

Chainbridge Medical Partnership

Quality Report

Shibdon Road
Blaydon on Tyne
Tyne and Wear
NE21 5AE
Tel: 01914615654
Website: www.chainbridge.nhs.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a planned comprehensive inspection of Chainbridge Medical Partnership on 20 January 2015.

Overall, we rated the practice as good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. Our key findings were as follows:

- The services had been designed to meet the needs of the local population.

- Feedback from patients was positive; they told us staff treated them with respect and kindness.

- The practice was visibly clean and tidy.

- The practice learned from incidents and took action to prevent any recurrence.

- There was a clear leadership structure and staff felt supported by management. The practice actively sought feedback from patients

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. For example, in addition to the usual methods of raising concerns the practice used a system to collect and report on a daily basis any issues as they arose. The practice used every opportunity to learn from internal and external incidents and to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. For example, the practice had a dedicated health and safety team and systems in place which ensured that weekly and monthly safety checks took place such as checking fire equipment, emergency lighting alarms and escape routes. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice used data from the Quality Outcomes Framework (QOF) to improve patient outcomes. In 2013/2014 the practice achieved an overall QOF score of 95.5% which was above the England average by 2 percentage points. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. For example, they undertook weekly ward rounds at three care homes, and in collaboration with the care homes, had developed and regularly reviewed patients' care plans. The practice undertook annual reviews of all patients with long-term conditions.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The results of the National GP Patient Survey from January 2015 showed patients felt the GPs and nurses involved them in decisions about their care. The GPs achieved 82%, compared to the national average of 75%,

Good



Summary of findings

and the nurses achieved 76%, compared to the national average of 66%. With regard to explaining the need for any tests or treatment, the GPs achieved 90%, compared to the national average of 82% and the nurses achieved 86%, compared to the national average of 77%.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients 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 had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available, easy to understand and evidence showed that the practice responded quickly to issues raised. We saw that lessons were learnt from complaints and shared with staff.

The data showed that for 91.1% of patients experiencing certain mental health problems such as dementia had their care reviewed in a face-to-face appointment in the preceding 12 months; this was 5.2 percentage points above the England average.

Good



Are services well-led?

The practice was rated as good for well-led. The practice had a clear vision and strategy which had quality and safety as its top priority. There was also a strategy in place to implement this vision.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management team. 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 upon. There was an active online patient participation group (PPG). Staff had received inductions, performance reviews and attended staff meetings and events. We found there was a high level of staff engagement and staff satisfaction.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, the practice carried out weekly ward rounds in three care homes in addition to any visits or telephone advice they provided these patients. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice had a register of all patients over 75 years and each had a named GP.

Pneumonia and influenza vaccinations were offered to all patients over 65 years and shingles vaccinations were offered to all patients aged 70, 75 and 79 years.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For example, the practice used patients' dates of birth to prompt them to invite patients for an annual review. In addition, for those patients who could not attend the practice they were visited by a GP or practice nurse to carry out their annual review. For those patients with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. Immunisation rates were high for all standard childhood immunisations. For example, the immunisation rates were currently 100% except for the preschool booster which were at 96.3%.

Good



Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Midwives and health visitors held weekly clinics at the practice.

The practice offered a range of sexual health services including screening for sexually transmitted diseases and offering various methods of contraception.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and provided continuity of care. For example, they offered appointments until 7.30pm on a Monday and Thursday. Patients were able to book appointments and order repeat prescriptions on-line, by telephone and in person. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this population group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They worked closely with the area Learning Disability Team who followed up any patients who had not responded to the practice's invitation for a review.

Systems were in place to identify patients, families and children who were at risk or vulnerable. Their patient records were coded to alert staff of any concerns about these patients before a consultation. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities to ensure they were safeguarded.

The practice sign-posted vulnerable patients to various support groups and other relevant organisations.

Good



People experiencing poor mental health (including people with dementia)

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

Nationally reported QOF data (2013/14) showed that 91.7% of people experiencing poor mental health had received an annual

Outstanding



Summary of findings

physical health check. This was 7.2 percentage points above the England average. The data also showed that 91.1% of patients with mental health issues had a comprehensive care plan documented in their record, in the preceding 12 months. This was 5.2 percentage points higher than the England average.

Reception staff had received Dementia Friends training to help them understand the issues surrounding dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Counsellors from MIND and staff from Gateshead Talking Therapies both held clinics in the practice two days each week for patients experiencing poor mental health.

The practice also had a dedicated notice board for this population group which displayed information about patients to support groups and self-help advice.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. They told us the staff who worked there were caring and understanding, and there were no problems getting appointments. They also told us they found the premises to be clean and tidy.

