Fell Tower Medical Centre

Quality Report

Fell Tower Medical Centre, 575-583 Durham Road,
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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?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Fell Tower Medical Centre on 15 January 2015.

Overall, the practice was rated as good. It was also good at providing services for older people; People with long-term conditions; families, children and young people; working age people (including those recently retired and students); and people whose circumstances may make them vulnerable. The service for people experiencing poor mental health required improvement.

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement.
- People's 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 training 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 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 had good facilities and was well equipped to treat patients and meet their needs.
- Data from the GP National Patient Survey demonstrated the practice performed similar to local and national averages in a number of areas.
- The practice had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. The practice had identified a number of areas for improvement during their planning for the CQC inspection.

Summary of findings

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

Importantly the provider should:-

- continue to improve their governance arrangements to ensure a strong link between analysis of their performance and continuous quality improvement, including use of audits, significant events and incidents analysis. Where areas for improvement are identified, the practice should develop robust plans to achieve the necessary improvements.

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?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement.

Information about safety was recorded, monitored and addressed. Identified risks to patients were assessed and well managed. There were enough staff to keep people safe. Medicines were well managed and there were arrangements in place to keep the practice clean and reduce the risks of the spread of infection.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with the average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence 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. 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

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 and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. We found the practice leadership had not previously had a sufficient focus on driving continuous improvement. The approach to service delivery and improvement was reactive and focussed on short-term issues. There was a weak link between audits, significant events and incidents and identified learning and quality improvement. The practice had identified a number of areas for improvement but did not yet have a clear plan as to how they would implement change. The practice had identified these improvements during their planning for the CQC inspection.

The partners held a view of the priorities and strategy for the practice, but this had not been communicated to staff. There was a documented 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. The practice sought feedback from patients and had a virtual patient participation group (PPG). 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. The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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 identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 learning disabilities. The practice had carried out health checks for people with learning disabilities. The practice offered longer appointments for people, if required.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They provided health services to two local services, Elizabeth House and Southern Wood Promoting Independence Care Centre, where patients would otherwise be at risk of poor access to primary medical care. They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Overall, the performance on QOF related to mental health indicators demonstrated the practice was performing lower than other practices. The practice had recognised this as an area for improvement. The practice had achieved 77.2% of the points available across the 10 indicators relating to patients with poor mental health, compared to a national average of 90.4%. They were lower than national average on a number of indicators relating to health checks on patients with relevant mental health conditions. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was lower than average at 68.8%, compared to the national average of 83.8%.

Summary of findings

What people who use the service say

We spoke with seven patients during the inspection. We also spoke with two members of the practice Patient Participation Group (PPG) by telephone following the inspection.

Patients told us staff were friendly, and treated them with dignity and respect. Also, when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand. Some patients told us that at times it was difficult to get through to the practice to make an appointment. Most patients told us they would recommend the practice to family and friends.

We reviewed four CQC comment cards completed by patients prior to the inspection. Patients commented positively on staff being polite and helpful, taking action when needed and the practice being clean and safe.

The latest GP Patient Survey completed in 2013/14 showed the majority of patients were satisfied with the services the practice offered. Most of the indicators below are above or in line with National averages.

- 90.3% described their overall experience of this surgery as good (national average 85.7%)
- 87.5% would recommend this surgery to someone new to the area (national average 78.7%)
- 76.0% were satisfied with the surgery's opening hours (national average 76.9%)
- 83.6% found it easy to get through to this surgery by phone (national average 72.9%)
- 91.6% were able to get an appointment to see or speak to someone the last time they tried (national average 85.7%)
- 96.3% said the last appointment they got was convenient (national average 91.9%)

These results were based on 109 surveys that were returned from a total of 367 sent out; a response rate of 30%.

Areas for improvement

Action the service SHOULD take to improve

The practice should continue to improve their governance arrangements to ensure a strong link between analysis of their performance and continuous quality improvement, including use of audits, significant events and incidents analysis. Where areas for improvement are identified, the practice should develop robust plans to achieve the necessary improvements.

Fell Tower Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Lead Inspector.** The team included a GP, a specialist adviser with a background in practice management and a CQC Sector Resource and Scheduling Analyst.

