Second Street Surgery

Quality Report

Second Street Surgery
Second Street
Gateshead
Tyne and Wear
NE8 2UR
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Date of inspection visit: 15 September 2016
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Second Street Surgery on 15 September 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- The practice carried out clinical audit activity and were able to demonstrate improvements to patient care as a result of this.
- Feedback from patients about their care was consistently positive and results of the National GP Patient Survey in relation to this were higher than local and national averages. Patients reported that they were treated with compassion, dignity and respect. Patient feedback in relation to access was comparable with local clinical commissioning group and national averages.
- Patients were able to access same day appointments. Pre-bookable appointments were available within acceptable timescales.
- The practice had a number of policies and procedures to govern activity, which were reviewed and updated regularly.
- The practice had proactively sought feedback from patients and implemented suggestions for improvement and made changes to the way they delivered services in response to feedback.
- The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring effectiveness and had achieved an overall result which was higher than local and national averages.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- The practice had a clear vision in which quality and safety was prioritised. The strategy to deliver this vision was regularly discussed and reviewed.

We saw some areas of outstanding practice:

- The practice participated in a telephone support service scheme to ensure vulnerable and other relevant patients were able to access regular support to help them make positive changes in their lives. This was a voluntary service created as part of an informal arrangement with three other practices in the area and with financial support from a local charity and enabled patients referred to the service to receive weekly telephone or skype calls for up to 12 weeks to offer support on issues such as isolation and loneliness
- The practice had identified a member of staff as a primary care navigator to ensure there was a holistic approach to ensuring a patient's medical and social needs were met and patients discharged from hospital were well supported. This included ensuring relevant patients were signposted to appropriate support services such as a befriending service, or practice telephone support service.
- The practice identified carers and ensured they were offered an annual health check and influenza vaccination and signposted to appropriate advice and support services. The practice had worked with a local carer's charity to aid the identification of their young carers. They were able to demonstrate that they were the highest Carer Pathway referrer in the Gateshead area for the period April 2015 to September 2015.

However, there were also areas where the provider should make improvements. Importantly, the provider should:

- Continue to promote and seek membership for a patient participation group.
- Regularly review the length of time patients wait to be called in for their appointments
- Ensure the cord mechanisms on vertical blinds in communal and clinical areas are tethered to prevent the risk of accidental choking for young children.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.

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

The practice was clean and hygienic and good infection control arrangements were in place. However, the practice should ensure the cord mechanisms on vertical blinds in communal and clinical areas are tethered to prevent the risk of accidental choking for young children.

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

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

Are services effective?

Good

The practice is rated as good for providing effective services.

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

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable with local clinical commissioning group (CCG) and national averages. The practice used the QOF as one method of monitoring effectiveness and were able to demonstrate that they had achieved 98.9% of the points

Summary of findings

available to them for 2015/16 (results not yet published). The last published results, which related to 2014/15 indicated that the practice had obtained 98.2% of the point's available (local CCG average 95.5% and national average 94.7%).

Achievement rates for cervical screening, influenza vaccination and the majority of childhood vaccinations were mixed but generally lower than local and national averages. For example, at 78%, the percentage of women aged between 25 and 64 whose notes recorded that a cervical screening test had been performed in the preceding five years was below the CCG average of 81% and national average of 82%. Childhood immunisation rates for the vaccinations given to two year olds ranged from 16.7% to 100% (compared with the CCG range of 64.7% to 93.5%). For five year olds this ranged from 57.1% to 85.7% (compared to CCG range of 90.1% to 97.3%).

There was evidence of clinical audit activity and improvements made to patient care and patient outcomes as a result of this.

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

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients we spoke with during the inspection and those that completed Care Quality Commission comments cards said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about the service was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Results from the National GP Patient Survey published in July 2016 were better than, or comparable with local CCG and national averages in respect of providing caring services. For example, 100% of patients who responded to the survey said the last GP they saw or spoke to was good at listening to them (CCG average 91% and national average 89%) and 92% said the last nurse they saw or spoke to was good at listening to them (CCG average 93% and national average was 91%).

Results also indicated that 99% of respondents felt the last GP they saw or spoke with treated them with care and concern (CCG average 88% and national average of 85%). 96% of patients felt the nurses treat them with care and concern (CCG average 93% and national average 91%).