We reviewed 15 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey, published in January 2015, showed the large majority of patients were satisfied with the services the practice offered. The results were:

- The proportion of patients who would recommend their GP surgery – 84%, compared to the national average of 78%;

- In respect of opening hours the percentage of patients rating their practice as ‘fairly satisfied’ or ‘very satisfied’ – 86%, compared to the national average of 76%;
- Percentage of patients rating their ability to get through on the telephone as ‘easy’ or ‘very easy’ – 82%, compared to the national average of 72%;
- Percentage of patients rating their experience of making an appointment as ‘fairly good’ or ‘very good’ – 79%, compared to the national average of 74%;
- Percentage of patients rating their practice as ‘fairly good’ or ‘very good’ – 92%, compared to the national average of 85%.

There were 278 surveys sent out and 110 were returned. There was a 40% completion rate.

Chainbridge Medical Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP, a specialist advisor in practice management and CQC colleague observer.

Background to Chainbridge Medical Partnership

Chainbridge Medical Partnership provides services to 11,119 patients, from Shibdon Road, Blaydon on Tyne, Tyne and Wear, NE21 5AE. The practice area covers Blaydon, Winlaton and Ryton. The practice provides their services under a NHS General Medical Services contract.

The practice is located in a purpose built two storey building, all patient facilities are situated on the ground floor. Parking is available close to the practice. The practice offers disabled parking outside the main entrance; wheelchairs are available in the lobby for patients with mobility problems. The practice provides a disabled WC, wheelchair and step-free access and power assisted doors.

The practice has six partners and four salaried GPs, three practice nurses, one health care assistant, a practice manager, an assistant practice manager, a practice administrator, 10 administration and reception staff and a cleaner.

The opening hours for the practice are 8.00am to 7.30pm on Monday and Thursday, and from 8.00am to 6.00pm each Tuesday, Wednesday and Friday.

The service for patients requiring urgent medical attention out of hours is provided through the 111 service and Gateshead Community Based Care Limited, which is also known locally as 'GatDoc'.

Why we carried out this inspection

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

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

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

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?

Detailed findings

- 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)

We carried out an announced visit on 20 January 2015. We spoke with eight patients, seven GPs, one nurse, the practice manager and three of the administration team. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 15 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards were complimentary about the service they had received and raised no concerns about their safety.

We saw that the practice used the Information from the Quality and Outcomes Framework (QOF) to monitor their patients. The practice had achieved 95.5% of the total points available to them for providing recommended clinical care and treatment. This was 2 percentage points above the England average. The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, e.g. diabetes and implementing preventative measures. The results are published annually.

The practice had a significant event audit (SEA) policy and procedures that staff followed. SEAs enable the practice to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care and treatment they provide. The practice also maintained an annual list of safety incidents which helped in identifying any emerging patterns.

We reviewed a sample of safety alerts the practice received and saw evidence that they had been followed up and actioned. We also saw evidence that SEAs were reported, investigated and steps taken to reduce the likelihood of any recurrence and any learning was shared with appropriate members of staff.

Learning and improvement from safety incidents

The practice was open and transparent when there were 'near misses' or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. For example, we saw that when a GP discovered a prescription error they reported it to the practice manager. The practice protocols were followed, the incident was investigated, and the patient informed and appropriate actions were taken to reduce the likelihood of a recurrence. We saw summaries of significant event meetings for October and July 2014. Both contained

four entries and included details of the incident and actions taken by the practice, such as reminding staff to be more vigilant when corresponding with insurance companies.

Staff told us that incidents were reviewed at regular practice meetings and changes were made as necessary. The practice held monthly quality and safety meetings which were used to address any patient safety issues and improve the quality of care. The practice held a SEA folder on their intranet where they filed incident reports and any learning and action points. All staff had access to this file.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines, or give guidance on clinical practice. They told us alerts came into the practice from a number of sources, including the General Medical Council (GMC) and the local clinical commissioning group (CCG.) All safety alerts were received by the practice manager who forwarded the email to all clinicians for action. All alerts were kept on the computer and hard copies had been taken as a back-up, since 2009. We reviewed a sample of alerts and saw that they had been processed correctly for example a medicines alert that had been followed up and actioned by the pharmacist and the other clinicians were made aware of the alert and actions taken.

Reliable safety systems and processes including safeguarding

In addition to the SEA processes the practice used the Safeguarding Incident and Risk Management System (SIRMS) to record monitor and analyse safety incidents. This is an on-line incident reporting system which enables information about incidents to be shared with local CCG member practices.

We saw the practice had safeguarding policies in place for both children and vulnerable adults which were reviewed in January 2014. We also saw the practice provided guidance on safeguarding for staff which included how to identify report and deal with suspected abuse. The practice displayed a contact list in all rooms of internal contacts and external agencies that might need to be informed when concerns arose such as the local police and Social Services.