Background to Fell Tower Medical Centre

Fell Tower Medical practice is based in the centre of Low Fell, a residential area of Gateshead. The practice provides services to around 7,300 patients from Fell Tower Medical Centre, 575-583 Durham Road, Low Fell, Gateshead, Tyne and Wear, NE9 5EY.

The practice is based in purpose built premises which are accessible from the main street or from the car park behind the surgery. There is level access for patients entering the building from the car park. Patient services are delivered from the ground and first floors, with lift or stair access between the two floors. It also offers disabled parking, a disabled WC, wheelchair and step-free access.

The practice has four GP partners, a salaried GP, a nurse practitioner, three practice nurses, two healthcare assistants, a practice manager and assistant practice manager, and a number of staff who carry out reception and administrative duties. There are both male and female clinicians at the practice.

Surgery opening times are Monday, Tuesday, Thursday and Friday 8:30am to 6pm, with extended hours on a Wednesday from 7am to 7:30pm.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

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

The practice population age distribution is similar to the national average, with the majority of patients within the 30 to 55 age range. The average male life expectancy is 76.4 and the average female life expectancy is 80.9.

There are a slightly more patients with a long-standing health condition (56.3%) compared to national averages (53.5%). The proportion of patients with health related problems in daily life (47.7%) is slightly lower than national average (48.9%). There are also lower than average number of patients with caring responsibilities at 13.3% compared to national averages (at 18.5%)

The CQC intelligent monitoring placed the practice in band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

Detailed findings

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.

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 our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 15 January 2015. We spoke with seven patients and nine members of staff. We spoke with and interviewed two GPs, a foundation year 2 (F2) doctor, the practice manager and assistant practice manager, a practice nurse, a healthcare assistant and three staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed four 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.

Good

Are services safe?

Our findings

Safe track record

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, they considered reported incidents, national patient safety alerts as well as comments and complaints received from patients.

The GPs we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. When we discussed incident reporting with nursing staff, they demonstrated knowledge of processes and procedures. However, they told us they had reported very few incidents. The practice had found there were a low number of incident reports from the nursing team and non-clinical staff. The practice management team had identified this as an area for improvement and were looking at ways to raise staff awareness and encourage staff to report incidents and near misses.

We saw that records were kept of significant events and incidents. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to view these. The reviews and investigations were not sufficiently thorough. The approach focused on addressing the immediate risk, but there was limited evidence to demonstrate the practice proactively identified, disseminated and acted upon learning to reduce the risk of similar incidents happening in the future. For example, for a number of incidents the learning identified focussed on reminding staff of their responsibilities. There was no evidence the practice had considered whether improvements to processes might help reduce the risk of errors reoccurring in the future.

We saw significant events were regularly discussed at practice partner meetings. However, there was no forum where these were discussed across different staff groups. Incident investigations were not communicated widely enough to support improvement and identify solutions. The practice had recognised this as an area for improvement and identified a practice wide approach would strengthen the opportunity to learn from events and incidents. They were at an early stage in redeveloping their approach.

The practice intended to use future 'time in' sessions to devote time as a whole practice to discuss the learning from significant events. ('Time in' sessions are a period of dedicated time the practice use for internal development and learning). They planned for this meeting to be held quarterly.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received role specific training on safeguarding. We saw evidence that GPs had received the higher level of training for safeguarding children (Level 3). Staff knew how to recognise signs of abuse in older people, vulnerable adults, young people and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff on the practice intranet.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to within the practice if they had a safeguarding concern.

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 or looked after children. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

Good

Are services safe?

The practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at A&E.

There was a chaperone policy, which was available on the staff intranet page. (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). Nursing staff and reception staff had been trained to be chaperones. Reception staff would act as a chaperone if nursing staff were not available.

Reception staff who had undertaken chaperone duties told us they had received training and had a recent Disclosure and Barring Service (DBS) check. DBS checks provide a criminal records check and barring functions to help employers make safer recruitment decisions. Not all relevant staff had received this check. The practice had identified this and applied for DBS checks for all relevant clinical and non-clinical staff within the last four weeks.

Medicines management

We found the practice had in place good arrangements for the management of medicines. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, and which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were appropriate arrangements for the handling of liquid nitrogen used in cryotherapy. (Cryotherapy is the use of low temperatures in medical therapy. It is used to treat a variety of benign and malignant tissue damage.)

