

# St Albans Medical Group

## Quality Report

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

### Ratings

#### Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

This announced comprehensive inspection was carried out on the 15 February 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified at our previous inspection on 1 March 2016. Overall the practice is now rated as good.

On 1 March 2016 we carried out an announced comprehensive inspection at St Albans Medical Group. The overall rating for the practice was requires improvement, having being judged as requires improvement for Safe and Well Led services. The full comprehensive report on the March 2016 inspection can be found by selecting the 'all reports' link for St Albans Medical Group on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

After the comprehensive inspection the practice wrote to us to say what they would do to meet the following legal requirements set out in the Health and Social Care Act (HSCA) 2008:

- Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

At our inspection of 15 February 2017 we found that:

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

# Summary of findings

- The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.
- The practice had reviewed access to appointments at the surgery, which included the introduction of telephone triage, extended access had been provided every weekday morning.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- The practice was aware of and complied with the requirements of the Duty of Candour regulation.

We saw one area of outstanding practice which was:

- The community linking project at the practice enabled the GPs and nurses to refer patients to a range of local, non-clinical services which lead to positive health and well-being outcomes. The project is the only one in the clinical commissioning group area that has been classified as Gold Standard by NHS England, it had been set up by

the practice. It had been awarded a NHS Alliance Trojan Mouse Award from the Kings Fund, for introducing changes in practice which leads to positive change in the life of a person or community. An evaluation of the project for the last six months of 2016 showed that 107 patients were referred from the practice and 72 were referred to other services which included, for example, citizen's advice bureau, social services and voluntary services.

The areas where the provider should make improvements are:

- Include information in response to complaints and for the practice complaint information leaflet to explain the process of taking the complaint further such as to NHS England or The Parliamentary and Health Service Ombudsman.
- Have a system in place to ensure the shared Health Centre defibrillator is being checked correctly by NHS properties staff.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. The practice had taken action to address the areas which required improvement during our previous inspection in March 2016.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.

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

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.

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

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

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

Good



### Are services effective?

The practice is rated as good for providing effective services.

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

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above the local clinical commissioning group (CCG) and national averages. They had achieved 100% of the points available to them for 2015/16 (CCG average 96.1%, national average 95.3%). The data for 2015/16 showed that the practice had received maximum points for all of the 19 clinical domain indicator

Good



# Summary of findings

groups, which included which included asthma, heart failure and chronic obstructive pulmonary disease (COPD) indicators. There was a system in place for clinical audit and the practice provided us with a programme of completed audits and suggested future audits.

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

The community linking project at the practice enabled the GPs and nurses to refer patients to a range of local, non-clinical services which lead to positive health and well-being outcomes.

## Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Data from the National GP Patient Survey showed scores from patients were above local and national averages. For example, 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.

There were 243 patients registered as a carer which was 2.9% of the practice population. There was written information available for carers to help them understand the various avenues of support available to them in the practice waiting room. The practice had a separate young carers list and had access to a young carer who could act as an advocate.

Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect.

Good



## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

The practice reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified. The practice provided a good range of services for patients for example; enhanced services for the monitoring of prostate cancer, diabetes, rheumatology, heart failure and osteoporosis. Patients said they could make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day and there were extended opening hours.

The practice had a system in place for handling complaints and concerns.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for being well-led. The practice had taken action to address the areas which required improvement during our previous inspection in March 2016.

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

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

There was a governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice had a business plan for 2016/2017 which set out what they planned to achieve

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

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

Good



# Summary of findings

## The six population groups and what we found

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

### Older people

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

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, patients at high risk of hospital admission and those in vulnerable circumstances had care plans in place and if appropriate were discussed at monthly multi-disciplinary meetings. There was a GP follow up telephone call (or visit if appropriate) to the patient within two days of hospital discharge. The practice had a complex care team of three GPs and three nurse practitioners. The practice had access to the community link worker, to support the care of complex elderly patients.

The practice maintained a palliative care register and end of life care plans were in place for those patients it was appropriate for. The practice was developing the use of Gold Standards Framework for patients with palliative care needs. One of the salaried GPs worked in a hospice one day per week and held a diploma in palliative care.

They offered immunisations for pneumonia and shingles to older people and in their own home where necessary. Prescriptions could be sent to any local pharmacy electronically.