The practice had safeguarding leads for both children and adults with responsibilities for overseeing safeguarding within the practice. The safeguarding lead for children was

Are services safe?

trained to Level 3 in respect of child safeguarding. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Most of the other GPs were also trained up to Level 3. One further GP had been booked to undertake the Level 3 training course. The nurses were trained to Level 2 and the Health Care Assistant (HCA) and administration staff were trained to Level 1. We saw training records that confirmed this. All staff had also been trained in adult safeguarding. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware and could help or support appropriately.

The practice had a chaperone policy which was reviewed annually. There were notices on display in all clinical rooms and the waiting areas informing patients of the availability of chaperones. We were told that all the chaperones were trained. Staff we spoke with confirmed this. The staff we spoke with were clear about the requirements of their roles as chaperones. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) All the chaperones had undergone a Disclosure and Barring Service (DBS) check. The 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.

Medicines management

The prescribing GP lead liaised with the pharmacist and a pharmacy technician, both provided by the local CCG, who worked at the practice once a week to improve prescribing and safety standards. The pharmacist team worked closely with GPs to undertaking medication reviews with patients by telephone or through face-to-face meetings. (A medicines review includes an examination of a patient's medicines, reaching an agreement with the patient about treatment, optimising the impact of medicines and minimising the number of medication related problems.)

The practice stored vaccines in two refrigerators as an added precaution should one fail. In addition we saw that the contact details for the relevant vaccine provider

companies were located next to each refrigerator for use in an emergency. We found the vaccines were stored securely and were only accessible to authorised staff such as staff who had received cold chain training. A cold chain is an uninterrupted series of storage and distribution activities which maintain items such as vaccines at a given temperature range. Maximum and minimum temperatures of the vaccine refrigerators were monitored daily by the practice manager or assistant practice manager. Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). (PGDs and PSDs are specific guidance on the administration of medicines authorising nurses and health care assistants to administer them.)

We saw that the practice kept their prescriptions securely in a locked cupboard. Staff told us that a limited number of staff had access to them. Prescription numbers were recorded on receipt into the practice and when given to a GP which offered a further level of security.

The practice had a process for monitoring the prescribing of disease-modifying antirheumatic drugs (DMARDs). DMARDs are a group of medicines that are used to ease the symptoms of rheumatoid arthritis and other conditions. Due to the potential side effects of these drugs patients prescribed them require regular monitoring. We saw evidence that the practice had reviewed their monitoring processes which included updating their spreadsheets and reminding clinicians if patients had missed any routine blood tests when considering issuing prescriptions.

All prescriptions were reviewed and signed by a GP before they were given to a patient.

Cleanliness and infection control

The premises were purpose built and under 12 months old when we inspected.

The practice was clean, bright, tidy and in excellent condition. Comments from patients we spoke with reflected this.

The practice had a lead for infection control and an infection control policy. All of the staff we spoke with about infection control said they knew how to access the practice's procedures for infection control.

The practice complied with current building regulation and codes which included conforming to infection control standards such as protection against legionella. The

Are services safe?

practice had scheduled a full infection control audit to take place in February 2015. However, this was started on the day of our inspection and concluded the following day. We were sent a copy of the audit; it did not highlight any concerns or issues.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single-use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We were told that all staff had received infection control training updates in the last 15 months.

The practice had a policy for handling specimens brought in by patients for testing such as urine. There was a purpose built clinical 'dirty' room which was used for testing and the safe disposal of the specimens. Staff spoke knowledgeably about the end-to-end process of receiving, handling, testing and disposing of specimens. They also told us about the actions they took to ensure their safety and reduce the likelihood of contamination and the spread of infection. We saw that the clinical 'dirty' room was clean, tidy and well equipped. There was PPE available and notices giving detailed guidance for staff on how to protect themselves and process the specimens.

The practice employed a cleaning contractor. We were told that the cleaning staff were given clear instructions regarding their role and tasks. We saw that there were recording charts in every area of the building for cleaners to complete to show that they had completed the relevant cleaning. The practice manager told us that they checked these charts during their daily building inspection. At the time of the inspection the practice was clean and tidy.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. The sharps bins were checked by the healthcare assistant (HCA) who sealed and replaced them as necessary. All clinical waste was removed from the practice weekly by an authorised contractor.

Equipment

The practice had processes in place to make sure that equipment was regularly checked to ensure that it was safe and effective to meet patients' needs. The fire extinguishers were checked annually. We saw that all the medical

equipment had been calibrated recently. We confirmed the defibrillator was checked weekly. (A defibrillator is a device that detects the heart's rhythm and automatically delivers a dose of electrical energy to the heart when needed.)