The practice identified carers and ensured they were offered an annual flu vaccination and signposted to appropriate advice and support services. At the time of our inspection they had identified 57

of their patients as being a carer (approximately 1.9% of the practice patient population). The practice were able to demonstrate that they were the highest Carer Pathway referrer in the Gateshead area for the period April 2015 to September 2015.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

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 and identified themes arising from them.

The practice's performance in relation to access in the National GP Patient Survey were comparable with local and national averages. For example, the most recent results (July 2016) showed that 94% of patients found it easy to get through to the surgery by phone (CCG average 79%, national average 73%) and 87% were able to get an appointment (CCG average 85% and national average 85%).

The practice was able to demonstrate that they continually monitored the needs of their patients and responded appropriately. The practice had become involved in a number of initiatives to improve services.

The practice implemented suggestions for improvements and made changes to the way they delivered services as a consequence of feedback from patients. For example, they had recruited a health care assistant and an additional receptionist and created more book on the day appointments in response to patient feedback. However, the practice did not have a patient participation group.

The practice were committed to either trying to secure new premises or extend and improve their current premises which were felt to be too small to offer a full range of services.

Are services well-led?

Good

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

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

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included

Summary of findings

arrangements to monitor and improve quality and identify risk. The practice had a comprehensive three year business plan which documented priorities such as succession planning, staff recruitment, premises and patient demographics.

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

The practice sought feedback from staff and patients, which it acted on. They did not have an 'actual' patient participation group but did have a 'virtual' group consisting of four patients whose opinion was sought by letter and email.

There was a strong focus on continuous learning and improvement at all levels.

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 Quality and Outcomes Framework (QOF) data for 2015/16 provided by the practice (the data had not yet been published) showed the practice had achieved good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients experiencing heart failure, stroke and transient ischaemic attack and for secondary prevention of coronary heart disease.

The practice health care assistant had the dual role of being the practice primary care navigator. This role involved a holistic approach to ensuring a patient's medical and social needs were referred or signposted to appropriate support services such as a befriending service, or practice telephone support service. The role also involved ensuring that patients discharged from hospital received a telephone call within three days of discharge to ensure that they were receiving appropriate post discharge support.

The telephone support service is a voluntary service created as part of an informal arrangement with three other practices in the area and with financial support from a local charity. This enables patients referred to the service to receive weekly telephone or Skype calls for up to 12 weeks to offer support on issues such as isolation and loneliness.

People with long term conditions

Good

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

Longer appointments and home visits were available when needed. The practice's computer system was used to flag when patients were due for review and the practice had commissioned an external provider to ensure that the recall system for long term conditions was efficient and robust. Patients with multiple long term conditions were offered an annual comorbidity (multiple condition) review when possible in their birthday month. These reviews were conducted as a home visit when required to ensure the same quality of care for housebound patients.

The QOF data for 2015/16 provided by the practice showed that they had achieved good outcomes in relation to the conditions commonly associated with this population group. For example:

Summary of findings

- The practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with asthma.
- The practice had obtained 100% of the points available to them in respect of hypertension.

Care plans were in place for patients most at risk of deteriorating health. Patients with certain long term conditions such as asthma and chronic obstructive pulmonary were issues with rescue packs to prevent an exacerbation of their condition.

Families, children and young people

Good

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

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

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

Data available for 2014/15 showed that the practice childhood immunisation rates for the vaccinations given to two year olds ranged from 16.7% to 100% (compared with the CCG range of 64.7% to 93.5%). For five year olds this ranged from 57.1% to 85.7% (compared to CCG range of 90.1% to 97.3%)

At 78%, the percentage of women aged between 25 and 64 whose notes recorded that a cervical screening test had been performed in the preceding five years was lower than the CCG average of 81% and national average of 82%.

Pregnant women were able to access a full range of antenatal and post-natal services at the practice.

The practice had appointed a Young People's Champion who had been involved in designing a young patients section of the practice website and a young people's practice information leaflet.

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).

Summary of findings

The needs of the working age population, those recently retired and students had been met. The surgery was open from 9am to 5.30pm and 6.30pm to 7.45om on a Monday; 9am to 5.30pm on a Tuesday, Wednesday and Friday and 9am to 12 midday on a Thursday. Appointment availability with a GP was generally available from 9.30am to 12.15pm then from 3pm to 5.30pm. However, a GP was always on site between 8am and 9.30am and 12.15pm to 3pm and on Thursday afternoons to deal with urgent appointment, advice and home visit requests. Patients registered with the practice were also able to access pre bookable appointments with a GP at one of three local health centres from 8am and 8pm on a weekday and 9am to 2pm on a weekend.