The practice provided care to patients living in two care homes; one of the GPs was the link for this and carried out weekly ward rounds and care plans. They worked closely with senior carers and the management of the care homes. There was also link working with the older person's specialist nurse.

The practice provided care to a local intermediate care facility for the complex and frail elderly. There was a dedicated GP available every day to access any patient with acute medical need at the centre. The practice provided the medical component of the assessment for new patients at the centre. They attended a weekly multi-disciplinary team meeting. A discharge summary was provided to the patient's usual GP on their discharge from the centre.

Two of the GP partners were clinical advisors, working one session each per week, to the care home vanguard in the clinical commissioning group area and at national level. Vanguard projects are projects in pilot areas aimed at creating more integrated services between health and social care.

Good



# Summary of findings

## People with long term conditions

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

Nationally reported QOF data (2015/16) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. The practice had received maximum points for all 19 clinical domain indicator groups, which included asthma, heart failure, diabetes and chronic obstructive pulmonary disease (COPD) related indicators.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Effective call and recall systems were in place, which helped ensure patients with long-term conditions received an appropriate service, which met their needs. These patients all had a named GP and received an annual review to check that their needs were being met. For those people with the most complex needs, the named GP worked with other relevant health and care professionals to deliver a multidisciplinary package of care. Visits were available by practice nurses for housebound patients with long term conditions.

The year of care project, which provides personalised care to patients to provide shared goals and action plans to enable them to self-manage their condition, had been implemented across a range of long-term conditions and the practice were a pilot for this. One of the nurse practitioners was trained to deliver this approach to other nurses in the locality.

The practice provided enhanced services for the monitoring of prostate cancer, diabetes, rheumatology, heart failure and osteoporosis.

Good



## Families, children and young people

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. We saw good examples of joint working with midwives, health visitors and school nurses.

Immunisation rates were in line with clinical commissioning group (CCG) and national averages. For example, the practice had achieved above the 90% target for all four sub-indicators for childhood immunisation rates for children up to age two.

Appointments were available outside of school hours and the premises were suitable for children and babies.

The community link worker who worked at the practice arranged for cards to be sent to patients on their 16th birthday which advised

Good





# Summary of findings

them of the services the practice could offer and that there was a young person's representative working in the reception of the practice. The practice had recently recruited a patient who was their young person health champion to consult with and improve access for young people.

## **Working age people (including those recently retired and students)**

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. There was a full range of health promotion and screening that reflected the needs for this age group. Flexible appointments were available, including telephone consultations and early morning access.

**Good**



## **People whose circumstances may make them vulnerable**

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

The practice regularly worked with multi-disciplinary (MDT) teams in the case management of vulnerable people. The community linking project at the practice enabled the GPs and nurses patients to a range of local, non-clinical services which lead to positive health and well-being outcomes.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Where appropriate, patients with complex conditions were discussed amongst the clinicians at their regular MDT meetings.

The practice held a register of patients living in vulnerable circumstances including patients with learning disabilities. Staff carried out annual health checks for patients who had a learning disability and offered longer appointments.

One of the GP partners was trained to level two for substance misuse and held a weekly joint clinic with the drug and alcohol abuse service in the practice.

The practice's computer system alerted GPs if a patient was a carer. There were 243 coded on the practice system which was 2.9% of the practice population.

**Good**



# Summary of findings

## People experiencing poor mental health (including people with dementia)

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

Nationally reported QOF data (2015/16) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. The practice had received maximum points for all 19 clinical domain indicator groups, which included dementia and mental health.

The practice maintained a register of patients experiencing poor mental health and recalled them for regular reviews including those patients experiencing dementia. Patients were advised how to access various support groups and voluntary organisations. Where appropriate patients with complex conditions were discussed amongst the clinicians at their regular MDT meetings.

Good



# Summary of findings

## What people who use the service say

We spoke with six patients on the day of our inspection; they were all patients who had recently attended a patient champion group. They all were very positive about the service they received from the practice. Common words used included good, friendly and helpful.

We reviewed nine CQC comment cards completed by patients prior to the inspection. The cards completed were positive, with the exception of one. Common words used to describe the practice included, very good, polite, caring and kind.

