Deerness Park Medical Group

Inspection 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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Overall summary

This practice is rated as Good overall. (Previous inspection January 2016 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Deerness Park Medical Group on 05 April 2018 and 18 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines. We were able to see the positive impacts on patient care and outcomes. Innovation was valued and actively encouraged.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients did not always find the appointment system easy to use, the practice had responded to patient concerns and initiated changes to the appointment and telephone systems in response to these concerns.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Staff were heavily invested in their roles and were empowered to develop their skills. For example, nurses had developed lead roles in the care of diabetes and heart failure. These lead roles supported continuity of care and effective communication between primary and secondary care.
- Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work.

We saw several areas of outstanding practice:

- The practice regularly supported local heath related projects. For example, the practice participated in a 'boilers on prescription scheme' that aimed to improve the health of patients with some long-term conditions by providing warm homes. Data provided by the practice showed in the last 18 months there had been a 60% reduction in the number of appointments needed by patients involved in this scheme. We also saw that attendances at A&E had reduced by 30% for patients involved in this scheme. Additionally, patients' energy bills had reduced by an average of 14% because of the improvement work carried out in their homes.
- The practice had responded to the patient concerns about the availability of appointments. The practice had introduced a cancellation list that helped clinicians 'safety-net' patients who were unable to obtain a same-day, urgent appointment. Patients who requested a same-day, urgent appointment but were not offered one were added to this list and given guidance on what to do if their symptoms worsened. The GPs and advanced nurse practitioners (ANPs) regularly reviewed this list throughout the day and contacted patients if a consultation slot became available. Patients were then either offered a telephone consultation or a face-to-face appointment if this was judged clinically necessary. The practice had audited the effectiveness of this approach. This had showed that, over a period of four months, 820 patients had been placed on this list, of which 43% had subsequently been contacted by a GP or an ANP. Those contacted had been offered either a telephone consultation or an appointment at the practice.
- The practice aligned new initiatives and changes to practise with local and regional strategy such as NHSE's Five Year Forward View. For example, the practice had introduced a new clinical skill mix model in August 2017. Administrative processes were also streamlined, and the introduction of the role of a supervising GP ensured the new clinical team and the practice nurses always had clinical support. A newly developed acute access team provided the majority of same day appointments and home visits. In total, these initiatives saved 160 hours of time per week. This enabled the GPs to focus on patients that required more complex clinical care, and the introduction of longer face-to-face GP appointments for most of the GPs. GPs faced fewer interruptions to their work.
- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship

Overall summary

in line with local and national guidance. Between November 2016 and March 2017, the practice took part in a clinical commissioning group (CCG) pilot to reduce antibacterial prescriptions by the introduction of an easy to use test for patients with a suspected lower respiratory tract infection. Data provided by the practice showed a reduction of between 7% (December 2016) and 38% (February 2017) compared to the same month the previous year for antibacterial prescriptions. The practice had continued this work as part of a wider antibiotic strategy. The practice shared the learning from this work with other local practices.

- The practice and the CCG had developed a digital version of the NEWS (National Early Warning Score). This system was designed to spot the early signs of illness in patients who lived in care homes. The system tracked medical observations, the score generated allowed the user to determine the appropriate level of care required. Requests for home visits were now backed up by a clear record of observations. The tracked information was shared with other healthcare professionals such as ambulance teams. Feedback from care homes was very positive. The project team was awarded a Health Service Journal award for Value and Improvement in Telehealth in 2016. The system was implemented at all of the care homes in Sunderland.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment. The practice had introduced a GP triage system for children under five. Following this, the practice had seen a 14% reduction in the number of patients under five that attended the local emergency department and a 15% reduction in the number that attend one of the local urgent care centers.

There two areas where the provider should make improvements are:

- Ensure the registration of the partnership with the Care Quality Commission accurately reflects the practice's partnership arrangement.
- Continue work to improve telephone access to the practice.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Deerness Park Medical Group

Deerness Park Medical Group is registered with the Care Quality Commission to provide primary care services for around 14,100 patients. The practice is part of Sunderland clinical commissioning group (CCG) and operates on a General Medical Services (GMS) contract agreement for general practice.