The practice offered sexual health and contraception services, travel advice, childhood immunisation service, minor surgery, antenatal services, smoking cessation advice and long term condition reviews. They also offered new patient and NHS health checks (for patients aged 40-74).

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. A text messaging service was available which was used to remind patients of their appointments. Pre-bookable telephone consultations were available on request.

From the end of September 2016 the practice were introducing a 24 hour per day/seven day per week service called patient partner which would enable patients to book, cancel and rearrange appointments using an automated telephone service.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances, including 9 patients who had a learning disability. Patients with a learning disability were offered an annual health check and flu immunisation.

The practice had established effective working relationships with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice identified carers and ensured they were offered appropriate advice and support and an annual health check and flu vaccination. The practice were the highest carer pathway referrer in the Gateshead area for the period April 2015 to September 2015.

Summary of findings

Vulnerable patients, including those experiencing bereavement, homeless patients and veterans, were able to access support through the practice telephone support service.

People experiencing poor mental health (including people with dementia)

Good

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

QOF data for 2015/16 provided by the practice showed that they had achieved the maximum score available for caring for patients with dementia, depression and mental health conditions:

Patients experiencing poor mental health were invited for an annual review with the health care assistant and GP which covered health surveillance, preventative advice and social prescribing. Patients were also signposted to various support groups and third sector organisations, such as local wellbeing and psychological support services.

The practice manager acted as the practice mental health champion and had previous experience of working with and supporting patients with mental health issues. The practice nurse acted as the dementia champion for the practice and ensured that support and advice was available for patients with dementia and their family and carers.

Summary of findings

What people who use the service say

The results of the National GP Patient Survey published in July 2016 showed patient satisfaction was generally higher than the local clinical commissioning group and national averages. Of the 341 survey forms distributed, 99 were returned (a response rate of 29%). This represented approximately 3% of the practice's patient list. For example, of the patients who responded to their survey:

- 94% found it easy to get through to this surgery by phone compared to a CCG average of 79% and a national average of 73%.
- 87% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85%, national average 85%).
- 91% described the overall experience of their GP surgery as fairly good or very good (CCG average 88%, national average 85%).
- 87% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 80%, national average 78%).
- 95% said their GP was good at explaining tests and treatment (CCG average 88%, national average 86%)
- 96% said the nurse was good at treating them with care and concern (CCG average 93%, national average 91%)

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 52 comment cards which were very complimentary about the standard of care received. The respondents stated that they found the surgery clean and hygienic and that they were confident they would receive good treatment. Words used to describe the practice and its staff included brilliant, 1st class, caring, professional, excellent, pleasant and wonderful.

We spoke with four patients during the inspection, all of whom said they were happy with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service SHOULD take to improve

- Continue to promote and seek membership for a patient participation group.
- Regularly review the length of time patients wait to be called in for their appointments
- Ensure the cord mechanisms on vertical blinds in communal and clinical areas are tethered to prevent the risk of accidental choking for young children.

Outstanding practice

- The practice participated in a telephone support service scheme to ensure vulnerable and other relevant patients were able to access regular support to help them make positive changes in their lives. This was a voluntary service created as part of an informal arrangement with three other practices in the area and with financial support from a local charity and enabled patients referred to the service to receive weekly telephone or skype calls for up to 12 weeks to offer support on issues such as isolation and loneliness
- The practice had identified a member of staff as a primary care navigator to ensure there was a holistic approach to ensuring a patient's medical and social needs were met and patients discharged from hospital were well supported. This included ensuring relevant patients were signposted to appropriate support services such as a befriending service, or practice telephone support service.
- The practice identified carers and ensured they were offered an annual health check and influenza

vaccination and signposted to appropriate advice and support services. The practice had worked with a local carer's charity to aid the identification of their young carers. They were able to demonstrate that they were the highest Carer Pathway referrer in the Gateshead area for the period April 2015 to September 2015.

Second Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. Also in attendance was a GP specialist advisor.