The latest GP Patient Survey published in July 2016 showed that scores from patients were above average in almost all areas. The percentage of patients who described their overall experience as good was 93%, which was above the local clinical commissioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 90% (local CCG average 82%, national average 79%).
- 96% said the GP was good at listening to them compared to the local CCG average of 91% and national average of 89%.

- 89% said the GP gave them enough time compared to the local CCG average of 90% and national average of 87%.
- 97% said the nurse was good at listening to them compared to the local CCG average of 93% and national average of 91%.
- 98% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 85% said they found it easy to get through to this surgery by phone compared to the local CCG average 78%, national average 73%.
- 83% described their experience of making an appointment as good compared to the local CCG average 76%, national average 73%.
- 93% said they find the receptionists at this surgery helpful compared to the local CCG average 89%, national average 87%.

These results were based on 110 surveys that were returned from a total of 276 sent out; a response rate of 39% and 1.3% of the overall practice population.

## Areas for improvement

### Action the service **SHOULD** take to improve

- Include information in response to complaints and for the practice complaint information leaflet to explain the process of taking the complaint further such as to NHS England or The Parliamentary and Health Service Ombudsman.

- Have a system in place to ensure the shared Health Centre defibrillator is being checked correctly by NHS properties staff.

## Outstanding practice

- The community linking project at the practice enabled the GPs and nurses to refer patients to a range of local, non-clinical services which lead to positive health and well-being outcomes. The project is the only one in the clinical commissioning group area that has been classified as Gold Standard

by NHS England; it had been set up by the practice. It had been awarded a NHS Alliance Trojan Mouse Award from the Kings Fund, for introducing changes in practice which leads to positive change in the life of a person or community. An evaluation of the project for the last six months of 2016 showed that

# Summary of findings

107 patients were referred from the practice and 72 were referred to other services which included, for example, citizen's advice bureau, social services and voluntary services.

# St Albans Medical Group

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector; the team included a GP specialist advisor.

## Background to St Albans Medical Group

St Albans Medical Group is registered with the Care Quality Commission to provide primary care services to predominantly the Felling and other areas of Gateshead from Felling Health Centre, Stephenson Terrace, Felling, Gateshead, NE10 9QG. We visited this address as part of the inspection.

The practice provides services to just over 8,400 patients of all ages. They are part of the NHS Newcastle Gateshead clinical commissioning group (CCG). The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice had previously provided services from a branch surgery in the Bede Centre in another area of Gateshead which closed following a flood, approximately a year ago; the practice was awaiting a decision from NHS England on the position of the closure.

The practice has four GP partners, who work 30 sessions per week between them; there are two salaried GPs both who work six sessions per week. Five are female and one male. There are three nurse practitioners whole time equivalent (WTE) 2.5, two practice nurses WTE 1.5 and two healthcare assistants 1.4 WTE. There is a community link worker attached to the practice. There is a practice development manager who is seconded to the practice for

20 hours per week until April 2017. There is a practice administrator and two reception supervisors. There are seven administration and reception staff. The practice is a training practice that has GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general medical training programme).

The surgery is open from 7:30am to 6pm, Monday to Friday. The consultation times are between 7:30am and 6pm Monday to Friday. Phone lines for appointments and other routine requests are open between 8:30am to 6pm each weekday.

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

Information taken from Public Health England placed the area in which the practice was located in the second most deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The average male life expectancy is 76 years and the average female life expectancy is 80 years, both of which are three years lower than the England average.

The percentage of patients reporting with a long-standing health condition is much higher than the national average (practice population is 71.9% compared to a national average of 56.9%). Higher numbers can indicate an increased demand for GP services.

## Why we carried out this inspection

We undertook a comprehensive inspection of St Albans Medical Group on 1 March 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory

# Detailed findings

functions. The practice was rated as requires improvement providing safe and well-led services and good for effective, caring and responsive services. We asked the practice to provide us with an action plan confirm how they were going to meet legal requirements. The full comprehensive report on the March 2016 inspection can be found by selecting the 'all reports' link for St Albans Medical Group on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

We undertook a follow up comprehensive inspection on 15 February 2017 to check that action had been taken to comply with legal requirements.

## How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

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

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

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 15 February 2017.
- Spoke with staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.

