilities also had other conditions, and that their needs in these areas were addressed via chronic disease clinics carried out by the practice nurse. We were able to confirm that, in addition to this, arrangements had also been made for this group of patients to receive an annual health check. A patient 'call and recall' system was in place which meant any follow-up appointments and future reviews were added to the calendar system used by the practice.

The practice manager told us they had very small numbers of patients within the practice population that could be classed as having poor access to healthcare because of their vulnerability. For example, there were no sex workers registered with the practice, and the practice population did not include any members of the travellers' community, or asylum seekers. The practice had a small number of patients who were identified as 'looked after' children. Alerts had been placed on the practice system to identify who these children were.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice had made arrangements to meet the needs of patients experiencing poor mental health. For example, the most recent QOF information available to us showed that the practice had identified patients with dementia and produced a register to help them deliver services to this group of patients. The practice obtained the majority of QOF points available to them for the dementia care and treatment they delivered. This showed they were following best practice in this area. We found that: 100% of patients diagnosed with dementia had had their care reviewed in the preceding 15 months; The majority of patients identified on the practice's mental health register had a comprehensive care plan documented in their records which had been agreed with them and their supporters. The practice provided us with feedback which explained why the remaining three patients did not have a care plan/ review documented.

We were told that, where it was considered appropriate, the GP would refer patients to appropriate secondary services for further assessment and treatment. This included referrals to the Improving Access to Psychological Therapies (IAPT) services, and counselling and memory clinics for patients with dementia. (IAPT is an NHS programme rolling out services across England offering interventions approved by the NICE for treating people with depression and anxiety disorders.) The practice also made referrals to local social services mental health teams where it was felt patients would be benefit from immediate treatment and support. The practice also signposted patients to the local MIND service which is an independent charity for local people with mental health needs. A range of leaflets was available in the reception area, including one informing patients how to access the local Sunderland MIND. Patients could also see a community psychiatric nurse or a counsellor from Sunderland MIND by appointment at the surgery.

The practice had the knowledge, skills and competence required to respond to the needs of patients experiencing poor mental health. For example, the GP had completed continuing professional development in dementia care and the practice manager had completed a mental health course. However, none of the records we looked at confirmed the GP and practice nurse had completed training in suicide prevention or mental health.

The practice supported patients' needs in relation to health promotion and the prevention of ill-health. For example, the practice provided patients with information about how they could access local support groups, as well information on health, wellbeing and recovery. Of those patients who responded to the 2013 in-practice patient survey:

- 92% of patients said the doctor and nurse who treated them helped them to understand their condition;
- 93% of patients said the doctor and nurse who treated them helped them to cope with their condition;
- 91% of patients said the doctor and nurse who treated them helped them to keep healthy.