Oldwell Surgery

Quality Report

10 Front Street, Winlaton, Blaydon, Tyne and Wear,
NE21 4RD
Tel: 0191 5002023
Website: www.oldwellsurgery.co.uk

Date of inspection visit: 8 January 2015
Date of publication: 19/03/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Detailed findings from this inspection

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Oldwell Surgery on 8 January 2015.

Overall, we rated the practice as good, although there were some areas where the practice should make improvements. Our key findings were as follows:

- Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.
- The practice achieved very good results in the most recent national patient survey, many scores were well above national averages.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

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

The provider must:

- ensure relevant checks are carried out on staff, in relation to recruitment of new staff and existing staff's professional registrations.

The provider should:

- undertake a risk assessment and implement procedures for the management and testing of the water supply for the presence of legionella (a type of bacteria found in the environment which can contaminate water systems in buildings).
- take steps to implement a system to show whether the clinicians had read patient safety alerts or taken action where needed.
- implement systems to assess what training is necessary for staff, how this is provided and the frequency, for example, chaperoning and fire safety.
- review arrangements for the storage of medicines.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients who used services were assessed, however, the systems and processes to address these risks were not sufficient to ensure patients were kept safe. For example, relevant checks on staff were not always carried out, staff carrying out the role of chaperones had not received appropriate training and the premises were not easily accessible for patients with mobility difficulties.

Are services effective?

Good

The practice is rated as good for effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audit, reviewing their processes and monitoring the performance of staff. Arrangements had been made to support clinicians with their continuing professional development but not all staff had received some basic training, such as fire safety. The practice worked with other healthcare professionals to share information.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. 89% of patients felt the nurses treated them with care and concern, compared to a national average of 79%. Patients were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was available for patients to help them understand the care available to them. We saw staff treated patients with kindness and respect, and ensured confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice, a named GP and 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. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment.

Summary of findings

Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had a patient participation group (PPG).

Good 

Summary of findings

The six population groups and what we found

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

Older people

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.

People with long term conditions

Good

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

The practice had systems to ensure care was tailored to individual needs and circumstances. We spoke with GPs and nurses who told us care reviews for patients with long term conditions took place at six monthly or yearly intervals. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. The practice ensured timely follow up of patients with long term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Families, children and young people

Good

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

We saw the practice had 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 school nurses and health visitors.

The practice advertised services and activities available locally to families. Lifestyle advice for pregnant women about healthy living, including smoking cessation and alcohol consumption was given by the GPs and midwives.

Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed.

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 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 which reflected the needs of this age group. We saw health promotion material was made easily accessible through the practice's website. This included signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation.

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.

Systems were in place in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered regular reviews. The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia.

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.	

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

They told us the staff who worked there were very helpful and polite. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

We reviewed 29 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest GP Patients Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were above average compared to GP practices nationally.

The results were:

- The proportion of patients who would recommend their GP surgery – 82% (national average 78%)
- GP Patient Survey score for opening hours – 79% (national average 77%)
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 80% (national average 73%)
- Percentage of patients rating their experience of making an appointment as good or very good – 83% (national average 75%)
- Percentage of patients rating their practice as good or very good – 88% (national average 86%).

Areas for improvement

Action the service MUST take to improve

- ensure relevant checks are carried out on staff, in relation to recruitment of new staff and existing staff's professional registrations.

Action the service SHOULD take to improve

- undertake a risk assessment and implement procedures for the management and testing of the water supply for the presence of legionella (a type of bacteria found in the environment which can contaminate water systems in buildings).
- take steps to implement a system to show whether the clinicians had read patient safety alerts or taken action where needed
- implement systems to assess what training is necessary for staff, how this is provided and the frequency, for example, chaperoning and fire safety
- review arrangements for the storage of medicines.

Oldwell Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP specialist advisor.

Background to Oldwell Surgery

Oldwell Surgery is located in the Winlaton area of Gateshead, Tyne and Wear.

The practice provides services to around 5,250 patients from one location; 10 Front Street, Winlaton, Blaydon, Tyne and Wear, NE21 4RD. We visited this address as part of the inspection.