The practice provides services from the following addresses, which we visited during this inspection:

- Deerness Park Medical Centre, Suffolk Street, Sunderland, SR2 8AD.
- Bunny Hill Health Customer Services and Primary Care Centre, Hylton Lane, Downhill, Sunderland, SR5 4BW.

The practice maintains a website: http://www.deernesspark.co.uk

Deerness Park Medical Centre is based in purpose built premises. All reception and consultation rooms are fully accessible and on one level. There is on-site parking and disabled parking. A disabled WC is available.

Bunny Hill Health Customer Services and Primary Care Centre is located within purpose built premises in the Downhill area of Sunderland. The service shares the premises with a walk-in centre and several external services. All reception and consultation rooms are fully accessible There is on-site parking and disabled parking. A disabled WC is available.

The practice is an approved training practice enabling them to deliver training to GP Registrars. A GP Registrar is a qualified doctor who is training to become a GP. There were no GP Registrars employed at the time of the inspection.

Patients can book appointments in person, on-line or by telephone. The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Vocare, which is also known locally as Northern Doctors Urgent Care.

- The practice has seven GP partners (two female, five male) and two salaried GPs (female), an advanced paramedic, an advanced nurse practitioner, a nurse practitioner, a senior nurse, four practice nurses and four health care assistants. They also employ a business manager (who is a partner), an operations manager and 16 staff who undertake administrative or reception roles. A clinical pharmacist works at the practice as part of a Department of Health pilot.

The practice's registration with CQC was not up to date, only four of the practice's partners were included on their registration with CQC. The practice had notified the CQC of these changes but they had not submitted an application to update their registration when we inspected the practice.

The age profile of the practice population is broadly in line with the local and national averages. Information taken from Public Health England placed the area in which the surgery is located in the second most deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

The proportion of patients with a long-standing health condition is above the national average (68% compared to the national average of 54%). The proportion of patients who are in paid work or full-time employment, or education, is below with the national average (57% compared to the national average of 62%).

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.
- The practice safeguarding lead had recently reviewed their safeguarding systems and processes and ensured they were effective, supported vulnerable patients and raised staff awareness. Staff we spoke with all gave examples of safeguarding actions taken by the practice and had a good awareness of how to identify and report concerns. Staff had completed 'Prevent' training to help identify people who may have been radicalised
- Staff who acted as chaperones were trained for their role and had received a disclosure and barring (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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. For example, the practice had reviewed the clinical team and developed a new clinical structure that included, for example, an advanced paramedic.
- There was an effective induction system for temporary staff tailored to their role. The practice produced clear and effective information for doctors training at the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Following the inspection, the practice took steps to ensure reception staff were aware of the potential symptoms of sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance.
- The practice had reviewed their antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. Between November 2016 and March 2017, the practice took part in a clinical commissioning group (CCG) pilot

to reduce antibacterial prescriptions by the introduction of an easy to use test for patients with suspected lower respiratory tract infections. Data provided by the practice showed a reduction of between 7% (December 2016) and 38% (February 2017) compared to the same month the previous year for antibacterial prescriptions. This was part of a wider antibiotic prescribing strategy; this strategy included patient education and work to ensure the practice adhered to antibiotic prescribing guidelines. The practice shared the learning from this work with other local practices.

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice as good for providing effective services overall. Population groups were rated as good except for older people, which was rated as outstanding.

Please note: Any Quality Outcomes (QOF) data unless otherwise stated relates to 2016/2017. QOF is a system intended to improve the quality of general practice and reward good practice.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. GPs were allocated a clinical area and took a lead in ensuring that the rest of the clinical team were made aware of current evidence based practice. The practice had an effective system in place that ensured changes were implemented effectively and embedded into practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice encouraged patients to use the electronic repeat prescription service. We saw that the practice was among the top 20% of GP practices in England for the use of electronic repeat prescriptions. In August 2017, approximately 31% of repeat prescriptions were dispensed this way. We also saw that the practice was exceeding the CCG target of 20% for the percentage of appointments booked using online access.
- One of the GPs had created an electronic template that ensured that medications issued by district nurses were quickly and accurately recorded.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medicines.
- The practice had a well-established ward round at a local care home; one of three regular GPs visited the care home each weekday. The GP's also took part in regular meetings with the care home. These visits ensured that care plans, medication reviews and repeat prescriptions were managed promptly.
- The practice used technology to improve treatment and support patient's independence. The practice and the clinical commissioning group (CCG) had developed a digital version of the NEWS (National Early Warning Score). This system ensured clinical care was provided on the basis of effective clinical records and observations.
- Patients aged over 75 were invited for a health check when they did not have an existing long-term condition. If necessary, they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice provided a dedicated hearing aid service that included testing and fitting of new hearing aids.
- The practice had a GP lead for the care of the elderly.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention. People