Background to Second Street Surgery

Dr Selwyn Brian Bolel officially took over Second Street Surgery in April 2016 and provides care and treatment to approximately 3014 patients predominantly from the Crawcrook, Blaydon, Wardley, Whickham, Chopwell and Gateshead areas of Tyne and Wear. The practice is part of the NHS Newcastle Gateshead Clinical Commissioning Group (CCG) and operates on a General Medical Services (GMS) contract.

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

Second Street Surgery

Second Street

Bensham

Tyne and Wear

NE8 2UR

The surgery is located in a single storey purpose-built building. All reception and consultation rooms are fully accessible for patients with mobility issues. However, the two entrance doors to the premises were offset with a small entrance hall in between and not electronically operated which could present difficulties for patients with mobility issues. An on-site car park is available which includes a dedicated disabled car parking spaces.

The surgery is open from 9am to 5.30 and 6.30pm to 7.45pm on a Monday; 9am to 5.30pm on a Tuesday, Wednesday and Friday; 9am to 12 midday on a Thursday. Appointment availability with a GP was generally available from 9.30am to 12.15pm then from 3pm to 5.30pm. However, we were told that the GP was always on site between 8am and 9.30am; 12.15pm to 3pm and on Thursday afternoons to deal with urgent appointment, advice and home visit requests. Appointments with the nurse were available from 9am to 5.30pm on a Monday, Tuesday, Wednesday and Friday and from 9am to midday on a Thursday. Patients registered with the practice were also able to access pre bookable appointments with a GP at one of three local health centres from 8am and 8pm on a weekday and 9am to 2pm on a weekend.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Gateshead Community Based Care Limited (known locally as GatDoc).

Second Street Surgery offers a range of services and clinic appointments including contraception advice, travel clinics, childhood immunisation service, long term condition reviews, minor surgery and smoking cessation advice.

The practice consists of:

- One single hand GP (male)
- One practice nurse (female)
- One health care assistant (female)
- One practice pharmacist (female)
- Five non-clinical members of staff including a practice manager and receptionists

Detailed findings

The average life expectancy for the male practice population is 74 (CCG average 77 and national average 79) and for the female population 81 (CCG average 81 and national average 83).

At 40.6%, the percentage of the practice population reported as having a long standing health condition was lower than the CCG average of 56.9% and national average of 54%. Generally a higher percentage of patients with a long standing health condition can lead to an increased demand for GP services. 71.2% of the practice population were recorded as being in paid work or full time education (CCG average 60.5% and national average 61.5%). Deprivation levels affecting children were lower than the local CCG average but higher than the national average. Deprivation levels affecting older people were higher that local and national averages.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 September 2016. During our visit we spoke with a mix of clinical and non-clinical staff including the GP, the practice nurse, the practice manager, practice pharmacist, health care assistant and receptionists. We spoke with four patients and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 52 Care Quality Commission (CQC) comment cards that had been completed by patients and looked at the records the practice maintained in relation to the provision of services. We also spoke to attached staff that worked closely with, but were not employed by the practice. This included the safe care lead from the district nursing team and a health visitor.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Staff were well aware of their roles and responsibilities in reporting and recording significant events.

Significant events were analysed and discussed and minuted at bi-weekly clinical and six weekly practice meetings and learning outcomes were identified and acted upon. However, the practice did not carry out an annual review of significant events. The practice manager told us that this was something she intended to implement in the near future.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. Trends and themes were identified and the practice regularly recorded relevant significant events and safeguarding incidents on the local clinical commissioning group's (CCG) Safeguard Incident and Risk Management System (SIRMS). The SIRMS system enables GPs to flag up any issues via their surgery computer to a central monitoring system, so that the local CCG can identify any trends and areas for improvement. A system was in place to ensure patient safety alerts were cascaded to relevant staff and appropriate action taken.