The practice is located in a purpose built two storey building; all patient facilities are situated on the ground floor.

The practice has two GP partners, two salaried GPs, a nurse practitioner, a practice nurse, a healthcare assistant, a practice manager, and 11 staff who carry out reception and administrative duties.

Surgery opening times at the practice are between 8:15am and 6:30pm Monday to Friday, with extended hours on a Wednesday evening until 7:15pm.

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 GatDoc.

The CQC intelligent monitoring placed the practice in band 6. 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.

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?

Detailed findings

- 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 8 January 2015. We spoke with nine patients and nine members of staff from the practice. We spoke with and interviewed three GPs, the practice manager, two members of the nursing team 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 29 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.

Requires improvement

Are services safe?

Our findings

Safe track record

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

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

Information from the QOF, which is a national performance measurement tool, showed significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. They showed us examples of significant events which had been reported and the subsequent actions taken.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. We spoke with the practice manager about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at practice management team meetings and during the weekly staff meetings, to ensure learning was disseminated and implemented.

We saw there had been a significant event in relation to a hospital admission which was potentially avoidable. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Any alerts were reviewed by the practice manager; information was then left in the staff meeting room for review by clinicians. However, there was no system in place to show whether the clinicians had read the alerts or taken action where needed..

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. This provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse.

There were identified members of staff with clear roles to oversee safeguarding within the practice. This role included reviewing the procedures used in the practice and ensuring staff were up to date and well informed about protecting patients from potential abuse. The clinicians and practice manager held monthly meetings to discuss ongoing or new safeguarding issues. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected. We saw records which confirmed all staff had attended training on safeguarding children and

adults. The GPs had received the higher level of training for safeguarding children (Level 3). Other clinical staff had received Level 2, whilst all other staff attended Level 1 training sessions.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues. In addition, the practice operated an 'early warning system', whereby any concerns about patients were noted and discussed at the safeguarding meetings.

The practice had a chaperone policy. Staff told us that a practice nurse or healthcare assistant undertook this role. If they were not available then a member of the administration team would act as a chaperone. Administration staff had not received chaperone training and were not clear about the requirements of the role. We raised this with the practice manager and they told us they would ensure chaperone training was arranged.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

The practice must improve the way they manage medicines.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely as the doors to these rooms were unlocked.

Some medicines, such as vaccines, have to be stored within a particular temperature range. Protocols were in place for the ordering, storing and handling of vaccines. There was a policy for checking medicines were kept at the required temperatures. We saw daily records were maintained, these showed the temperatures within the fridges were within the appropriate range.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Medicines to be used in emergencies were available. We saw records which showed they were regularly checked by one of the practice nurses to ensure they were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. A pharmacist visited the practice each week to carry out medicines audits, cost effectiveness reviews and assist with the development of the medicines management policy.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Records of blank prescription form serial numbers were not made on receipt into the practice or when the forms were issued to GPs. This is contrary to guidance issued by NHS Protect, which states that 'organisations should maintain clear and unambiguous records on prescription stationery stock'.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The practice nurse was the nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. Such as, action to take in the event of a spillage. The policy stated that infection control training would take place on an annual basis. We found staff had not received any formal training in infection control. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies.

The risk of the spread of infection was reduced as personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that were impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable. We saw the curtains were clearly labelled to show when they were due to be replaced. The practice had an agreement with the local NHS Trust for the decontamination of clinical equipment. There was no formal contract in place or arrangements to ensure the quality of the service provided. During the inspection the practice manager contacted the NHS Trust and arranged for a new contract and service level agreement to be issued.

Requires improvement

Are services safe?

The practice employed its own domestic staff. We saw the domestic staff completed cleaning schedules, although it was not always clear how frequent tasks were necessary, for example, on a daily, weekly, monthly and annual basis. The practice nurse carried out regular infection control audits. We saw records confirming recent checks had been carried out and the actions agreed. For instance, some of the consultation rooms had fabric covered chairs which were stained and not easy to clean. An order for more suitable chairs had since been placed.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place however, the sharps bins had not been signed and dated to show they had been properly assembled.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then wore PPE when emptying the box and transferring the specimens. We confirmed with a practice nurse that all clinical staff had up to date hepatitis B vaccinations. We saw there was a spillage kit (these are specialist kits to clear any spillages of blood or other bodily fluid) and staff knew where this was held.