with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice participated in a 'boilers on prescription scheme' that aimed to improve the health of patients with some long-term conditions by providing warm homes. Data provided by the practice showed in the last 18 months there had been a 60% reduction in the number of appointments needed by patients involved in this scheme.
- The practice's performance on most long-term condition indicators was comparable to national averages. For three indicators their performance was below national averages. Preliminary date for 2017/2018 showed there had been some improvements. We found that the practice had an effective system to invite patients to attend review appointments; the practice told us that they completed these reviews opportunistically and encouraged patients to attend.
- The practice held weekly diabetes clinics; they had completed two clinical audits in this area as well as on-going quality improvement work, which had showed they provided effective care. The practice told us they focused on engaging patients to manage their own care and managing patients who often presented with complex health needs and difficulties with compliance.
- The surgery offered an International Normalised Ratio (INR) test for patients on warfarin who lived in the Sunderland area. The practice had completed an audit that determined the service offered was effective. For example, data collected in May 2016 showed that 72% of patients had test results in line with national guidance. May 2017 data showed that this had increased to 75%. The target was 60%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 74%, which was broadly in line with the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening were in line with local and national averages.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End-of-life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a GP lead for palliative care. The practice had recently reviewed the end-of-life care they provided. Monthly palliative care meetings were held that had an educational focus. The practice had a system that ensured all clinical staff were made aware of the notes made on each patient's record following the meeting.
- The practice held a register of patients living in vulnerable circumstances. For example, homeless people, travellers and those with a learning disability. The practice had a lead nurse for patients with a learning disability.
- The practice offered annual health checks to patients with a learning disability. 107 patients were on this register, all of these patients were offered an annual health check and 52% had attended (2017/2018 data). The practice told us they had changed their

appointment system for these checks and expected this figure to improve in the coming year due to these changes. Patients with learning disabilities were offered longer appointments.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. The practice's performance on the mental health indicators was comparable to national averages apart from for one indicator.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected, there was an appropriate referral for diagnosis.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- The most recent published Quality Outcome Framework (QOF) results for 2016/2017 showed overall, the practice achieved 86% of the total number of points available, compared to the CCG and England average of 97%. The overall exception reporting rate was 10% compared to the CCG average of 11% and the England average of 9.6% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)
- We discussed the QOF performance with the practice. They demonstrated that they had an effective system to invite patients for review appointments. The practice told us that patients often failed to respond so they saw patients opportunistically when they could. The practice told us that they sent three letters to each patient before they exception reported the patient and we saw records that confirmed this.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice participated in medicines optimisation work. The lead GP and the clinical pharmacist worked together to support a CCG scheme that reduced prescribing costs at the practice. Data provided by the practice showed an estimated reduction of £150,904 for 2017/2018. This data also showed that the practice had saved £26,476 between October 2017 and December 2017.
- We saw that the practice completed a wide range of quality improvement activity that was developed in line with the needs of their patients. In 2017/2018, the practice had completed 11 two-cycle clinical audits and two single-cycle reviews. Clinical audit was linked to safety, effectiveness and adherence to guidance. For example, one audit looked at the management of patients with diabetes to ensure they were on the optimum dose of a medicine to treat diabetes. The second cycle of this audit showed the practice had increased the number of patients on the optimal dose from 35% to 78%. Some patients could not tolerate the optimal dose and some patients had required education and support to make the change.
- One audit looked at the management of patients who were prescribed a medicine to treat acute and chronic pain that is not routinely recommended to ensure it was prescribed in line with recent local guidance. The final cycle of this audit showed the practice had decreased the number of patients prescribed this medication from 31 to one (this management of this patient's pain was currently being managed by a pain clinic and would not be routinely changed by the practice).
- Other quality improvement work was completed. For example, one of the GPs had noticed that an unnecessary medicine had been prescribed for a patient. They had reviewed other patients who were prescribed this medicine and ensured it had been