Portable appliance testing (PAT) had been carried out in 2013 and was scheduled for testing in March 2015. (Portable appliance testing is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.

Staffing and recruitment

We saw that the practice had a recruitment policy and equality and diversity policy. The practice manager told us that they took up references and obtained photographic proof of identity and satisfactory documentary evidence of any relevant qualifications in accordance with regulations. Checks were also made to ensure that staff maintained their registration which allowed them to practice. The practice undertook an induction process for all new staff. The practice always took up references before confirming an employee's appointment. Staff we spoke with, and the staff personnel records we looked at, confirmed this.

All clinical staff that were in contact with patients had been subject to DBS checks. The practice manager told us that if they needed a locum GP they would go through an agency and make sure that appropriate background checks had been undertaken. This demonstrated that the practice would take reasonable steps to ensure that the staff they employed were suitable to work with vulnerable patients.

We reviewed two staff records which included details of annual appraisals. They include discussion of achievements and training needs. Staff we spoke with confirmed appraisals had taken place

We looked at the training records for the practice and saw that staff had been offered training which included, for example, safeguarding and cardiopulmonary resuscitation (CPR.) (This is a first aid technique that can be used if someone is not breathing properly or if their heart has stopped.) We confirmed staff had completed other courses appropriate to their work.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff. The practice had a staffing policy which detailed the minimum number of staff

Are services safe?

for each staff group. The practice also produced monthly and weekly work rotas for all staff to ensure adequate staffing levels were maintained and there was a procedure for managing staff absences.

Monitoring safety and responding to risk

The practice had a well-established system in place to manage and monitor health and safety. For example, they had a health and safety team which included the practice manager, assistant practice manager and practice administrator. There were systems in place which ensured that weekly and monthly safety checks took place such as checking fire equipment, emergency lighting, alarms and escape routes. We saw that health and safety information was displayed on two dedicated notice boards. The information on display included a reminder to staff of their individual responsibility for the health and safety of other people who may be affected by the practice's activities.

The practice had employed a specialist contractor in health and safety to provide them with up-to-date information and documentation, and to notify them of any changes in legislation which might affect them. The contractor also undertook annual inspections to ensure the practice were complying with the current health and safety regulations.

The practice manager, or a colleague in their absence, undertook an inspection of the premises every morning before the practice opened to ensure there were no problems. The results of these inspections were recorded and action taken if required.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, a fire or flood. We were told that copies of the plan were kept on a shared folder on the intranet and the practice manager and all the partners had individual copies stored off-site. In addition, the practice manager had a copy on a memory stick for extra security. The plans included essential contact numbers such as electricity suppliers and the water authority.

The practice had resuscitation equipment and access to emergency medicines. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. We saw that they were within their expiry dates and that they were regularly checked. All staff had received CPR (resuscitation) training. Clinical staff had also received anaphylaxis (a sudden allergic reaction) training. We looked at training records which confirmed this. In addition, we were told that all clinical staff had been trained to use the defibrillator. Staff had sufficient support and knew what to do in emergency situations.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was considered in line with recognised best practice standards and guidelines.

GPs and nurses demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was an emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and from local health commissioners (Newcastle West Clinical Commissioning Group (CCG)). This guidance was available to all staff on the practice intranet.

The practice had processes in place to ensure current guidance was being followed. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing and following the current guidance. The practice was aware of its achievements in comparison to other local practices and nationally.

The practice used computerised tools such as the reporting analysis and intelligence delivering results (RAIDR) tool to identify groups of patients or individual patients who were at risk of admission to hospital.

The practice coded patient records using specific READ Codes. These are codes which provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems. This enabled them to easily identify patients with long-term conditions and those with complex needs.

We found from our discussions with the GP and the nurse that staff completed, in accordance with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. There were regular clinics where patients were booked in for an initial review of their condition; they were then scheduled for recall appointments. This ensured patients had routine tests, such as blood or spirometry (a spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function) tests to monitor their condition.

The clinicians also used other equipment such as an electrocardiogram (ECG) to test and record the rhythm and

electrical activity of the heart, to aid effective diagnosis. We were told that the practice undertook six monthly reviews of all their patients who were suffering from heart failure which included a review of all their medical conditions.

QOF data showed that 100% of patients with a diagnosis of heart failure had been confirmed by an ECG or by specialist assessment 3 months before or 12 months after entering on to the register, which was 4.7% above the England average.

All new patients were asked to complete a questionnaire to screen for alcohol misuse. Where the results indicated potential concerns patients were offered an appointment to see a GP. The practice had a lead GP for alcohol misuse. (A GP at the practice leads in this area). They had received advanced training in treating patients with alcohol misuse problems and were qualified to give treatment including detoxification. The practice also referred patients to the local 24/7 alcohol misuse service for additional help when required.