A member of the nursing staff was qualified as an independent prescriber. We saw evidence they received regular supervision and support in their role.

Maximum and minimum temperatures of the refrigerator was checked and recorded every day when the surgery was open. This ensured that the vaccines were fit for use.

Vaccines were administered by practice nurses using directions that had been produced in line with legal requirements and national guidance. We saw copies of directions that were signed by the nurses who used them.

Blank prescription forms were handled in accordance with national guidance and were kept securely. All prescriptions were reviewed and signed by a GP before they were given to the patient. There were safe procedures in place to issue repeat prescriptions. Some prescriptions were collected by local pharmacies. The practice had implemented a procedure to reduce the risk of errors or misplacement of prescriptions being collected by local pharmacies.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury. Personal protective equipment including disposable gloves, aprons and coverings was available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Staff used single use instruments to reduce the risk of the spread of infections. Cleaning kits for dealing with spillage of bodily fluids were available in the reception area. There were also sufficient supplies of hand sanitising gel and hand soaps available in clinical areas and toilet facilities.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The privacy curtains in the consultation rooms were changed every six months or more frequently if necessary. We saw records were kept of when each curtain had been changed.

The practice had not undertaken an audit of infection control arrangements within the last two years. An infection control audit helps practices identify areas to improve and potential infection risks.

Good

Are services safe?

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were sharps disposal boxes in all the clinical areas of the practice. There were also contracts in place for the collection of both general and clinical waste.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

Staff told us they had received training recently in infection control procedures, including handling specimens and hand washing. Staff records confirmed this had taken place.

We saw a number of patients hand in specimens to reception staff to send away for testing. We observed this was done in a way to minimise the risk of infection.

The cleaning cupboard was well stocked, with cleaning schedule and procedures available for staff to refer to. There was a record kept on the back of clinical doors showing when the room had been cleaned and cupboards restocked with medicines and supplies. There were contact details available for domestic staff to raise any concerns identified.

We saw the most recent legionella risk assessment had been carried out in December 2013 and that the practice had processes in place to monitor and reduce the risk of infection by waterborne legionella. Although the practice manager was able to describe the actions the practice took to reduce the risk of legionella, such as run water through the two showers within the practice, there was no record made that these actions had taken place.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw that where required, equipment was calibrated (adjusted for accuracy) in line with manufacturer's guidelines. For example, weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and registration with the appropriate professional body.

The practice had recently revised their policy in relation to DBS checks. This policy set out the risk assessment to be undertaken for each role to determine whether a staff member would be subject to a standard or enhanced DBS check prior to the offer of employment. Following this review the practice had identified that not all relevant staff had been subject to a DBS check either during the recruitment process or at an appropriate interval. The practice had therefore within the last four weeks applied for DBS checks for all such clinical and non-clinical staff.

The practice manager routinely checked the professional registration status of GPs and nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. Staff told us there were effective arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Good

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. These included regular checks of the building, staffing, dealing with emergencies and equipment. The practice manager undertook a monthly walk around the building to identify and manage health and safety risks.

The practice had not undertaken a general health and safety risk assessment. They had developed a number of specific assessments where risks had been identified. For example they had completed an assessment on the use of the practice car park during icy weather.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to emergency medicines and oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment.

Emergency medicines were available in a secure area in the practice and all staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. Copies of the plans were held by the practice manager and GPs at their homes so contact details were available if the building was not accessible.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, we were told that patients with long term conditions such as COPD (chronic obstructive pulmonary disease) were invited into the practice to have their condition and any medication they had been prescribed reviewed for effectiveness.

The practice delivered a regular baby clinic to provide a six week check on the health of new babies, as part of the NHS New-born and Infant Physical Examination (NIPE) programme.

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex or race were not taken into account in this decision-making unless there was a specific clinical reason for this.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included scheduling clinical review, managing child protection alerts and medicines management. The practice had previously had clinical lead roles for different population groups, but this had lapsed over time. The practice planned to reinstate these roles to five greater clinical leadership and improvement of outcomes for patients.

