Marine Avenue Medical Centre

Quality Report

Marine Avenue
Whitley Bay
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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Marine Avenue Medical Centre on 16 November 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired), vulnerable people, and people experiencing poor mental health (including dementia) population groups. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to checking medicine expiry dates, carrying out a legionella risk assessment and undertaking formal infection control audits.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients we spoke with said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice was able to demonstrate how it was responding to problems experienced by patients in obtaining an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Review and strengthen the process for checking expiry dates of medicines stored on the premises
- Strengthen the processes currently in place to identify and support carers
- Ensure there is a more formal approach to carrying out and documenting infection control audits which includes a regular review of action points
- Safely secure the cord/chain mechanisms on vertical blinds to reduce the risk of accidental choking for small children

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events
- 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, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to safeguard patients from abuse.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the practice needed to strengthen the arrangement in place to check for out of date medicines held on the premises. They also need to ensure that a legionella risk assessment was carried out and that a programme of formal infection control audits was implemented. The practice should also ensure that cord/chain mechanisms on vertical blinds are anchored to reduce the risk of accidental choking for small children.

Are services effective?

Good

The practice is rated as good for providing effective services.

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

Data from the Quality and Outcomes Framework showed patient outcomes were comparable to local Clinical Commissioning Group (CCG) and national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 91.8% of the point's available (local

Summary of findings

CCG average 96.7% and national average 93.5%). Managers were aware of the areas where they needed to improve and were dedicated to improvement. Achievement rates for cervical screening and the majority of childhood vaccinations were above local and national averages. Flu vaccination rates were below local and national averages

There was evidence of clinical audit activity and improvements made as a result of this.

Staff had received inductions and were given the opportunity to undertake both mandatory and non-mandatory training. Staff had received an annual appraisal.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about the service was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Results from the National GP Patient Survey published in July 2015 were variable in respect of providing caring services with the practice scoring lower than the CCG and national averages in some areas and higher in others. For example, 92% of patients who responded to the survey said the last GP they saw or spoke to was good at listening to them (CCG average 91% and national average 87%) and 80% said the last nurse they saw or spoke to was good at listening to them (CCG average 91% and national average was 91%).

Results also indicated that 78% of respondents felt the nurse treated them with care and concern (CCG average 91% and national average of 90%). 91% of patients felt the GP treated them with care and concern (CCG average 88% and national average 85%).

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It 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. Patients we spoke with said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. The practice's scores in relation to access in the National GP Patient Survey were variable. The most recent results (July 2015) showed that 51% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and the national average of

Summary of findings

65%. 77% of patients were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%. However, the practice was aware of this and was taking steps to try and improve access.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and apologies issued to complainants when appropriate.

Are services well-led?

Good

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

It had a clear vision and strategy and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was above the local clinical commissioning group (CCG) average of 99.9% and the England average of 97.9%.

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission and those in vulnerable circumstances had comprehensive care plans.

One of the GPs had been identified as the lead for elderly care. Patients recently discharged from hospital were contacted to ensure that their condition was stable and reduce the risk of readmission.

People with long term conditions

Good

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

Longer appointments and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice held a weekly diabetic clinic which was attended by a dietician. Lead GPs had been identified for the most common long term conditions.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in relation to some of the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with cancer, atrial fibrillation, depression, epilepsy and osteoporosis. However, performance in relation to other conditions was below average. For example, the practice had only obtained 83.7% of the points available to them for diabetes compared to 92.9% locally and 89.2% nationally.

Summary of findings

Families, children and young people

Good

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

The practice had identified the needs of families, children and young people, and put plans in place to meet them. There were processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as health visitors.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for all routine vaccinations offered to children up to the age of five were above CCG averages.

At 82% the practice's uptake for the cervical screening programme was the same as the clinical commissioning group (CCG) average.

Baby and immunisation clinics were held on a Wednesday morning. One of the GPs carried out six to eight week postnatal checks at the same time. This meant that any baby identified as needing to see a GP during the baby clinic or their immunisation appointment was able to see a GP immediately.