The practice had not carried out a risk assessment and did not have procedures in place for the management and testing of the water supply for the presence of legionella (a type of bacteria found in the environment which can contaminate water systems in buildings).

Equipment

Staff had access to appropriate equipment to safely meet patients' needs. The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG) machines and fire extinguishers. We looked at a sample of medical and electrical equipment throughout the practice. We saw regular checks took place to ensure the equipment was in working condition.

Staffing and recruitment

We saw the practice had an up to date recruitment policy in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. We looked at a sample of personnel files. Most staff had worked at the practice for many years but we reviewed the records for the two most recently appointed members of staff. We found the appropriate recruitment checks had been completed for one member of staff. However, there was no evidence of references or photographic identification for the other person. The practice manager told us verbal references had been obtained but these had not been recorded.

The practice manager and all clinical staff that were in contact with patients had been subject to Disclosure and Barring Service (DBS) checks, in line with the recruitment policy.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff. Procedures were in place to manage absences. For example, the practice manager said when a GP was on leave or unable to attend work, another GP from the practice or a locum provided cover.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council). They told us they did not routinely carry out these checks and did not have systems in place to assure themselves of the continuing registration of staff. We checked the registers and saw all staff were appropriately registered with the relevant body.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. 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.

Requires improvement

Are services safe?

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols.

The practice had some systems in place to manage and monitor health and safety. The fire alarms and emergency lights were tested on a weekly basis. The practice manager told us fire drills were carried out every six months. We saw records confirming these checks had been carried out. We saw only one member of the team had attended fire safety training. The practice manager told us they were going to arrange further training for other staff.

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 oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with regarding emergency procedures knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. A resuscitation trolley was located in the main treatment room. The defibrillator and oxygen were accessible and records of weekly checks of the defibrillator were up to date.

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. The plan was regularly discussed by staff and case studies and scenarios were reviewed at team meetings to help ensure staff were aware of action to take in such circumstances.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up to date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up to date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners.

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, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where people were booked in for recall appointments. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition.

The clinicians we interviewed demonstrated evidence based practice. New guidelines and the implications for the practice's performance and patients were discussed at the daily meetings.

Interviews with three GPs and two practice nurses demonstrated that the culture within the practice was to refer patients onto other services on the basis of their assessed needs, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the monthly practice meetings, and/or the daily 'all staff' meetings as required.

Examples of clinical audits included an audit of patients taking a particular type of medicine. An initial audit was carried out. This demonstrated that 31 patients required a clinical review of their condition and medicines. Measures were put into place to contact patients and the audit was repeated the following year. The second cycle of the audit demonstrated that 100% of relevant patients had received a review.

The practice used an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices. We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that the practice was performing the same as, or better than average, when compared to other practices in England in most areas. For example, a higher proportion of patients with a fragility fracture (100%) were being treated with appropriate medicines compared to the national average (81%). One of the indicators demonstrated that a lower percentage of women between the ages of 25 and 65 had received a cervical screening test than in other practices (71% compared to a national average of 82%). GPs told us they were aware of this and were contacting patients to encourage them to take the tests.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff.

Once a month the practice closed for an afternoon for protected learning time (Time In, Time Out sessions). Some of the time during these afternoons was dedicated to training. Some training was also delivered by external experts, for example, a session on the 'Dementia Friends' initiative had been arranged.

Each of the four GPs at the practice took a turn at leading educational sessions. We saw records of recent sessions which covered topics such as new medicines and protocols.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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 by NHS England can the GP continue to practice and remain on the performers list).

Good

Are services effective?

(for example, treatment is effective)

Staff told us they felt supported and had received an annual appraisal. Staff records confirmed the appraisals had taken place but these were not linked into any training plans staff's for future development.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

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 monthly palliative care meeting was held, which involved practice staff and the district and Macmillan nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. Practice staff worked closely with a community matron who was employed by the local secondary care provider to work in the area covered by the practice.