The practice had a system in place for completing clinical audit cycles. They had recognised that their approach to audit could be strengthened to build a stronger link between the audits and improving outcomes for patients. The practice planned in future to complete two clinical audits and one non-clinical audit per year. The practice sent us three clinical audits prior to the inspection. Two of these had been completed on behalf of the practice by a clinical services organisation. These were completed in November 2014 and the full audit cycle was not yet complete as a re-audit had not taken place. The third audit related to the care and treatment of patients with a learning disability. This included checking whether the practice's learning disability register was up to date and complete and that where appropriate patients with a learning disability had been invited to a health check. The first audit found that not all relevant patients had been added to the register and not all had been invited for a health check. The follow up audit confirmed that following improvement action the register was up to date and complete and all patients had been invited to attend an appropriate health check.

The practice had in place clinical templates to guide staff in the assessment, monitoring and treatment of patients with long term conditions. There were systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us they had a register of patients with caring responsibilities and also those with poor mental health.

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had achieved 99.1% of the points available for clinical results; this was above the national averages of 96.4%.

This practice was an outlier on one QOF clinical target. This related to the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a

Good

Are services effective?

(for example, treatment is effective)

record of alcohol consumption in the preceding 12 months. The practice value was 44.6% compared to an England average of 88.6%. The practice told us they asked about alcohol consumption during health reviews for those patients on the mental health register. They told us recent data showed this had now improved to 80%.

The practice had achieved 77.2% of the points available across the 10 indicators relating to patients with poor mental health, compared to a national average of 90.4%. The practice were lower on the indicator relating to those with relevant mental health conditions who had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. The practice value was at 78.5% compared to a national average of 85.9%. They were lower than national average on a number of indicators relating to health checks on patients with relevant mental health conditions, such as monitoring of cholesterol, blood glucose levels and body mass index.

The percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the preceding 12 months was slightly better than average at 96.6% (compared to nationally 95.3%).

The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was lower than average at 68.8%, compared to the national average of 83.8%. However, the percent of patients who had relevant health checks (such as glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate level) recorded between 6 months before or after entering on to the register was 100% (compared to a national average of 80.2%).

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. Once a month the practice closed for an afternoon for Protected Learning Time (PLT). A part of the time during these afternoons was dedicated to training. The practice attended learning events provided by the local Clinical Commissioning Group (CCG).

The practice was in the process of reviewing the mandatory training for each staff group, to ensure staff have the skills, experience and knowledge to deliver safe and effective care. We saw the plan covered a number of key areas such as equality, diversity and human rights, health and safety, infection control and information governance.

We saw that where staff had attended training, a copy of the training certificate was kept on file. However, a full record was not maintained. For example, where staff members had attended 'time out' training sessions provided by the local CCG their attendance was recorded, but the details of which sessions they had attended were not. This made it more difficult for the practice to monitor what training staff had undertaken and where the skills gaps were.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed can the GP continue to practice and remain on the performers list).

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported. We spoke with a new member of staff who told us they had an induction and had felt well supported when they joined the practice.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs.

We saw various multi-disciplinary meetings were held. For example, a weekly clinical team meeting was held, this included GPs, nurses and the district nursing team. Child protection meetings were held quarterly and palliative care

Good

Are services effective?

(for example, treatment is effective)

review meetings were held two or three times a year. There were well established links with local Macmillan nurses. This helped to share important information about patients including those who were most vulnerable and high risk.

Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out of hours' provider and the ambulance service.

Staff told us the practice provided services to the Southern Wood Promoting Independence Care Centre. This service provided intermediate care with short term residential care for periods of up to six weeks for patients experiencing difficulty coping at home, following hospital admission or for short periods of respite care. They provided services to a local supported accommodation service for young mums aged 16-25 with pre-school children. The practice offered health care to all patients who used these services, whether they were a patient with the practice or not.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

The practice had systems in place to provide staff with the information they needed. Electronic patient records were used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled paper communications, such as those from hospital, to be scanned and saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

GPs we spoke with 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.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for the fitting of contraceptive implants and routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Health promotion and prevention

New patients were offered a 'new patient check'. The initial appointment was scheduled with one of the Healthcare Assistants, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting areas. This included information about screening services, smoking cessation and child health. We found there was very little information available for patients about mental health conditions or links to local mental health services

Good

Are services effective?