Reviewed a sample of the practice's policies and procedures.

# Are services safe?

## Our findings

At our previous inspection on 1 March 2016, we rated the practice as requires improvement for providing safe services. The practice could not assure us that the arrangements in respect of the management of medicines were safe and that arrangements were in place to control the potential spread of infections.

These arrangements had significantly improved when we undertook a follow up inspection on 15 February 2017. The practice is now rated as good for providing safe services.

### Safe track record and learning

At our previous inspection we said that non-clinical staff's knowledge of significant events was limited.

At this inspection we saw that systems had been improved. All staff were fully aware of the significant event process and they could tell us about events they had raised.

Significant events were discussed at the fortnightly education meetings in the practice, or earlier if required. There was also a quarterly forum to discuss significant events. We saw examples of these; they all had learning outcomes and action points raised. Events were then added to the local clinical commissioning group's (CCG) Safeguard Incident & Risk Management System (SIRMS), where incidents and events met the threshold criteria. There had been twelve significant events in the last year.

The practice's ethos complied with the requirements of the Duty of Candour. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

There was a system in place to manage the safety alerts. The practice administrator managed this process. They ensured this was effective and that decisions were made by the appropriate person and the alerts were acted on accordingly. All alerts were stored in a folder. The medicines optimisation pharmacist would be passed all the safety alerts appropriate to medicines and they managed these.

### Overview of safety systems and processes

At our previous inspection we saw that the practice had some systems, processes and practices in place to keep people safe. At this follow up inspection we saw that improvements had been made:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level three for children.
- There was a notice displayed in the waiting area, advising patients that they could request a chaperone, if required. The practice nurses and health care assistants carried out this role. They had all received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We confirmed they had received chaperone training.
- At our previous inspection in March 2016 we saw that the practice did not have suitable arrangements in place to assess, prevent and control the spread of infections. The practice could not demonstrate that privacy curtains in treatment rooms were changed on a regular basis; staff had not received appropriate training for infection control. Some concerns, for example, the signing and dating of sharps boxes on construction were not picked up by an infection control audit.
- We saw at this inspection that appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. Issues from the previous inspection had been addressed. One of the practice nurses was the infection control lead; they and the staff had received relevant infection control training to their role. There were infection control policies in place, an audit had been carried out and concerns addressed. Regular infection control and hand hygiene audits had been carried out and where actions were raised these had been addressed. There were spillage kits available.
- At our previous inspection we saw that the practice did not have suitable arrangements in place for the proper

## Are services safe?

and safe management of medicines. The practice did not have a suitable medicines refrigerator and the calibration of the temperature of the refrigerator was not acceptable.

- We saw at this inspection that the arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording and handling.). Prescription pads were securely stored and there were systems in place to monitor their use. Vaccines were suitably stored and monitored. Daily temperature checks of the vaccine refrigerators were carried out and appropriate records were maintained. 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.) The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacist, who also produced a quarterly medicines optimisation report.
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We reviewed a sample of recruitment files for both staff and GPs, including locums, and saw that checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. We saw that the clinical staff had medical indemnity insurance.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. The policies and risk assessments had been complied in line with NHS property services policy, they owned the building. The practice development manager who had received specialised training in health and safety had carried out risk assessments in May 2016. The staff at the practice had all been trained in health and safety. There was a fire safety risk assessment. There were two trained fire wardens in the building and staff had received fire safety training. There had been a fire drill carried out in the last year. All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The GPs met twice yearly to discuss annual leave and cover arrangements and locums would be sought if necessary. Many of the staff worked part-time which meant there was flexibility to cover each other's leave.

### Arrangements to deal with emergencies and major incidents

Staff had received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen, which were shared with the other practice in the building. Although the caretaker carried out a check of this equipment, the practice did not have a system in place to ensure it had been checked and was effective. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

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



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The staff kept themselves up to date via clinical and educational meetings. This information was used to develop how care and treatment was delivered to meet patient needs.

### Management, monitoring and improving outcomes for people

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

The latest publicly available data from 2015/16 showed the practice had achieved 100% of the total points available to them which was above the local clinical commissioning group (CCG) average of 96.1%, and a national average of 95.3%, with an overall exception reporting rate of 12.7%, which was above the England average of 9.8%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. All exceptions were reviewed by the nurse manager and discussed with the GP partners; a standard template for this was used.