prescribed correctly. When it had not been prescribed correctly, the patient was reviewed and the medicine was no longer prescribed. The clinical pharmacist supported this work.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long-term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- Staff were proactivity supported and encouraged to acquire new skills, use their transferable skills and share best practice. For example, some of the healthcare assistants at the practice had been trained at the practice and previously worked as administrators. The practice had supported them to change their role and continued to do this.
- The practice provided effective educational support for clinical staff and adapted their arrangements when required. The advanced practitioners employed by the practice had a dedicated teaching session twice each month, these sessions covered areas identified by the GPs or the advanced practitioners. On the day of the inspection, staff told us that these education sessions, and the on-going clinical support, were excellent.
- As part of a national pilot the practice employed a clinical pharmacist. The practice had supported the pharmacist to obtain their independent prescribing qualification. This meant that the pharmacist was able to prescribe medicines to patients.
- The practice had introduced the role of a supervising GP to support the clinical staff working at the practice. Staff feedback on this role was very positive.
- All of the staff spoke positively of the support for training and development offered by the practice. We saw that that staff had completed a wide range of mandatory and non-mandatory training. For example, staff had completed training in conflict resolution, dementia awareness, privacy and dignity, domestic violence and the Mental Capacity Act
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice took part in clinical commissioning group (CCG) led work to reduce the number of accident and emergency (A&E) attendances emergency admissions to hospital. Data provided by the practice showed that they had reduced the percentage of patients who attended A&E and emergency admission to hospital who were part of a multi-disciplinary team (MDT) process. These reductions were comparable to the reductions achieved across the locality and the CCG. For the whole population of patients, the practice had reduced the number of patients admitted to hospital as an emergency by 5.78% (compared to a locality reduction of 2.35% and an overall CCG increase of 1.35%). The practice told us that they attributed these improvements, in part, to the new clinical skill mix model they had introduced.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long-term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community

services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end-of-life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- The practice website provided a good range of health promotion information.
- The practice had completed work to promote the use of over the counter medicines by patients. A list of medicines that were available to purchase over the counter by patients was produced by the clinical pharmacist. GPs worked to reduce the number of these medicines they prescribed. Vulnerable patients were excluded from this work. The practice ensured patients were given an explanation of any changes made.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients about the way staff treat people was positive.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients' timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- Results from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with or above local and national averages.
- The practice carried out patient surveys on a regular basis; they acted on patient feedback to improve patient care.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice as good for providing responsive services overall. Population groups were rated as good except for older people, which was rated as outstanding.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. They took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the patients had access to extended hours appointments seven days a week. Telephone consultations and home visits were available.
- The practice had responded to the difficulties in recruiting GPs and the difficulties they faced in providing sufficient appointments. They had introduced a new clinical skill mix model in August 2017. An acute access team provided the majority of same day appointments and home visits; this enabled the GPs to focus on more complex care and had allowed the practice to introduced longer face-to-face GP appointments for some of the GPs.
- The practice had responded to the patient concerns about the availability of appointments. They had introduced a cancellation list system. Patients who requested a same day appointment but were not offered one were added to this list and given guidance on what to do if their symptoms worsened. The GPs and advanced nurse practitioners reviewed the lists and contacted patients if an appointment slot became available. They had a telephone consultation or were seen at the practice.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end-of-life was coordinated with other services. The practice ensured their end-of-life care remained effective and responsive to patients needs by a review of their palliative care systems and processes by the palliative care lead.
- Additional services such as travel vaccinations and minor surgery were available.
- The practice was a hub for 24, 48 and 72-hour ECG (electrocardiogram) monitoring for all practices in the Sunderland area. The practice's healthcare assistants supported this service, results were forwarded promptly to other practices and cardiologist provided guidance when needed.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had introduced a dedicated hearing aid service that included testing and fitting of new hearing aids approximately 18 months ago. The practice told us that they had received excellent feedback from patients.
- The practice had lead GPs for palliative care and the care of the elderly. Older patients were offered immunisations at home if they could not travel to the practice.
- The practice used technology to improve treatment and support patient's independence. The practice and the clinical commissioning group (CCG) had developed a digital version of the NEWS (National Early Warning Score). This system was designed to spot the early signs of illness in patients who lived in care homes. The system tracked medical observations, the score generated allowed the user to determine the appropriate level of care required. Requests for home visits were now backed up by a clear record of observations. Feedback from care homes was very positive. The project team was awarded a Health Service Journal award for Value and Improvement in Telehealth in 2016. The system was implemented at all of the care homes in Sunderland.
- The practice had a weekday ward round at a local care home; one of three regular GPs visited the care home each weekday.
- The practice offered immunisations for shingles and pneumonia to older people.