(for example, treatment is effective)

and support agencies. The practice told us they gave patients details of local support services such as the new integrated wellness scheme, to help them improve or maintain their health and wellbeing. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice's website also provided some information for patients on health promotion and prevention. This included a link to information to inform patients they could self-refer to the local physiotherapist service, Connect Physical Health.

Patients with long term conditions were recalled to check on their health and review their medications for effectiveness. 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. We were told this worked well to prevent any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. 84.3% of women who were eligible were noted as being screened within the last five years (compared to 81.9% average nationally).

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. MMR vaccination rates for five year old children were 92.5% compared to an average of 91.5% in the local CCG area. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was in line with the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice. The evidence from both these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national patient survey showed that 90.3% of those surveyed described their overall experience of the surgery as good (compared to a national average of 85.7%).

The practice was also rated well on consultations with doctors and nurses. For example, 93.5% had confidence and trust in the last GP they saw or spoke to. This compared with a national average of 92.5% and a local Clinical Commissioning Group (CCG) area average of 93.9%. Also, 96.1% had confidence and trust in the last nurse they saw or spoke to. This compared with a national average of 86.2% and a local CCG average of 89.6%. In the practice's own survey the majority of patients rated GPs at the practice good or very good for :-

- Putting patients at ease (98%);
- Being polite and considerate (100%);
- Listening to patients (96%); and,
- Giving patients enough time (95%).

Patients completed CQC comment cards to tell us what they thought about the practice. We reviewed four CQC comment cards completed by patients prior to the inspection. Patients commented positively on staff being polite and helpful, taking action when needed and the practice being clean and safe. One comment related to difficulties in the process for making an appointment and another with not feeling like the GP listened to them.

We spoke with seven patients during the inspection. We also spoke with two members of the practice Patient Participation Group (PPG) by telephone following the inspection. Patients told us staff were friendly, and treated them with dignity and respect. Also, when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand. Some patients told us that at times it was difficult to get through to the practice to make an appointment. Most patients told us they would recommend the practice to family and friends.

Staff were familiar with the steps they needed to take to protect people's 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 that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, 77.0% of practice respondents said the GP was good at involving them in care decisions and 92.2% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG area and national averages.

Most of the patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Most 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 they wished to receive.

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

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91.2% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the practice website also told people how to access a number of support groups and organisations. There was little information displayed relating to mental health conditions.

The practice routinely asked patients if they had caring responsibilities. This was then noted on the practice's computer system so it could be taken into consideration by clinical staff. Practice staff told us they referred patients to the Gateshead Carers organisation or encouraged them to self-refer.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff were familiar with the individual needs of their patients and the impact of the local socio-economic environment. Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We saw the practice referred patients to other services where the aim was to help particular groups of patients to improve their health. For example, smoking cessation programmes, and advice on weight and diet.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey from 2014 confirmed this. 86.9% of patients felt the doctor gave them enough time, 93.5% felt they had sufficient time with the nurse. These results were in line with national or better than averages (85.3% and 80.2% respectively).

The practice had a virtual Patient Participation Group (PPG). To encourage a wider range of members the practice had recently changed to a virtual group, using email correspondence to gather the views of members. There was an action plan in place, developed following consultation with the PPG. Actions included plans to increase access by increasing the number of telephone consultations available, to deliver flu vaccinations to linked nursing and residential homes earlier in the flu season and focus on the identification of carers within the practice.

We spoke with two members of the group who said they felt the practice valued their contribution. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. They told us following feedback from the PPG the practice was reviewing the appointment system to improve access to appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended with early morning and late evening appointments available on a Wednesday. This helped to improve access for those patients who worked full time or were in full time education.

Services had been designed to reflect the needs of the diverse population served by the practice. The practice had access to and made use of translation services, for those patients whose first language was not English.

The premises and services had been adapted to meet the needs of people with disabilities. All patient facilities had step free entrances. A lift was available between the two floors where patients accessed services. There was a bell available at the entrance from the car park so patients could alert staff if they were having difficulty entering the building. However, there was no bell available on the Durham Road entrance, so patients were unable to call for assistance.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet and baby changing facilities were available for all patients.