Requests for urgent appointments for children aged under one were facilitated the same day.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been met. The practice was open from 8.20am to 6.30pm on a Monday to Friday (with appointments running from 8.30am to 6.15pm) and on a Saturday morning from 9am to 12 midday. As a result of patient feedback the Saturday morning surgery was staffed by either a GP or a nurse on an alternative week basis.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. The practice also offered a travel vaccination service.

Summary of findings

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. Patients with learning disabilities were invited to attend the practice for annual health checks and were routinely offered a longer appointment.

The practice had effective working relationships with multi-disciplinary teams in the case management of vulnerable people. 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

At 87% the percentage of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented was comparable with the national average of 88%. The percentage of patients with dementia whose care had been reviewed in a face to face meeting in the preceding 12 months was 74% (national average 84%).

Staff had received training on the Mental Capacity Act and Deprivation of Liberty Standards and the practice had achieved the Dementia Friends accreditation.

The practice hosted three trainee counsellors from the local Talking Therapies service. Patients with mental health issues who would benefit from counselling were offered appointments with the trainee counsellors in the first instance to reduce the waiting time to see a fully qualified counsellor.

Summary of findings

What people who use the service say

The results of the national GP patient survey published on 2 July 2015 showed the practice performance was variable when compared with local and national averages with come results being lower and some higher. 272 survey forms were distributed and 120 were returned, a response rate of 44.1%. This represented 1.6% of the practice's patient list.

- 83.7% found it easy to get through to this surgery by phone compared to a CCG average of 81.7% and a national average of 73.3%.
- 77% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85.6%, national average 85.2%).
- 90.1% described the overall experience of their GP surgery as fairly good or very good (CCG average 89.1%, national average 84.8%).
- 77.4% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 81.4%, national average 77.5%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 14 comment cards which were all positive about the standard of care received. Words used to describe the practice and its staff included caring, outstanding, dedicated, skilled, friendly and helpful. Some negative comments were included in three of the comments cards in relation to difficulty experienced in getting an appointment, unhelpful and unknowledgeable staff and problems experienced in obtaining a repeat prescription.

We spoke with five patients during the inspection, four of whom were members of the practice patient participation group. All five patients said they were happy with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service SHOULD take to improve

- Carry out a legionella risk assessment
- Review and strengthen the process for checking the expiry dates of medicines stored on the premises
- Strengthen the processes currently in place to identify and support carers
- Ensure there is a more formal approach to carrying out and documenting infection control audits which includes a regular review of action points
- Safely secure the cord/chain mechanisms on vertical blinds to reduce the risk of accidental choking for small children.

Marine Avenue Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP specialist adviser and a specialist advisor with experience of practice management.

Background to Marine Avenue Medical Centre

The practice is located in Whitley Bay and provides care and treatment to 7,200 patients from Whitley Bay, Monkseaton, Earsdon and the surrounding areas (postcodes NE25, NE26 and NE27). It is part of the NHS North Tyneside Clinical Commissioning Group (CCG) and operates on a General Medical Services (GMS) contract.

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

Marine Avenue Medical Centre, Marine Avenue, Whitley Bay, North Tyneside, NE26 3LW

The practice is located in a modern purpose built two storey building which was erected in 2006. All reception and consultation rooms are fully accessible. If patients with mobility problems need to access the upper floor of the building a lift is in operation. On-site parking is available, which includes disabled parking bays.

The practice is open between 8.20am to 6.30pm, Monday to Friday (with appointments running from 8.30am to 6.15pm) and from 9am to 12 midday on a Saturday. The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited (NDUC).

Marine Avenue Medical Centre offers a range of services and clinic appointments including family planning, chronic disease management clinics, children's clinics, immunisations, cervical screening, travel advice and immunisations. The practice consists of:

- Three GP partners (two female and one male)
- One GP registrar (female)
- Two practice nurses (both female)
- One healthcare assistant (female)
- 12 non-clinical staff including a practice manager, office manager, medical secretary, clinical receptionists, an apprentice and a cleaner

The practice is a training practice and provides training to GP registrars.

The area in which the practice is located is in the ninth (out of ten) most deprived decile. In general people living in more deprived areas tend to have greater need for health services.