Staff commented they worked well with the local CCG and felt supported. The practice was also a member of a group of GP practices located in the Outer West Gateshead area who met regularly to build relationships and share learning with the aim of improving patient care. One of the GP partners was the clinical lead for this group. One of the ongoing projects was a review of hospital discharges and how these could be improved to ensure safe arrangements were in place.

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 hour's provider and the ambulance service.

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and actioning any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

Regular meetings were held throughout the practice. These included all staff meetings, clinical meetings and multi-disciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care. One of the GP partners told us the practice had an 'open door' policy and welcomed other healthcare staff to attend their daily meetings to share information.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a practice policy on consent, this provided guidance for staff on when to document consent.

Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgery procedures or contraceptive implants.

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.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Some staff had recently received specific training on consent and the MCA.

Good

Are services effective?

(for example, treatment is effective)

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. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

The practice proactively identified people who needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients who had been diagnosed with dementia. Nationally reported data form 2013/14 showed that 86.2% of eligible patients on the register had a face to face review of their care in the preceding 12 months. This was slightly below the local average (87.4%) but above the national average (83.8%). The data showed that 100% of eligible patients with dementia had received a range of specified tests six months before or after being placed on the practice dementia register.

Patients with long term conditions were reviewed each year, or more frequently as necessary. Arrangements were in place to contact patients who did not attend to ensure they received a review.

New patients were offered a 'new patient check', with the healthcare assistant, 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).

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. A campaign had been launched to give advice to parents on action to take if their child was unwell. 'Keep children safe from infection' posters and hand-outs were published and on display in the waiting room. These gave simple to read information on the signs to look for in children and when to seek medical advice.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. Staff told us about some of the services offered to patients. These included 'exercise on prescription' and access to a local health and wellbeing service. The practice's website provided detailed guidance on 'leading a healthy lifestyle'. The website was regularly updated and included links to support organisations.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was higher than the overall average for other practices nationally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with nine patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments left by patients on the 29 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, friendly, empathetic, professional, helpful and respectful.

We looked at data from the National GP Patient Survey, published in July 2014. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the practice was above national and local average scores on whether patients would recommend the practice (82% compared to 78% nationally) and on the helpfulness of reception staff (94% compared to 88% nationally). We saw that 94% of patients said they had confidence and trust in their GP and 85% said their GP was good at treating them with care and concern. 89% of respondents said the nurse was good at treating them with care and concern. This was well above the national average of 79%.

Many of the staff members had worked at the practice for several years. Staff told us they had a good knowledge of their practice population and so were able to provide personalised care. One of the GPs told us how they worked with reception staff to establish which patients needed to be included on a carer's register.

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 but in some cases conversations taking place in those rooms could be overheard. We spoke to the lead GP who said they would look into this and consider how this could be improved.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately, although this facility was not advertised.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. We reviewed the 29 completed CQC comment cards; patients felt they were involved in their care and treatment. One person commented that the doctors explained everything 'thoroughly'. Another person said staff always listened and responded to their needs.

The results of the National GP Patient Survey from July 2014 showed patients felt the GPs and nurses involved them in decisions about their care and listened to them. Scores for both doctors and nurses were above both the national and local averages:

- 91% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 90% said the last nurse they saw or spoke to was good at listening to them (national average 80%)
- 80% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 75%)
- 76% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 67%).

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice had very few patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this

Good

Are services caring?

area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring, reassuring and supportive.

We saw there was a variety of patient information on display throughout the practice. This included information on mental and emotional health and support groups.

The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs informed them of a local carer support group.

Support was provided to patients during times of bereavement. The practice manager told us a visit to those who had lost a loved one was offered once the practice had been notified. The practice also offered details of bereavement services upon request, with information displayed on notice boards in the patient waiting area. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times. Support was tailored to the needs of individuals, with consideration given to their preference at all times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. There had been very little turnover of staff in recent years which enabled good continuity of care and accessibility to appointments with a GP or nurse of choice. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

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.