The data for 2015/16 showed that the practice had received maximum points for all 19 clinical domain indicator groups, which included asthma, dementia, heart failure and mental health indicators. This practice was not a statistical outlier for any QOF (or other National) clinical targets. Outcomes for patients were consistently better than expected when compared with other similar services.

All staff were actively engaged with activities to monitor and improve quality and outcomes. The practice provided us with a spreadsheet of completed audits and suggested

future audits. There had been 18 in the last 12 months. These were triggered by new clinical guidance, significant events, personal interest, changes in prescribing practice and monitoring of effectiveness.

There was an audit carried out looking at proactive care and discharge letters at a residential care facility which promoted independence, for which the practice provided care. The second audit cycle showed that 84% of patients had a baseline assessment of which none had previously. The second cycle showed a reduced number of unplanned care contacts with GPs from an average of 3.4 per patient to 2 in the second audit cycle.

### Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered topics relating to the responsibilities of their job role.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. The operations manager carried out a quarterly review of training to ensure staff were up to date with training. All staff had received an appraisal within the last twelve months. We saw examples of these. Staff told us they felt supported in carrying out their duties.
- All GPs in the practice had received their revalidation (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.). The practice was a training practice that had GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general medical training programme).
- At our previous inspection the practice had identified training as an area for improvement. The practice had purchased an on-line training computer package which they said they staff found easy to use. Staff had received training which included: fire and health and safety, basic life support, being open, safeguarding children and adults, infection control, counter fraud and information governance awareness. Clinicians and practice nurses

# Are services effective?

## (for example, treatment is effective)

had completed training relevant to their role. Both of the supervisors of the administration staff were being supported by the practice to carry out a management course. The practice had training booked on autism awareness for staff.

### Coordinating patient care and information sharing

The practice had systems in place to plan and deliver care. Information on care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

One of the GP partners was trained to level two for substance misuse and held a weekly joint clinic with the drug and alcohol abuse service in the practice.

Staff worked together and with other health and social care services. Multi-disciplinary team (MDT) meetings took place monthly; the district nurse, health visitor and social worker attended where possible. At these meetings data and knowledge of patients was used to identify high risk patients who may have needed follow-up contact or a care plan put in place. There was a GP follow up telephone call (or visit if appropriate) to the patient within two days of hospital discharge. The practice had access to a community matron nurse practitioner and neurology nurse practitioner and the community link worker, to support the care of complex elderly patients.

The practice had a palliative care register which was discussed at the monthly MDT meeting in order to manage the care, treatment and support of these patients. The practice was developing the use of Gold Standards Framework for patients with palliative care needs. The Gold Standards Framework gives training to all those providing end of life care to ensure better lives for people and recognised standards of care. One of the salaried GPs worked in a hospice one day per week and held a diploma in palliative care.

Two of the GP partners were clinical advisors, working one session each per week, to the care home vanguard in the locality. Vanguard projects are projects in pilot areas aimed at creating more integrated services between health and social care.

### Consent to care and treatment

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

### Health promotion and prevention

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

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 81%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates were in line with clinical commissioning group (CCG) and national averages. For example, the practice had achieved above the 90% target for all four sub-indicators for childhood immunisation rates for children up to age two.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the health care assistant or practice nurse or the GP if appropriate. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

There was a community linking project at the practice, which is a social prescribing project. Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services which lead to positive health and well-being outcomes. The project was originally set up and funded jointly by the practice and the local CCG. It has since been taken on and funded by a local charity. The project was the only one in the locality and had been classified as Gold Standard by

# Are services effective?

(for example, treatment is effective)

NHS England and the local CCGs. It had been awarded a NHS Alliance Trojan Mouse Award from the Kings Fund, for introducing changes in practice which leads to positive change in the life of a person or community.

The community link worker at the practice attached to the project supported patients who attended the practice with non-medical issues to access appropriate local services, activities, groups and networks. This project took a holistic view of the patients' needs, recognising the wider social problems that can impact on the health and wellbeing of patients. We spoke with a number of patients who had come into contact with this project. All spoke very highly of the support they had received and what this meant for them personally, including help to access resources, increased social inclusion and support with obtaining work. The GPs we spoke with told us they had implemented a very simple referral process to this project and the criteria for referral was very flexible.