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

Overview of safety systems and processes

The practice had systems, processes and practices in place which generally kept patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice held regular multi-disciplinary meetings to discuss vulnerable patients. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The GP was trained to level three in children's safeguarding.
- Chaperones were available if required. Staff who acted as chaperones had all received appropriate training and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene and we observed the premises to be clean and tidy. A cleaning schedule was in place. The last infection control audit had been carried out in November 2015 and had identified action points and areas for improvement. We saw evidence of these action points either being addressed or in the process of being addressed. For example, the provider had ensured that a visible laminated handwashing poster had been placed in all clinical rooms and toilets. A comprehensive infection prevention and control policy was in place.
- An effective system was in place for the collection and disposal of clinical and other waste.
- The cord mechanisms on vertical blinds in communal and clinical areas were not tethered which could present a risk of accidental choking to young children. We raised this matter with the practice manager on the day of the inspection who assured us that immediate remedial action would be taken.
- We reviewed the personnel files of staff members and found that appropriate recruitment checks had been undertaken for all staff prior to employment. Good induction processes were in place for all staff, including locums.
- The provider was aware of and complied with the requirements of the Duty of Candour regulation. The GP and practice manager encouraged a culture of openness and honesty.
- Patient safety alerts were recorded, monitored and dealt with appropriately.
- The practice had systems in place for knowing about notifiable safety incidents and actively identified trends, themes and recurrent problems. They had recorded 18 significant events during the period November 2015 to the date of our inspection. Significant events were regularly discussed and analysed at regular clinical and practice meetings and appropriate action taken. For

example, the practice had recorded a significant event where a patient had denied collecting a prescription for a controlled drug and had requested a replacement. As a result the practice had implemented a system where the patient had to sign a form when they collected a prescription for a controlled drug as well as recording the collection on the practice computer system. However, the practice did not carry out an annual review of significant events.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Blank prescription pads were stored securely.
- Patient group directions (PGDs) and patient specific directions (PSDs) had been adopted by the practice to allow nurses and health care assistants to administer medicines in line with legislation. PGDs and PSDs allow registered health care professionals, such as nurses, to supply and administer specified medicines, such as vaccines, without a patient having to see a doctor.

Monitoring risks to patients

Risks to patients were assessed and well managed:

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and staff were aware of their roles and responsibilities in relation to this. Staff had received fire safety training; fire alarms were tested on a weekly basis and fire evacuation drills carried out annually. The practice had a variety of other risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Annual leave was planned well in advance and staff had been trained to enable them to cover each other's roles when necessary.
- The practice regularly used locum GPs. When this was necessary, however, they used locums who had worked for them regularly in the past, who were aware of practice policies and procedures and known by staff and patients. A locum induction pack was available.

Arrangements to deal with emergencies and major incidents

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

- All staff received annual basic life support training.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.
- The practice had good arrangements in place to respond to emergencies and major incidents. Emergency medicines were easily accessible and all staff knew of their location. A defibrillator and oxygen were available on the premises. All the medicines we checked were in date and fit for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice held bi-weekly clinical meetings which were an opportunity for clinical staff to discuss clinical issues and patients whose needs were causing concern. The GP also attended clinical meetings held with three other practices as part of an informal GP federation arrangement where best practice and relevant information was shared.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2014/15 showed the practice had achieved 98.2% of the total number of points available to them compared with the clinical commissioning group (CCG) of 95.7% and the national average of 94.7%. Information provided by the practice showed that this had improved to 98.9% for the 2015/16 period (results not yet published).

The 2014/15 data showed that at 6.2% their overall clinical exception rate was lower than the local CCG average of 8.9% and national average of 9.2%. The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

- The 2015/16 QOF data provided by the practice showed that they had obtained the maximum points available to them for 18 of the 19 QOF indicators, including asthma, cancer, hypertension, osteoporosis and for caring for patients who had a learning disability or required palliative care. The exception was for diabetes for which the practice had obtained 95.5% of the points available to them.

1. The practice carried out clinical audit activity to help improve patient outcomes. We saw evidence of several audits including a two cycle audit to evaluate the need for on-going treatment for patients prescribed bisphosphonates (drugs used to slow down or prevent bone damage) for five years or more. The audit resulted in ten patients commencing a drug holiday and 12 patients being referred for bone mineral density scans. Other audits included one to ensure shared care arrangements were in place for patients prescribed methphenidate (a central nervous system stimulant used to treat patients with attention deficit hyperactivity disorder and narcolepsy).

In addition to clinical audits the practice had also carried out quality audits when concerns had been identified. For example, due to concerns regarding the quality of the GPs recording of consultations on patients medical records the GP concerned had undertaken additional training to aid improvement in this area. This had included attending a course on record keeping in general practice, considering best practice shared by other GPs, enlisting a bespoke training course on the use of the practice computer system and patient coding; and enlisting a mentor.