The practice had access to large print information for patients who were visually impaired, and gave us examples of how they had met the needs of visually impaired patients. The practice had a hearing loop available for those with a hearing impairment.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 8:00am and 6:00pm Monday to Friday. There were extended hours on a Wednesday from 7am to 7:30pm. Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the internet. 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 gave the telephone number they should ring depending on the circumstances. This information was also available on the practice website.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. The National GP Patient Survey found that 83.6% of patients rated the ease of getting through to someone at GP surgery on the phone as easy or fairly easy. However, some of the patients we spoke with told us that it could be difficult to get through to the practice to make an appointment. The practice was looking at how to improve this following similar feedback from the practice Patient Participation Group (PPG).

The most recent National GP Patient Survey (2014) showed that patients were generally satisfied with access to the service. This showed 91.6% were able to get an appointment to see or speak to someone the last time they tried and 96.3% said the last appointment they had was convenient. 76.0% of patients who responded were satisfied with the opening hours this compared with a 76.9% national average.

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.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

The complaints policy was outlined in the practice leaflet and was available on the practice's website. There was no information displayed in the practice itself to inform patients about the complaints process. The practice addressed this during the inspection and put up information informing patients about the complaints process.

Of the seven patients we spoke with and the four CQC comment cards, none raised concerns about the practice's approach to complaints.

We saw the summary of complaints that had been received in the 12 months prior to our inspection. The practice had received nine complaints. We looked at four of these in detail. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The partners held a view of the priorities and strategy for the practice, but this had not been communicated to staff. The partners recognised they needed to improve their approach to communicating with practice staff and were in the process of planning how to do this effectively. The practice had identified a number of key areas where they planned to improve the service. In particular they planned to increase the opportunities to learn from audits, incidents, events and complaints. These areas for improvement had not been formally documented in an action plan. We were concerned that without a formal action plan the practice would be unable move forward with their plans in a sustainable and effective way. A number of the areas for improvement had been identified as a result of the practice planning for the CQC inspection.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures and saw they had been reviewed regularly and were up-to-date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. The practice planned to strengthen its governance processes by introducing whole staff meetings to increase opportunities for shared learning and improvement.

The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a limited number of clinical and non clinical audits. They had recognised this as an area for improvement. In the future they planned to undertake a minimum of two complete clinical audits and one non-clinical audit per year.

Leadership, openness and transparency

The practice had a leadership structure in place which supported staff to deliver on their responsibilities. They were looking to strengthen this to have a clearer focus on how the practice could support continuous improvement. This included increasing the number of significant events reported by staff by supporting their understanding of what these are and giving opportunities for the practice to discuss them as a team. Also increasing audit activity and having a clearer link with how these support the practice to improve.

There were some leads in place, such as an infection control lead, but the practice was looking to strengthen their approach. They planned to reinstate clinical leads for different population group to provide leadership and support for staff in these areas. We spoke with nine members of staff and they were all clear about their own roles and responsibilities.

We found the practice leadership had not previously had a sufficient focus on driving continuous improvement. There was a weak link between audits, significant events and incidents and identified learning and quality improvement. The practice had identified a number of areas for improvement but did not yet have a clear plan as to how they would implement change.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. These were easily accessible to staff via a shared intranet on any computer within the practice.

Staff told us that regular meetings were held for each team within the practice and that notes were kept of these meetings. They told us they felt well-supported by the practice management team.

The practice had a patient contract which set out clearly the expectations for patients using the service.

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

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. The practice had a virtual patient participation group (PPG). There was a PPG action plan in place. Key priorities for 2014-15 included to increase access by increasing the number of telephone consultations available; to deliver flu vaccinations to linked nursing and residential homes

Are services well-led?

Requires improvement

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

earlier in the flu season; and, focus on the identification of carers within the practice. The practice published an annual report into the work of the PPG and this was available on the practice website.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results from this survey were available on the practice website.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT, there were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us example where they had suggested improvements and these had been considered and implemented. For example, following feedback staffing for immunisation clinics was increased to two nurses, so they could provide each other with peer support.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had.

Management lead through learning and improvement

The approach to service delivery and improvement was reactive and focussed on short-term issues. The practice had plans to improve their approach to leading change through learning and improvement. However, they had not yet identified the actions that were needed to achieve the desired improvements.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place. Staff members had personal development plans.