The practice's age distribution profile showed higher percentages of patients in the under 14 and 40-44 year age groups than the national average. Average life expectancy for the male practice population was 78 (national average 79) and for the female population 82 (national average 83).

Detailed findings

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We also spoke with multi-disciplinary staff who worked with, but were not employed by, the practice. This included a physiotherapist and a health visitor. We carried out an announced visit on 15 December 2015. During our visit we spoke with a mix of clinical and non-clinical staff including GPs, the practice nurses, the practice manager, the officer manager, the health care assistant and a clinical receptionist. We spoke to five patients, four of whom were members of the practice patient participation group (PPG) and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 14 Care Quality Commission (CQC) comment cards that had been completed by patients. We also looked at the records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff were well aware of their roles and responsibilities in reporting and recording significant events. The practice had an up to date significant event policy and reporting form
- Significant events were analysed and reviewed as a standing agenda item at monthly practice meetings.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an error where an electronic prescription had not automatically been sent to the patient's nominated pharmacy had led to relevant staff receiving additional training on the use of the electronic prescription service system. Another, where an urgent hospital referral had been actioned incorrectly led to a review of staff cover arrangements and the decision to create a step by step guide on dealing with hospital referrals.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Practice management told us that they needed to improve what they reported through the safeguard incident and risk management system (SIRMS). SIRMS is an online system which enables practices to easily and efficiently report all issues, concerns and incidents which affect their patients to their local clinical commissioning group (CCG). The CCG are then able to identify trends and themes arising from all practices within their area and offer appropriate advice and support if necessary.

National patient safety alerts were disseminated by the practice manager to the GPs, practice nurses and the officer manage who would disseminate these to additional practice staff if required. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. We saw evidence that patient safety alerts were then discussed, as a standing agenda item, at various staff meetings to ensure appropriate action had been taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- 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 who 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. All clinical staff had received level three safeguarding training.
- There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.
- Notices in the waiting room and next to all consultation couches advised patients that chaperones were available if required. Staff who acted as chaperones had received appropriate training and all practice staff had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice generally kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The arrangements for storing medicines requiring refrigeration were good with minimum and maximum temperatures being checked and recorded on a daily basis. A process was also in place for checking medicine expiry dates. However, during our inspection we did find one box of tablets that had expired in July 2015. When we highlighted this to practice staff we were assured that steps would be taken to strengthen processes to ensure this did not happen again

- An effective system was in place for the collection and disposal of clinical and other waste.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, the practice recruitment policy needs updating to ensure it includes the need to seek proof of qualifications (where appropriate).

Monitoring risks to patients

Risks to patients were gernerally assessed and well managed although there were some areas where improvement was required.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice maintained appropriate standards of cleanliness. We observed the premises to be clean and tidy and a comprehensive cleaning schedule was in place. The practice nurse was the infection control lead and had received infection control training. However, although we were told that the practice nurse and the office manager carried out a regular inspection of the premises to look at cleanliness and risk of infection there was no evidence of any formal infection control audits. The practice had a legionella management policy and an up to date legionella risk assessment which had concluded that the risk of contamination was low.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. GP leave was planned well in advance and if the practice did need to use locum GPs they tried to use the same ones who were known to the patients and familiar with practice policies and procedures. An effective locum induction pack was in operation.

During the inspection we did find that the cord and chain mechanism on a set of vertical blinds in the waiting room area was not anchored down which could present a risk of accidental choking for small children. We mentioned this to the practice manager during our inspection who informed us that this problem would be rectified immediately.

Arrangements to deal with emergencies and major incidents

The practice had good arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers and panic buttons in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- 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 comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan, which had been reviewed and updated in July 2015, included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. The practice worked with a pharmacist to monitor antibiotic and other prescribing and used the RAIDR system (a healthcare intelligence tool) to look at clinical data, identify at-risk patients and link primary care data to secondary care admissions.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 91.8% of the total number of points available to them compared with the local CCG average of 96.7% and national average of 93.5%. GPs we spoke with felt that the reason for the result being lower that local and national averages was due to the lack of substantive GPs working at the practice and problems with recruitment and retention. It was hoped that new arrangements in place, such as the GP led triage system, employment of an in house pharmacist and training one of the practice nurses to be a nurse prescriber, would lead to an overall improvement in the QOF results.