People with long-term conditions:

Good

Are services responsive to people's needs?

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice held weekly diabetes clinics at Deerness Park and Bunnyhill; patients could still book an appointment at time that suited them if required. These clinics were run by the lead GPs and lead nurse for diabetes.
- The practice had developed the role of the nursing team to include nurses that had lead roles in the care of diabetes and heart failure. Patients with diabetes moved between GP and nurse led appointments depending on the level of care and support required. The GPs at the practice were able to initiate insulin for diabetic patients. This role ensured easier access to appointments for patients with diabetes and a point of contact for those who wanted to discuss any concerns they had. Heart failure was chosen as the practice had a high number of patients with this condition. The nurse had completed advanced training that supported this role; they were therefore able to offer additional support for patients. These nurses had developed close working relationships with community and secondary care providers that ensured effective and responsive support for patients. These close working relationships and the continuing care they offered patients supported a holistic approach to delivering care.
- One of the GPs had created an electronic template that ensured the information to complete an insulin passport for patients with insulin dependent diabetes was collected quickly and accurately, a copy of this information was then given to the patient.
- The surgery offered an International Normalised Ratio (INR) test for patients on warfarin who lived in the Sunderland CCG area. The INR is a blood test that needs to be performed regularly on patients who are taking warfarin to determine their required dose. By being able to have the test at the surgery, patients did not have to travel to their local hospital for the test.
- As part of a pilot scheme, the practice employed a clinical pharmacist. They dealt with changes to medications, prescribing queries and provided expert advice to all members of the clinical team. They attend multi-disciplinary team meetings and supported safe and effective prescribing to the wider healthcare team.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment. The practice had introduced a GP triage system for children under five. Following this, the practice had seen a 14% reduction in the number of patients under five that attended the local emergency department and a 15% reduction in the number that attend one of the local urgent care centers.
- The practice provided a full contraceptive and sexual health service with easy access to emergency contraception.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and weekend appointments were available as part of a local extended access scheme.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances. For example, homeless people, travellers and those with a learning disability. The practice had a lead nurse for patients with a learning disability. Most staff had completed learning disability awareness training.
- The practice maintained a register of patients with learning difficulties and took steps that reduced anxiety for these patients. For example, longer appointments were available.
- The practice maintained a register of patients who were veterans of the armed forces who are vulnerable, they

signposted veterans to sources of speciality help and support. They also ensured that where their condition was related to service in the armed forces the patient had access to priority NHS care.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice was part of the Sunderland Safe Place scheme; this was a scheme for all vulnerable people and not limited to patients at the practice. Vulnerable people could ask for support and advice at any location that was part of the scheme. Staff had received training to support them in carrying out this role.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had been awarded Dementia Friends accreditation and practice staff had completed dementia training.
- Information about various voluntary groups and support organisations was available for patients.

Timely access to care and treatment

Patients were not always able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. The practice used a text message system to remind patients of their appointments.
- Patients with the most urgent needs had their care and treatment prioritised.
- We spoke to two patients and they reported that the telephone system was not easy to use and it was sometimes difficult to get a timely appointment. The practice told us that a new telephone system was shortly to be introduced. The practice had surveyed patients to enable them to identify what patients would like to be included in the new system. The new system had been discussed with the patient participation group. The practice had responded to concerns about appointment availability by reviewing the clinical mix at the practice and by the development of the cancellation list system.

Results from the National GP Patient Survey showed patients sometimes responded positively to questions about access to services, however, results were generally lower than local and national averages.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from an analysis of trends. They acted as a result to improve the quality of care. The practice also shared learning from complaints with the patient participation group (PPG).