The practice employed a pharmacist on a part time basis whose role included involvement in clinical audit activity. They ensured patients were coded correctly on the practice computer system which made certain they were receiving appropriate support. In addition, they were involved in reviewing practice policies and procedures. A further pharmacist worked with the practice on a regular basis to monitor the prescribing of antibiotics and a number of other medicines. This ensured the practice were committed to improving the quality of care delivered while making efficiency savings in terms of prescribing that could be reinvested into the NHS. The practice had been aware that they were high prescribers of antibiotics and had taken steps to address this. For example as a high proportion (approximately 45%) of the practices patients were Jewish the GP had written an article for a popular local Jewish newspaper detailing when it was appropriate to prescribe antibiotics. In addition, the practice had developed an information leaflet for patients giving advice on what steps they could take to treat or ease symptoms when the prescribing of antibiotics was not appropriate.

The practice had a palliative care register and discussed the needs of palliative care patients at regular multi-disciplinary team meetings.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

The staff team included a GP, practice nurse, practice manager, practice pharmacist, health care assistant and receptionists. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, health and safety, infection control, information governance, safeguarding and appropriate clinical based training for clinical staff.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurse was supported in seeking and attending continual professional development and training courses and attended locality practice nurse meetings. The practice nurse told us that there were plans for her to access clinical support with nurses from three other local practices as part of an informal GP federation arrangements.

The practice had a staff appraisal system in operation which included the identification of training needs and development of personal development plans.

We looked at staff cover arrangements and identified that there were sufficient staff on duty when the practice was open. Holiday, study leave and sickness were covered in-house whenever possible. The practice regularly used locum GPs who were familiar with practice policies and procedures and known by staff and patients.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary meetings took place on a regular basis and that care plans were reviewed and updated.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including Mental Capacity Act 2005. Practice staff were due to undertake training on the Mental Capacity Act and Deprivation of Liberty Standards in October 2016.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurses assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

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

Vaccination rates for 12-month and 24-month old babies and five-year-old children were mixed but generally comparable with CCG averages. For example, data available for the 2015/16 period showed that childhood immunisation rates for the vaccinations given to two year olds ranged from 16.7% to 100% (compared with the CCG range of 64.7% to 93.5%). For five year olds this ranged from 57.1% to 85.7% (compared to CCG range of 90.1% to 97.3%)

At 78%, the percentage of women aged between 25 and 64 whose notes recorded that a cervical screening test had been performed in the preceding five years was lower than the CCG average of 81% and national average of 82%. The percentage of relevant patients who had been screened for bowel cancer had increased from 46.9% in 2014 to 67% in 2015. The practice had achieved this by ensuring patients who did not respond to a written invitation letter received a telephone call from a practice receptionist outlining the importance of being screened and offering a testing kit to be sent to them.

Good

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. This included health checks for patients aged over 75, NHS health checks for patients aged between 40 and 74 and new patient health checks. The practice had carried out 54 over 75 health checks during the period 1 April 2015 to 31 March 2016 and 45 NHS health checks since 1 April 2016 to the date of our inspection. All 314 patients who had registered with the practice since being officially taken over by the current GP in April 2016 had been offered a new patient health check. The practice carried out appropriate follow-ups where abnormalities or risk factors were identified. Information such as NHS patient information leaflets were also available.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

We received 52 completed CQC comment card which were very complimentary about the caring nature of the practice. We also spoke with four patients during our inspection. They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the National GP Patient Survey (published in July 2016) showed patient satisfaction was generally higher than local and national averages in respect of being treated with compassion, dignity and respect. For example:

- 96% said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 96% and the national average of 95%.
- 99% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Results from the National GP Patient Survey showed patient satisfaction was generally higher than local and national averages in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 100% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 95% said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national averages of 82%.
- 92% said the last nurse they spoke to was good listening to them compared to the CCG average of 93% and the national average of 91%.
- 96% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

The practice had access to a translation service for patients who did not have English as a first language. A hearing loop was also available.