We were told that all patients over 75 years of age had been allocated a named GP who was responsible for their care. This helped to ensure continuity of care. The practice kept a register of patients with learning disabilities which enabled them to monitor their care effectively.

Management, monitoring and improving outcomes for people

We saw that the practice had a system in place for completing clinical audit cycles. The practice provided us with a sample of four audits. We reviewed two clinical audits they had recently undertaken. One covered minor surgery procedures and the other contraceptive implants. The minor surgery audit was undertaken to establish the rates of infection post minor surgery, identify likely causes and make changes to reduce the likelihood of patients developing an infection. Two audit cycles were completed. The first audit cycle recorded that 43 procedures were performed and there were no post-operative infections. In the second audit cycle recorded that 65 procedures were carried with one post-operative infection. The practice achieved a very low rate of post-operative infections. In respect of the audit of the contraceptive implants audit the practice contacted patients to get feedback of their experience their implant fitting/removal to determine if any improvements were necessary. The results were very positive. There were no issue or concerns. Re-audits were scheduled to take place in 2016.

Are services effective?

(for example, treatment is effective)

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. We saw that under the clinical results heading, the overall achievement for QOF (2013/14) was 95.5%, which was 2 percentage points above the England average. However, the achievements per clinical indicator were mixed but broadly in line with the England averages. The data indicated that the practice had performed well against some clinical indicators. For example, the practice had achieved 100% of the total points available to them for providing recommended care and treatments to patients with heart failure. We saw that 100% of patients with a particular type of heart failure had been prescribed recommended medicines. This was 7.9 percentage points above the England average. However, we also saw that the practice had performed less well against other indicators. For example, the practice had only achieved 85.5% of the total points available to them for providing recommended care and treatment to patients with diabetes. We saw that the last cholesterol test of 78.6% of patients with diabetes was below the prescribed measure. This was three percentage points below the England average. The practice told us that they had developed plans to address areas for improvement such as diabetes.

We saw that the practice took action to improve their performance in the diagnosis of dementia. They developed and implemented a dementia diagnosis plan. The practice told us that their screening for dementia rates had improved from seven patients in a six month period in 2013 to 98 patients in the same period in 2014. This resulted in nine patients being diagnosed with dementia which was an increase of over 10% in the diagnosis rate at the practice.

Effective staffing

Practice staffing included administrative, clinical and managerial staff. We reviewed staff training records and saw that the practice had a process in place for recording training undertaken and when this needed updating. Clinical staff maintained their individual continuing professional development (CPD) records. Good medical practice requires doctors and nurses to keep their knowledge and skills up-to-date throughout their working life and to maintain and improve their performance. CPD is a key way for them to meet their professional standards.

We saw from the staff training records that staff had attended courses which included safeguarding for children and vulnerable adults. All staff were either up-to-date with

attending mandatory courses such as basic life support. Staff undertook 'Time in and Time out' training courses which gave them an opportunity to undertake undisturbed formal and informal training. Reception staff had received Dementia Friends training.

We saw records that showed all GPs 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 the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.)

We were told that all staff had received an annual appraisal and had a personal learning plan agreed. The practice had an 'open door' policy whereby all staff were encouraged to freely raise any issues or concerns in meetings, or privately with the practice manager, and GPs. All staff we spoke with confirmed this and told us they would have no problems in raising any issues and also said they felt very supported by the practice.

All staff we spoke with were complimentary about their colleagues and told us that they all worked well as a team, for example, covering for each other during periods of sickness and holidays, and were mutually supportive. The patients we spoke with were also complimentary about the staff. There were no negative comments, and five positive comments, about staff in the 15 CQC comment cards we reviewed.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet their patients' needs. For example, the health visitor held weekly clinics at the practice and babies due for vaccination were vaccinated by the practice nurse. With the cooperation of the care homes the practice undertook weekly ward rounds of their registered patients. The practice coordinated consultations for patients who were unable to attend the practice. These patients were visited at home by an appropriate clinician such as a GP, practice nurse, community matron or district nurse. Various health care professionals such as midwives, mental health team, health visitors used the practice to provide services. Counsellors from MIND and staff from Gateshead Talking Therapies both held clinics in the practice two days each week for patients experiencing poor mental health.

Are services effective?

(for example, treatment is effective)

The practice told us that this had promoted good working relationships between the practice and these health care professionals. Correspondence from external health care and service providers, such as letters from hospital including discharge summaries, blood tests, information from out-of-hours providers and the 111 service, were received both electronically and by post. We were told that all patient correspondence was scanned, stored on the practice intranet, coded and sent to the relevant clinician to action, on a daily basis.