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing well-led services.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The practice's registration with CQC was not up to date, only four of the practice's partners were included on their registration with CQC. The practice had notified the CQC of these changes but they had not submitted an application to update their registration when we inspected the practice.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- The practice were accredited Investors in People. Investors in People is a scheme that is used to demonstrate effective management and that an employer is committed to staff development.
- Leaders had a deep understanding of the issues, challenges and priorities in their services and in the local area and they worked to address them. The practice manager worked closely with the local CCG; they had jointly developed a local improvement initiative. As a key part of a Quality Premium group a new three-part quality premium scheme had been developed that focused on improved patient outcomes and reduced the administrative burden on practices. All practices in Sunderland opted to be part of the scheme. Practices committed to a wide range of work that included medicines optimisation work, improved end-of-life care and work that ensured care was standardised for patients with learning disabilities across the CCG.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed their vision, values and strategy jointly with patients, staff and external partners. They had a mission statement that staff were aware off. The mission statement had recently been reviewed and the practice planned to ask staff for their feedback very shortly. The practice's five values had been developed in line with CQC key questions. For example, the practice aimed to 'provide an effective health care service' by ensuring clinicians kept their knowledge and skills current, promoted health for their community and by hosting of external services (such as the hearing aid and INR clinics).
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned their services to meet the needs of the practice population. The practice aligned new initiatives and changes to practise with local and regional strategies such as NHSE's Five Year Forward View. They had had introduced a new clinical skill mix model in August 2017. An acute access team provided the majority of same day appointments and home visits; this enabled the GPs to focus on more complex care and had allowed the practice to introduce longer face-to-face GP appointments for some of the GPs.
- The practice monitored progress against delivery of the strategy.
- A practice charter had been created which detailed the standards the practice aimed to provide for patients and patient responsibilities. A copy of this charter was given to each patient who registered at the practice.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. Staff were proud of the organisation as place of work and spoke highly of the culture. There were high levels of satisfaction across all staff groups.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Outstanding ☆

Are services well-led?

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- All staff were considered valued members of the practice team. Clinical staff were given protected time for professional development and evaluation of their clinical work. We saw a strong team culture and all staff were focused on improving the quality of care.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. The practice had developed an effective and supportive clinical leadership structure. Each GP was allocated a lead role, for example: prescribing, care of the elderly, diabetes, palliative care. Each lead GP provided support and education in their lead area for the practice.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to improve quality and effectiveness. .
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Outstanding ☆

Are services well-led?

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, at the previous inspection we had seen that the practice had invited a local learning disability group and review the practice to make sure it reflected the needs of patients with learning disabilities.
- There was an active patient participation group. The practice regular shared learning from complaints and significant events with the patient participation group and invited them to provide feedback on service developments, for example, the new telephone system the practice planned to introduce.
- The service was transparent, collaborative and open with stakeholders about performance. The practice took a leadership role in the health system to identify and proactively address the challenges and meet the needs of the population. Partners at the practice were actively engaged with the clinical commissioning group (CCG). One partner was the lead for the CCG urgent care strategy. The practice manager, who was a partner in the practice, was the CCG lead for veterans and learning disabilities. One of the partners was lead of diabetes for part of the CCG area

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work.
- The practice regularly supported local heath related projects. For example, the practice participated in a 'boilers on prescription scheme' that aimed to improve the health of patients with some long-term conditions by providing warm homes.
- Staff knew about improvement methods and had the skills to use them.
- The practice had responded to the patient concerns about the availability of appointments. The practice had introduced a cancellation list that helped clinicians 'safety-net' patients who were unable to obtain a same-day, urgent appointment. Patients who requested a same-day, urgent appointment but were not offered one were added to this list and given guidance on what to do if their symptoms worsened. The GPs and advanced nurse practitioners (ANPs) regularly reviewed this list throughout the day and contacted patients if a consultation slot became available. Patients were then either offered a telephone consultation or a face-to-face appointment if this was judged clinically necessary.
- As part of a national pilot the practice employed a clinical pharmacist, the practice had provided additional support for the clinical pharmacist by enabling them to undertake a course that allowed them to prescribe medications for patients. Medication queries and patient safety alerts were more effectively and promptly managed reducing risks to patients. The practice estimated that this role had reduced the workload of each GP by 30 minutes each day.
- The practice and the CCG had developed a digital version of the NEWS (National Early Warning Score). This system was designed to spot the early signs of illness in patients who lived in care homes. The system tracked medical observations, the score generated allowed the user to determine the appropriate level of care required.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.