The project was able to refer patients who met the criteria for counselling, with a one to two week wait which reduced waiting times. The project secured passes to patients to gain 12 weeks free access to the local leisure centre. The community link worker arranged for cards to be sent to patients on their 16th birthday which advised them of the services the practice could offer and that there was a young person's representative working in the reception of the practice.

An evaluation of the project for the last six months of 2016 showed that 107 patients were referred from the practice and 72 were referred to other services which included, for example, citizen's advice bureau, social services and voluntary services.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

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

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

We spoke with six patients on the day of our inspection; they were all patients who had recently attended a patient champion group. They all were very positive about the service they received from the practice. Common words used included good, friendly and helpful.

We reviewed nine CQC comment cards completed by patients prior to the inspection. The cards completed were positive, with the exception of one. Common words used to describe the practice included, very good, polite, caring and kind.

The practice told us they had recognised that waiting times for transport to hospital, if required, in urgent cases from the surgery were long. Because of this reason the practice had an account with a local taxi company; at their expense they could provide instant transport to hospital for patients.

Results from the National GP Patient Survey in July 2016 showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was above local and national averages for its satisfaction scores. For example, of those who responded:

- 96% said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 96% and the national average of 95%.

- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 93% said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey showed scores for GPs were almost all higher than local and national averages in relation to involvement in planning and making decisions about their care and treatment. For example:

- 96% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 89% said the GP gave them enough time compared to the local CCG average of 90% and national average of 87%.
- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 97% said the nurse was good at listening to them compared to the local CCG average of 93% and national average of 91%.
- 98% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.

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

### Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included information regarding living alone, carer support, public health awareness and information for veterans.

## Are services caring?

The practice's computer system alerted GPs if a patient was a carer. Carers were coded on the practice computer system. (Clinical coding is the translation of clinical terminology as written by a clinician into statistical code which can then be searched upon at a later date). There were 243 coded on the practice system which was 2.9% of the practice population. There was written information available for carers to help them understand the various avenues of support available to them in the practice waiting room. The practice had a separate young

carers list and had access to a young carer who could act as an advocate. An advocate helps people make informed choices, speaks up on their behalf and listens to their needs.

Staff told us that if families had suffered bereavement, depending upon the families wishes the GP would telephone or visit to offer support and if appropriate the practice would send a sympathy card to the family.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

For example, the practice had a social prescribing project in place to help meet the non-medical needs of patients. This was part funded by the CCG and a local voluntary sector organisation.

The practice provided care to patients living in two care homes; one of the GPs was the link for this and carried out weekly ward rounds and care plans. They worked closely with senior carers and the management of the care homes. The practice provided care to a local intermediate care facility for the complex and frail elderly.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Effective call and recall systems were in place, which helped ensure patients with long-term conditions received an appropriate service, which met their needs. These patients all had a named GP and received an annual review to check that their needs were being met. For those people with the most complex needs, the named GP worked with other relevant health and care professionals to deliver a multidisciplinary package of care. Visits were available by practice nurses for housebound patients with long term conditions.

The year of care project, which provides personalised care to patients to provide shared goals and action plans to enable them to self-manage their condition, had been implemented across a range of long-term conditions and the practice were a pilot for this. One of the nurse practitioners was trained to deliver this approach to other nurses in the locality.

The practice completed an analysis to improve their understanding of patient behaviour in accessing services. This informed them to make a decision to change their skill mix. They employed two additional nurse practitioners which had success at improving access and reducing workload pressure for the clinical team.

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

- The practice offered extended opening times and was open from 7.30am each week day morning.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- The practice provided enhanced services for the monitoring of prostate cancer, diabetes, rheumatology, heart failure and osteoporosis.
- A family planning service was available which included IUD also known as coil) and contraceptive implant fitting and removal service.
- Patients were able to receive travel vaccinations by appointment with the practice nurse.
- There were disabled facilities, a hearing loop and translation services available.
- The practice delivered a substance misuse service.