The practice regularly held various multidisciplinary meetings such as palliative care, (which took place quarterly), safeguarding and planning meetings. We were told that palliative care nurses, district nurses, community nurses and health visitors attended the relevant meetings.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. These records generated alerts which included prompts to staff that a patient needed medical reviews such as blood tests and dementia reviews.

Staff told us that they had created a special notes section in the clinical records of patients who were at risk of an emergency admission into hospital. The special notes included important information about patients' medical conditions as well as details of their treatment preferences. Staff said this information was shared with the out of hours service which helped ensure patients received appropriate care and treatment.

We were told that the practice used the NHS 'Choose and Book' facility to make referrals on behalf of their patients. They estimated that this accounted for 76% of their referrals.

Regular meetings were held throughout the practice. These included staff, clinical and multidisciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed with appropriate staff and other health care professionals to enable continuity of care.

Consent to care and treatment

All clinical staff had received training on the Mental Capacity Act (MCA) (2005). We found that staff we spoke with were aware of the MCA and their responsibility in respect of consent prior to giving care and treatment. They

described the procedures they would follow where patients lacked capacity to make an informed decision about their treatment. Staff we spoke with were able to give examples of how they obtained consent. They also showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. (Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.)

Health promotion and prevention

A range of health promotion information was available to patients in the lobby, reception and waiting area of the practices. In the waiting areas the practice had notice boards which were dedicated to various patient groups such as older people, and more general categories such as information for carers and support and help. The notice boards displayed information signposting patients to support services such as walking paced sports for older people, child health clinics, and support for post-natal stress and smoking cessation.

There was also a television screen in the main waiting area which displayed health care advice and information. There was a stand in the lobby with information about chlamydia and self- test kits were available for patients. The practice offered NHS health checks to all 40 to 70 years old patients. The practice proactively identified patients who needed ongoing support. In particular, they identified carers and coded their records so that clinicians were made aware of this before these patients attended appointments.

Carers were invited to a meeting at the practice in October 2014 to meet a representative from Gateshead Carers. The practice took this opportunity to update the carers on the services available. They also held a one-to-one meeting with carers and offered them a flu vaccination as part of the day.

The practice undertook annual reviews for patients with long-term conditions in addition to more frequent appointments when necessary. The practice identified patients who would benefit from treatment and regular monitoring, for example, they offered flu vaccinations and immunisations for children in line with current national guidance. Nationally reported QOF data showed that the practice had achieved child immunisation rates higher than the local CCG averages in all areas. For example, they had achieved a 97.4% rate for MMR immunisations for children

Are services effective?

(for example, treatment is effective)

aged 12 months, compared to the CCG average of 94.9% and a 100% rate for meningitis C immunisation for 5 year olds, compared to the CCG average of 95.9%. The practice figures currently showed that the immunisation rates were 100% except for the preschool booster which were at 96.3%.

The practice offered personalised care to meet the needs of the older patients in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. Pneumonia and influenza vaccinations were offered to all patients over 65 years and shingles vaccinations were offered to all patients aged over 70 years of age.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with eight patients during our inspection. They were complimentary about the services they received. Comments left by patients on the 15 CQC comment cards we received also reflected this.

We looked at data from the National GP Patient Survey, published in January 2015. They issued 278 questionnaires and 110 were returned. This showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example in the category of overall good experience the practice achieved 92%, compared to the national average of 85% and regarding the helpfulness of reception staff, they achieved 84%, compared to the national average of 87%. We saw that 98% of patients said they had confidence and trust in their GP, compared to the national average of 92% and 91% said their GP was good at treating them with care and concern, compared to the national average of 83%. We also saw that 96% of patients said they had confidence and trust in their nurse, compared to the national average of 86% and 84% said their nurse was good at treating them with care and concern, compared to the national average of 78%.

Staff we spoke with told us how they would protect patients' dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

We saw the reception staff dealt with patients pleasantly and warmly. The reception staff were aware of the need for confidentiality. They ensured conversations were conducted in a confidential manner. For example, staff spoke quietly so their conversations could not be overheard. There was a room available for use if patients wished to speak to receptionists in private. There were notices on display offering this facility to patients. The practice also had a touch screen available for patients to indicate they had arrived for their appointments

Care planning and involvement in decisions about care and treatment

Staff told us that they used a patient centred approach when providing care and treatment to patients. The practice undertook monthly reviews of their patient list to identify new patients and those recently diagnosed with long-term conditions, and contacted them to invite them for a review. The reviews were tailored to suit each patient's needs and included a comprehensive review of all their conditions as well as a medication review.