At 8.9% their clinical exception rate (the QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect) was above the local CCG average of 8.2% but below the national average of 9%. This suggests that the practice operated an effective patient recall system, where staff were focussed on following patients up and contacting non-attenders.

- Performance for diabetes related indicators was lower than the local CCG and national averages (83.7% compared to the CCG average of 92.9% and national average of 89.2%). However, the percentage of patients on the diabetes register with a record of a foot examination and risk classification in the preceding 12 months was 94.4% (CCG average 89.3% and national average 88.3%)
- Performance for hypertension related indicators was lower than average (92.3% compared with a CCG average of 98.1% and national average of 97.8%)
- Performance for mental health related indicators was lower than average (76.9% compared with a CCG average of 95.2% and national average of 92.8%).
- The practice had received 100% of the points available to them for atrial fibrillation, cancer, depression, epilepsy, heart failure, learning disability, osteoporosis and palliative care related indicators. All of these were comparable to of higher than local and national averages.

The practice was able to demonstrate that it had carried out two cycle clinical audits to help improve patient outcomes. This included an audit of the long term monitoring of patients with diabetes and an audit to assess the short term prescribing of metoclopramide (a medicine used to treat nausea and vomiting). The metoclopramide audit resulted in the practice introducing prescribing guidance and a drive to ensure patients were only prescribed medication lasting five days or less in line with guidance issued by the Medicines and Healthcare Products Regulatory Agency (MHRA).

The practice had a palliative care register and held regular multi-disciplinary palliative care meetings to discuss the care and support needs of palliative care patients and their families.

Effective staffing

The staff team included medical, nursing, managerial, administrative and cleaning staff. The partnership consisted of three GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, health and safety, infection control, information governance, safeguarding and appropriate clinical based training for clinical staff.

Good

Are services effective?

(for example, treatment is effective)

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (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 nurses reported they were supported in seeking and attending continual professional development and training courses. The practice was also a training practice for GP registrars.

All practice staff received an annual appraisal from which personal development and training plans were developed. Our interviews with staff confirmed that the practice was proactive in identifying and providing training and funding for relevant courses and personal development opportunities.

We looked at staff cover arrangements and identified that there were sufficient GPs on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible although the practice did also use temporary non-clinical staff and locum GPs. When the practice did have to use locum GPs they tended to use regular locums who were aware of practice policies and procedures and known to the patients. An effective locum induction pack was in operation.

Coordinating patient care and information sharing

The information needed to plan and deliver 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 investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated. Feedback from attached staff who worked with the practice, such as a physiotherapist and a health visitor, was very good.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

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

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 120 patients who participated in the National GP Patient Survey published in July 2015, 82% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 81.4% and local clinical commissioning group average of 85.8%. The same survey revealed that 72% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 84.8% and local CCG average of 87%.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients requiring palliative care, carers and those with a long-term and mental health condition or learning disability.

The practice's uptake for the cervical screening programme was 82.2%, which was higher than the national average of 81.9%.

Childhood immunisation rates were better than local CCG averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 99% to 100% (compared with the CCG range of 97.3% to 100%). For five year olds this ranged from 95.2% to 100% (compared to CCG range of 92.2% to 98.3%).

Good

Are services effective?

(for example, treatment is effective)

Flu vaccination rates were below average. For the over 65s this was 61.6% (national average 73.2%), and for at risk groups 44.6% (national average 52.2%).

Patients had access to appropriate health assessments and checks. These included chronic disease reviews and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice had invited 130 patients for NHS health checks during the period 1 April 2015 to 15 December 2015. 93 patients had accepted this invitation.

Good

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 people 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 room to discuss their needs.