### Access to the service

The practice was open from 7:30am to 6pm, Monday to Friday. The consultation times were between 7:30am and 6pm Monday to Friday. Pre-bookable appointments could be booked up to six weeks in advance; urgent appointments were also available for patients that needed them. The practice had reviewed access to appointments at the surgery, which included the introduction of telephone triage, extended access had been provided every weekday morning.

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

- 88% of patients were satisfied with the practice's opening hours compared to the local CCG average of 81% and national average of 76%.
- 85% said they found it easy to get through to this surgery by phone compared to the local CCG average 78%, national average 73%.

# Are services responsive to people's needs?

(for example, to feedback?)

- 83% described their experience of making an appointment as good compared to the local CCG average 76%, national average 73%.

The practice had an action plan to address some of the results from the National GP Patient Survey as they felt they could achieve some higher scores. There were actions in place to improve the appointment system and to look at the possibility of increasing the time slots for the GP appointments.

## **Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual

obligations for GPs in England. The operations manager was the designated responsible person who handled all complaints in the practice. Complaints and lessons to be learned were discussed at practice meetings.

There had been 11 complaints in the last twelve months. The practice had a practice specific information leaflet for patients wishing to make a complaint available at the reception. We looked at the responses to some of the complaints and saw where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. However, the practice information leaflet and the responses to the complaints did not contain information about taking the complaint further such as to NHS England or The Parliamentary and Health Service Ombudsman.



# Are services well-led?

Good 

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

## Our findings

At our previous inspection on 1 March 2016, we rated the practice as requires improvement for being well-led as there was no business development plan, there were only some governance arrangements in place and the practice had not actively sought feedback from patients to improve services.

These arrangements had significantly improved when we undertook a follow up inspection on 15 February 2017. The practice is now rated as good for being well-led.

### Vision and strategy

The practice mission statement was to provide the best health care to the community given by appropriately trained and skilled staff, through effective teamwork and within the available resources.

The practice had a business plan in place for 2016/2017 which set out what the practice planned to achieve. This included more effective governance, service development, including elderly patient care and the development of a patient forum. The goals and objectives were summarised and given dates to be actioned by.

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

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. Improvements had been made since our previous inspection.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities; the GPs were involved in the day to day running of the practice.
- There were leads for areas such as business which included governance and health and safety; for clinical matters, for example, medicines management and palliative care; for administration, for example, human resources and patient awareness.
- Practice specific policies were implemented and were available to all staff.

- The staff including the GPs and practice administrator had an understanding of the performance of the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There were effective arrangements in place to manage areas such as long term conditions by the practice nurses who were overseen by the GPs.

### Leadership and culture

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

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

The practice had faced an extraordinary and exceptionally challenging situation over the last 15 months due to a complex staffing situation. This was handled positively and they used the situation as a driver for change and improvement.

There was a rolling schedule of meetings held at the practice. Every five weeks there was either a governance, multi-disciplinary (safeguarding, palliative and frail/vulnerable patient), education or primary healthcare team meeting. There were weekly team meetings held for staff and regular partners meetings. We saw examples of the meeting minutes. The GPs met for coffee every morning to discuss the day to day patient issues in the practice and to provide support to each other.

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

The practice had a virtual patient participation group (PPG) in recent years but the practice had not found this useful in gathering the views of patients. They were now in the process of setting up a group of patients and a meeting of 'patient champions' had been held to try and get a group



# Are services well-led?

Good 

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

of patients together to seek their views on the practice. The practice had recently recruited a patient who was their young person health champion to consult with and improve access for young people.

The practice had a newsletter which was produced quarterly which updated patients on news in the surgery, for example, electronic prescriptions, the appointment system and changes to practice staff.

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Opportunities for individual training were identified at appraisal. The practice were to hold a team building event for staff in the coming weeks.

## Continuous improvement

The leadership were driving continuous improvement. The GPs demonstrated a strong commitment to learning and improvement within the practice. For example;

- The community linking project at the practice enabled the GPs and nurses to refer patients to a range of local, non-clinical services which lead to positive health and well-being outcomes.
- The practice had employed several new members of staff recently which had given them the opportunity to consider their skills to match the practice in the recruitment process.
- The practice had reviewed access to appointments at the surgery, which included the introduction of telephone triage, extended access had been provided every weekday morning.
- Support had been provided to the locality GP access fund project to support extended access to GP and nurse appointments in hub locations across the locality.