Patients with a learning disability were offered an annual influenza immunisation and health check which were available as a home visit if preferred. The practice held a register of nine patients recorded as living with a learning disability.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations

The practice identified carers and ensured they were offered an annual health check and influenza vaccination

Good

Are services caring?

and signposted to appropriate advice and support services. The practice computer system alerted clinicians if a patient was a carer. At the time of our inspection they had identified 57 of their patients, including young patients, as being a carer (approximately 1.9% of the practice patient population). The practice had worked with a local carer's charity to aid the identification of their young carers. The practice were able to demonstrate that they were the highest Carer Pathway referrer in the Gateshead area for the period April 2015 to September 2015.

Patients known to have experienced bereavement were sent a condolence card and contacted by the primary care navigator to ensure they were receiving appropriate support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- There were longer appointments available for anyone who needed them.
- Home visits were available for older patients, housebound patients and patients who would benefit from these.
- People could access appointments and services in a way and time that suited them. As a lack of space in the practice meant that they were unable to recruit any additional reception staff the practice were implementing a system which would enable patients to book, cancel and rearrange appointments 24 hours per day and seven days per week using an automated telephone system.
- Patients registered with the practice were also able to access pre bookable GP appointments at three local health centres up to 8pm weekdays and on weekends as part of a local extended hour's provision.
- There were disabled facilities and translation services available. Patients also had access to a hearing loop.
- All patient facilities were easily accessible to patients with a mobility issue.
- The practice offered online services to book appointments and request repeat prescriptions.
- Practice staff had been identified as mental health, dementia and carers leads to ensure relevant patients were receiving appropriate care and support services.
- The practice health care assistant had the dual role of being the practice primary care navigator. This not only ensured that patients were being referred or signposted to appropriate support services but also that patients discharged from hospital received a telephone call within three days of discharge to ensure that they were receiving appropriate post discharge support.
- The practice had worked with three other local practices to gain funding and support from a local charity to set up a telephone support service. This enabled vulnerable patients and patients with long term conditions to receive a weekly telephone or skype calls for up to 12 weeks to offer support on issues such as isolation, loneliness, drug and alcohol problems.
- The practice were working with 12 other practices to identify and implement new ways of working. This would involve the consideration of delivering back office functions collectively, sharing clinical functions, developing multi-disciplinary training hubs, promoting Gateshead as an attractive place to work to aid problems with clinical staff recruitment and engaging more effectively with the local community.

Access to the service

The surgery was open from 9am to 5.30pm and 6.30pm to 7.45pm on a Monday; 9am to 5.30pm on a Tuesday, Wednesday and Friday and 9am to 12 midday on a Thursday. Appointment availability with a GP was generally available from 9.30am to 12.15pm then from 3pm to 5.30pm. However, a GP was always on site between 8am and 9.30am and 12.15pm to 3pm and on Thursday afternoons to deal with urgent appointment, advice and home visit requests. Patients registered with the practice were also able to access pre bookable appointments with a GP at one of three local health centres from 8am and 8pm on a weekday and 9am to 2pm on a weekend.

Results from the National GP Patient Survey (July 2016) showed that patients' satisfaction with how they could access care and treatment was mixed when compared with local and national averages. For example:

- 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and the national average of 76%.
- 94% of patients said they could get through easily to the surgery by phone compared to the CCG average of 79% and the national average of 73%.
- 94% of patients described their experience of making an appointment as good compared to the CCG average of 76% and the national average of 73%.
- 55% of patients said they usually waited less than 15 minutes after their appointment time compared to the CCG average of 68% and the national average of 65%.
- 87% were able to get an appointment to see or speak to someone the last time they tried compared with the CCG average of 85% and a national average of 85%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 29% felt they didn't normally have to wait too long to be seen compared with the CCG average of 60% and national average of 58%.

Patients we spoke to on the day of the inspection and those who completed CQC comment cards reported that they were able to get an appointment within an acceptable timescale. We looked at appointment availability during our inspection and found that an urgent GP appointment was available the following day and a routine GP appointment was available two working days later. The next routine appointment with a nurse was also available two working days later.

Listening and learning from concerns and complaints

The practice had an effective system in place for monitoring, dealing with and responding to complaints.

- Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager had been identified as lead for dealing with complaints.
- We saw that information was available in the reception area to help patients understand the complaints system.

The practice had recorded two complaints during the previous 12 months. We found that these complaints had been satisfactorily handled and dealt with in a timely way.