We received 14 completed CQC comment cards of which 11 were very complementary about the practice. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Negative comments received were in relation to difficulties experienced in obtaining an appointment, unhelpful staff and problems experienced in obtaining a repeat prescription. We also spoke with five patients during our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We had received one complaint from a patient prior to our inspection (July 2015) regarding the attitude of staff, delay in getting an appointment and feeling rushed during an appointment. However, the same complainant had praised the care afforded to them by the GPs.

Results from the National GP Patient Survey showed patient satisfaction in respect of being treated with compassion, dignity and respect varied when compared to local and national averages. For example:

- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 99% 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%.
- 78% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 90%.
- 85% patients 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 they felt involved in decision making about the care and treatment they received. The majority 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 patients responses varied in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 87%.
- 92% said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 86%.
- 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 81%.
- 80% said the last nurse they spoke to was good listening to them compared to the CCG average of 91% and the national average of 91%.
- 84% said the nurse gave them enough time compared to the CCG average of 93% and the national average of 92%.

The practice had access to a translation service for patients who did not have English as a first language. The practice did not have a hearing loop. Patients with a visual impairment were coded on the practice computer system to alert reception staff and GPs to offer additional support.

Good

Are services caring?

Patients with a learning disability were routinely offered longer appointments which they tried to schedule at the end of surgery when the practice was quieter and less stressful for the patient. The practice was also pro-active in offering annual health checks to their patients with a learning disability and had been recognised as a regional standard bearer for their achievement on this area. The practice had 32 patients recorded on their learning disability register all of whom had been invited for a health check.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received generally indicated that staff responded compassionately when they needed help and provided support when required.

There was very little information in the waiting room and none on the practice website to tell patients how to access support groups and organisations. The practice had a register of their carer's and had registered 65 of their patients as being carers. However, they were not proactive in identifying carers or in signposting them to appropriate services or for a carers assessment. Staff told us that the practice would often send condolence cards to patients who had experienced bereavement and offer families a home visit a month later. There was a notice in reception advising patients of bereavement support organisations.

The practice hosted three trainee counsellors from the local Talking Therapies service. Patients with mental health issues who would benefit from counselling were offered appointments with the trainee counsellors in the first instance to reduce the waiting time to see a counsellor.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of its local population and planned services accordingly. Services took account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care.

- There were longer appointments available for anyone who needed them. Patients with a learning disability were routinely offered a longer appointment.
- Home visits were available for older patients, housebound patients and patients who would benefit from these.
- The appointment system operated by the practice ensured that patients could generally get an urgent same day appointment following triage by a GP. Requests for routine appointments could usually be facilitated within an acceptable timescale. All children under the age of 1 and the top 2% of patients most at risk of hospital admission were routinely offered a same day appointment.
- The practice was open on a Saturday morning and provided appointments with either a GP or a nurse on alternative weeks.
- There were disabled facilities and translation services available. The practice did not have a hearing loop
- All patient facilities were easily accessible to patients with a mobility issue.
- The practice hosted three trainee counsellors as an aid to reducing waiting times for referrals to counselling services for patients with mental health issues
- Patients were able to use online services to book appointments and request repeat prescriptions. The practice was also in the process of developing a mobile app to aid patient access which would also contain responses to frequently asked questions.

The practice was able to demonstrate that it had implemented suggestions for improvements and made changes to the way it delivered services in response to patient feedback. For example, the practice had changed its Saturday morning surgery from being GP appointments only to being staffed by a GP or a nurse on alternate weeks. The practice had also made changes to its automated telephone system as a result of patient feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and the practice was open on a Saturday morning. The majority of the practice population were English speaking patients but access to a translation service was available if needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities for patients were all on ground level. If patients did need to access the 2nd floor for any reason a list was in operation.

Staff told us that they did not have any patients who were of "no fixed abode". However, if someone of no fixed abode came to the practice asking to be seen and would register the patient so they could access services. They regularly saw transient patients from a local caravan park.

There was a system for flagging vulnerability in individual patient records which alerted staff to be extra vigilant or offer additional support as and when required. .