Patients told us they felt they had been involved in decisions about their care and treatment. They told us that the clinical staff took their time with them and always involved them in decisions.

Patients that the practice had highlighted as being at risk of hospital admission had care plans. The practice told us that the plans were drawn up with the assistance of the patient's family or carers where possible. The practice carried out weekly ward rounds in the care homes for their patients. The ward rounds included meetings with staff and family members to complete emergency healthcare plans and improve patient care.

The results of the National GP Patient Survey published in January 2015 showed patients felt the GPs and nurses involved them in decisions about their care. The GPs achieved 82%, compared to the national average of 75% and the nurses achieved 76%, compared to the national average of 66%. With regard to explaining the need for any tests or treatment the GPs achieved 90%, compared to the national average of 82% and the nurses achieve 86%, compared to the national average of 77%. This demonstrated that most patients who responded were satisfied with the way they were treated.

We saw that access to interpreting services was available to patients, should they require it. Longer appointment times were also available.

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. The practice held registers of various patients, such as those with learning disabilities aged 18 and over, patients suffering from Chronic Obstructive Pulmonary Disease (COPD – the name for a collection of lung diseases including chronic bronchitis, emphysema). These enabled the practice to monitor these patients and the care offered to them.

Are services caring?

Quality Outcome Framework (QOF) data showed that 91.1% of patients with mental health issues had a comprehensive care plan documented in the record, in the preceding 12 months; this was 5.2% percentage points higher than the England average.

Patient/carer support to cope emotionally with care and treatment

Staff told us that in addition to pre-bookable appointments the practice offered urgent appointments on the same day. The practice also undertook home visits for those patients not well enough to attend the practice.

The practice held a register of carers which helped them monitor the health and wellbeing of this group of patients. We were told that the practice received positive feedback from their carers meeting in October 2014 and they intend to hold similar events in the future.

Staff told us that bereaved relatives and carers would usually be contacted or visited by a GP to offer them support. The practice also sent them sympathy cards.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and various support groups and services.

The practice worked with patients experiencing poor mental health and provided personalised support. In addition, staff from Gateshead Talking Therapies and counsellors from MIND both held clinics two days a week at the practice. The practice told us that this had enabled good working relationships to develop between the clinical teams to the benefit of patients. The practice also held regular multidisciplinary team meetings where they planned care for patients who would benefit from coordinated support from other health care providers in conjunction with the care provided by the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice used electronic notes and alerts which were attached to medical records to advise staff that patients had additional needs such as, for example, they were at risk of emergency admission in which case any queries were processed as a priority.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG such as changing the practice telephone number and providing a photo board to identify staff members. A PPG is a group of patients registered with a practice who work to improve services and the quality of care and treatment provided to patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. The data showed that for patients experiencing certain mental health problems such as dementia 91.7% had been reviewed in a face-to-face appointment in the preceding 12 months, which was 7.9% above the national average.

There was parking available in a car park a short distance from the practice. The buildings had step free access for patients with mobility difficulties. The practice provided wheelchairs. The consulting and treatment rooms were located on the ground floor and accessible for all patients. There were power assisted doors which gave access to reception both waiting areas and the corridors leading to the treatment and consulting rooms. The push buttons for

the doors were located at a height suitable for all users to operate. There were disabled toilet facilities available at the practice. The practice had mobile induction loop equipment available for patients with hearing difficulties.

The practice had arrangements in place to access interpretation services for patients whose first language was not English. Any patients requiring this service were given longer appointments.

Access to the service

Opening times for the practice were 8.00am to 7.30pm on Monday and Thursday and 8.00 to 6.00pm Tuesday, Wednesday and Friday. GP appointments could be booked one month in advance or on the same day. The practice also provided an annual Saturday morning influenza vaccination clinic for eligible patients to attend without an appointment for vaccination. Other vaccinations such the shingles vaccination were also offered at these clinics.

Patients were able to book appointments either by calling into the practice, on the telephone and online. The practice offered consultation at the surgery, home visits where appropriate and telephone consultations. The practice told us that telephone calls from patients were returned at a time convenient to the patient whenever possible. Staff told us that patients suffering from some long term conditions such as diabetes were given longer appointment times if necessary.

Requests for repeat prescriptions were processed by 2pm the following working day and other medication requests were processed within 48 hours.

Patients we spoke with commented on the appointments system. They said they were satisfied with the appointment systems operated by the practice. This was reflected in the results of the most recent National GP Patient Survey (2015). This showed 79% of respondents described their experience of making an appointment as 'very good' or 'fairly good', in comparison to the national average 74% and 97% said that the last appointment they got was 'convenient for them', in comparison to the national average 92%.

Patients we spoke with also told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from 2015 confirmed this with

Are services responsive to people's needs?

(for example, to feedback?)