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 vision was to deliver high quality care and promote good outcomes for patients

The practice mission statement, which was included in the practice patient information leaflet was:

'Second Street Surgery aims to offer our patients a more personalised service. We want to know our patients and we aim to always take the time to listen to them and involve them in decision about their care'.

The practice had a formal three year business plan which was developed in February 2015. Priorities such as succession planning, staff recruitment, training, premises, and office organisation had been identified and were due to be reviewed in October 2016. The business plan also made reference to the fact that the practice had a high proportion of Jewish patients and the expansion of young Jewish families in the area together with a number of new housing developments were likely to contribute to growth in list size.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure. Staff were aware of their own roles and responsibilities as well as the roles and responsibilities of others.
- Up to date practice specific policies were available for staff and were easily accessible
- Arrangements were in place to identify and manage risks and implement mitigating actions.
- There was evidence of clinical audit activity which improved outcomes for patients
- The practice continually reviewed their performance in relation to, for example the Quality and Outcomes Framework, referral rates and prescribing.

Leadership and culture

The GP had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The GP and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. However, the practice manager was more involved in the day to day running and management of the practice.

There was a clear leadership structure in place and staff reported that they felt supported by management.

- Clinical meetings were held on a bi-weekly basis which included discussions about palliative care, high risk and vulnerable patients. The practice also held monthly practice meeting, monthly palliative care meetings and six weekly safeguarding meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. They also said they felt respected and valued.

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

The practice encouraged and valued feedback from patients, the public and staff. They proactively sought patients' feedback and engaged them in the delivery of the service.

- The practice had gathered feedback from patients through patient surveys, feedback and complaints received.
- Results from latest National GP Patient Survey had indicated that 55% of respondents usually waited 15 minutes or less after their appointment time to be seen (CCG average 68% and national average 65%). The practice had identified this was because the GP was spending a longer than what was considered to be normal time consulting with his patients. Although this demonstrated the caring approach of the GP this was creating delays. The practice manager had therefore worked with the GP to develop a number of strategies to make sure consultations were efficient and appropriate.
- Feedback from other sources, such as the practice Friends and Family test (a test used to assess whether existing patients would be likely to recommend the practice to friends or family members) and Healthwatch had led to the practice implementing a number of other improvements. This had included reducing the length of the telephone answer machine message; recruiting an additional receptionist; creating more book on the day

Are services well-led?

Good

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

appointments; advertising the availability of late night appointments; introducing annual comorbidity long term condition reviews and providing telephone consultations

- The practice did not have an 'actual' patient participation group (PPG) but did have a 'virtual' group consisting of four members whose opinion was sought by letter and email. The practice manager told us they had tried on several occasions to recruit members but that there had been little interest. However, we did not see any evidence of the development of a group being advertised or promoted in the practice waiting room. The practice manager told us that the practice was part of an informal GP federation with three other practices in the area. Together they had recruited a Health and Social Care Co-ordinator whose role would include promoting patient participation groups. The practice were planning to hold a coffee morning for potential PPG members in November 2016 which would also be attended by the local clinical commissioning group health champion lead and the community development lead from the local authority.

Continuous improvement

The practice was committed to continuous learning and improvement at all levels. They were committed to either moving to new premises with more room and better facilities or to extending and refurbishing their current premises. They had also worked with the staff team over the past year to improve working conditions. This had included the implementation of regular supervision and training sessions as well as contract revisions to include additional annual leave and the provision of sick pay.

The practice team was forward thinking and took part in local pilot schemes and initiatives to improve outcomes for patients in the area. This included:

- Appointing a member of staff as a primary care navigator to ensure there was a holistic approach to ensuring a patient's medical and social needs were met and patients discharged from hospital were well supported.
- Participating in a telephone support service scheme to ensure vulnerable and other relevant patients were able to access support to help them make positive changes in their lives
- As a lack of space in the practice meant that they were unable to recruit any additional reception staff the practice were implementing the a system which would enable patients to book, cancel and rearrange appointments 24 hours per day and seven days per week using an automated telephone system.
- Implementing an informal GP federation with three other local practices to share best practice, clinical support and ideas
- Working with 12 other practices to identify and implement new ways of working at scale. This would involve considering delivering back office function collectively, sharing clinical functions, and developing multi-disciplinary training hubs, promoting Gateshead as an attractive place to work to aid problems with clinical staff recruitment and engage more effectively with the local community.