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The practice was open from 8.20am to 6.30pm on a Monday to Friday (with appointments running from 8.20am to 6.15pm) and from 9am until 12 midday on a Saturday. On a Monday to Friday the practice operated a GP led triage system which ensured that any patient requiring an urgent appointment and any child under the age of one were seen the same day. The introduction of the triage system had led to a 30% reduction in the number of patients for whom an urgent appointment was actually necessary. The practice were also using a colour coding system on their computer system to ensure that appointment requests from the top 2% of their patients most at risk of hospital admission were seen immediately. The Saturday morning surgery was reserved for pre bookable appointments only with appointments being available with either a GP or a nurse on alternative weeks.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 73% of patients were satisfied with the practice's opening hours compared to the CCG average of 82% and the national average of 75%.
- 84% patients said they could get through easily to the surgery by phone compared to the CCG average of 82% and the national average of 73%.
- 60% patients described their experience of making an appointment as good compared to the CCG average of 78% and the national average of 73%.
- 51% patients said they usually waited less than 15 minutes their appointment time compared to the CCG average of 72% and the national average of 65%.
- 77% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.

The practice were aware of the results but felt that the introduction of their triage system, employment of an in house pharmacist and training the practice nurse to become a nurse prescriber would lead to improvements in this area. People we spoke to on the day of the inspection reported that they were able to get appointments when they needed them.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message advised patients of who they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available on request and were routinely offered to patients with learning disabilities. Home visits were made to patients resident in local care homes and one of the GPs operated a weekly ward round approach with one local nursing home where the practice had a number of patients.

Appointments were available outside of school hours and appointments with a nurse and a GP were available on Saturday mornings to benefit people who worked.

The practice was trialling the employment of an in-house pharmacist and were hoping to develop one of their nurses as a nurse prescriber, both of which they hoped wold relieve some of the demand on the GPs and improve the systems in place for chronic disease management.

Listening and learning from concerns and complaints

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

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Complaints and lessons learned from them were discussed at staff meetings as a standard agenda item
- We saw that information was available in the practice to advice patients how to make complaints. The practice website did not include any guidance on how to make a complaint

We looked at seven complaints that the practice had received during the period August 2015 to the date of our inspection. We found that these had been satisfactorily handled, dealt with in a timely way and apologies issued when necessary. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a complaint from a patient regarding difficulty experienced in obtaining a repeat prescription led to the practice telephone system being reconfigured to enable patients to leave a message requesting a repeat prescription request when the surgery was closed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their mission statement was:

'We strive to care for our patients from cradle to grave in a caring, friendly and efficient environment'.

The practice had a business plan and had identified their priorities as being the recruitment of a GP and nurse or look at alternative ways of delivering an effective service. For example, as the practice had been unsuccessful in their attempts to recruit a nurse practitioner they were considering developing and training a practice nurse to be a nurse prescriber. Other priorities specifically for non-clinical staff included:

- Strengthening the arrangements to support carers
- Implementing further Dementia Friends training
- Designating administrative staff as the point of contact or lead for patients with a particular long term medical condition, such as chronic obstructive pulmonary disease or those in need of palliative care.

We spoke with several members of staff and they all knew and understood the vision and values and knew what their roles and responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and procedures and found they were up to date and fit for purpose.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

The GP partners and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice held fortnightly meetings for clinical staff and fortnightly 'huddle' meetings for all staff members.

The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. They also reported that they were given the opportunity to seek training and professional development opportunities. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received.

The practice PPG had been established in September 2015 and met on a monthly basis. PPG members who we spoke with stated that they were in the process of developing aims and objectives for the future but that these were likely

Are services well-led?

Good

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

to include developing patient surveys, considering ways of supporting lonely and vulnerable patients, and in encouraging patients to take ownership of and self manage their conditions.

The practice had carried out patient surveys. The survey carried out in March 2015 indicated that there was a low satisfaction rate in respect of the ease of being able to get an appointment. In response the practice had arranged for the local CCG transformation team to review capacity issues and suggest possible solutions.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff were given the opportunity of a regular appraisal which included the development of a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

The practice was a GP training practice and provided training to GP registrars. Practice management told us that the practice was closely involved with the local CCG which enabled them to participate in future planning within the region. One of their GPs was a member of the CCG audit committee.