93% of patients stating the doctor gave them enough time and 86% stating they had sufficient time with the nurse. These results were well above the national averages (85% and 80% respectively).

The practice had an up-to-date practice leaflet which provided information about the services available, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Notices displaying the complaints process were on display in the waiting room. The practice leaflet explained that the practice manager would be happy to deal with any concerns patients had about the services they provided.

None of the eight patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 15 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy and the action they needed to take if they received a complaint which included informing the practice manager of any complaints made to them. We saw a summary of complaints made to the practice for 2014. We saw that they had received seven complaints. A summary of the complaint, details of the steps taken to address the complainant were recorded. Any learning from the complaints was recorded and shared with staff at staff meetings.

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 mission statement which was, to provide high quality, safe, and effective professional primary care services to their patients in a clean, suitably equipped and safe environment. The partners' strategy to achieve their mission had included moving the practice to the current new location. The partners were involved in designing and fitting out the building which ensured that the premises were fit for purpose and suitable for the needs of patients and staff. This enabled the practice to deliver their services from a safe and secure environment.

The staff we spoke with all knew and understood the vision and values and what their responsibilities were in relation to these. The practice told us that the services they provided were patient centred. Staff we spoke with confirmed this as did comments made by patients on the CQC comment cards.

The practice manager told us that the practice had an open and 'no blame culture' where staff were encouraged to discuss issues with colleagues and GPs when the need arose. Staff we spoke with confirmed this and told us that the practice was very supportive and they had no concerns about raising any matters with colleagues, GPs or the practice manager.

Governance arrangements

We saw that the practice had a well-developed leadership structure. There were clear lines of accountability for all aspects of patient care and treatment which included details of nominated individuals who were responsible for various clinical and non-clinical areas.

The practice had a number of policies and procedures in place which governed their day-to-day activities. Staff were able to access these on the practice's intranet. Staff told us that they worked in accordance with their policies and procedures. For example, they told us they followed patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. The policies and procedures that were in place, and feedback from staff, showed us that effective governance structures were in place.

Staff told us that they interacted with their colleagues throughout the day, supporting each other to provide their patients with good care and treatment. We saw that the practice held various regular team meetings such as monthly quality meetings. We saw copies of minutes of these meetings. They covered various topics which included care planning and patient participation. Action plans were formulated and followed up at subsequent meetings. Monthly clinical meetings were also held with the clinical team. Other regular team meetings were held with relevant colleagues and health care professional to discuss safeguarding and palliative care issues.

Leadership, openness and transparency

The practice had a clear corporate structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. Staff undertook lead roles in such areas as infection control and monitoring QOF data and practice performance. There were GP leads for specific clinical areas. The management team had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Staff told us they worked in a supportive team and there was an open culture in the practice and felt they could report any incidents or concerns they might have. In addition, the practice told us that they had an open door policy for all attached staff and encouraged them to come in to the practice to talk to any relevant members of staff whenever necessary. This environment helps to promote honesty and transparency at all levels within the practice and effective care for patients.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from staff through meetings, appraisals and informal discussions during their day-to-day activities. Staff we spoke with told us these meetings provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice provided staff with access to a noticeboard to record any daily mishaps, concerns or observations which were openly discussed and action taken where appropriate. Staff we

Are services well-led?

Good 

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

spoke with told us the practice was open to suggestions and acted upon them. We saw the practice also used the various meetings to share information about clinical and administration issues.

We saw the results of a Friends and Family survey dated December 2014. The practice received 402 responses. Of those patients who responded a significant number said they were 'likely' or 'extremely likely' to recommend the practice to friends and family if they needed similar care and treatment.

There was a suggestions box in reception which patients could use to comment about the practice. The practice gave us an example of where a patient alerted the practice that a grab rail needed to be installed in the disabled toilet. We were told this had been addressed to promote patient safety.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was supportive of training. They said they had received the training they needed, or it

had been scheduled, to carry out their roles and responsibilities and maintain their clinical and professional development. Staff training included 'Time-in' and 'Time-out' sessions. These sessions give staff protected time to undertake uninterrupted training. The practice undertook regular time in training workshops within the practice. Staff also attended time out workshops run by the CCG. Staff told us that they had appraisals which included agreeing future training courses to increase their skills and competencies.

The practice told us that they were planning to become a GP training practice and had taken on a GP to lead that process. They demonstrated their strong commitment to learning by aspiring to provide opportunities for GP Registrars to complete their specialist training.

The practice had an effective approach to incident reporting in that it encouraged reporting and the review of all incidents. Team meetings were held to discuss any significant incidents that had occurred. The practice had completed reviews of significant events and other incidents and shared these with staff and other relevant health care providers.