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. 91% of patients felt the doctors and nurses gave them enough time. These results were well above the national averages (86% and 81% respectively).

The practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

There was information available to patients in the waiting room and reception area, about support groups, clinics and advocacy services.

The practice had established a 'virtual' Patient Participation Group (PPG). This was a group of patients who were asked for their opinions and suggestions via email or on the telephone. We spoke with two members of the PPG. They gave us examples of improvements that had been made following discussions between the PPG and the practice. This included offering the facility to book appointments further in advance and ensuring the noticeboard in the waiting room contained appropriate and useful information.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, opening times had been extended to provide additional appointments each Wednesday evening. This helped to improve access for those patients who worked full time.

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure patients' needs were met.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. One of the nurses specialised in this area, they explained how patients were also offered longer appointment times when necessary.

Free parking was available directly outside the building. The practice building was difficult for patients with mobility difficulties or those who used a wheelchair to access. The main entrance door was not automatic and there were no signs advising how patients could ask for help to open the door. We raised this with the lead GP and practice manager. They told us they would review the signage to the entrance area. The consulting rooms were large with easy access for all patients. There was also a toilet that was accessible to disabled patients and baby changing facilities for use.

Only a small minority of patients did not speak English as their first language. There were arrangements in place to access interpretation services.

Access to the service

The practice was open between 8:15am and 6:30pm Monday to Friday. Evening appointments were available on a Wednesday until 7:15pm.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. The website contained details of which sessions each of the GPs worked so patients were able to see when

Good

Are services responsive to people's needs?

(for example, to feedback?)

they were available. Patients we spoke with during the inspection commented they found this useful. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made readily available every day. The practice had a number of care home residents registered with them. In order to support these patients, one of the GPs visited the home each week.

The practice manager told us if a patient wanted an emergency appointment then they could have one the same day. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day. If there were no appointments available then patients would be invited in to the 'open surgery'. They would be seen by either the duty doctor or nurse practitioner.

All of patients we spoke with, and those who filled out CQC comment cards, said they were satisfied with the appointment systems operated by the practice. Many people commented they were able to get an appointment or speak to someone at short notice. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 93% (compared to 86% nationally) of respondents able to get an appointment or speak to someone when necessary and 80% (73% nationally) found it easy to get through on the telephone.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice's contracted out of hours provider was GatDoc.

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

Listening and learning from concerns and complaints

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

None of the nine patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 29 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

The practice had received four formal complaints in the 12 months prior to our inspection and these had been reviewed as part of the practice's formal annual review of complaints. 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. Staff we spoke with felt involved in the process.

We looked at some of the complaints the practice had received. We saw these had all been thoroughly investigated and the complainant had been communicated with throughout the process. We found the practice listened and learned from the complaints. For example, the practice had a 0844 telephone number installed, following a number of complaints from patients a local phone number was also made available.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values included providing a practice in which patients are safe and cared for.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They all told us they put the patients first and aimed to provide person-centred care. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Governance arrangements

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

There was a management team in place to oversee the practice. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. 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 the lead GP. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice manager and GPs actively encouraged staff to be involved in shaping the service.

We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

Staff told us they were aware of the decision making process. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions.

The practice had completed a number of clinical and internal audits. An infection control audit had recently been carried out. The results of this had been discussed with the practice management team and plans were in place to address the issues identified.

Leadership, openness and transparency

The practice had a clear leadership structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. The GPs all had individual lead roles and responsibilities, for example, safeguarding, risk management, performance and quality. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Daily meetings were held each lunch time. Staff told us there was an open culture in the practice and they could report any incidents or concerns they might have. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported, and these had been investigated and actions identified to prevent a recurrence. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team.

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their daily meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice.

The practice had carried out a recent patient survey and had established a 'virtual' patient participation group (Oldwell Surgery Patient Reference Group). Communication with patients was one of the key areas identified in the patient survey. The practice had acted upon the survey and had introduced a monthly newsletter. This was available in the reception area and copies were emailed to patients who had registered their email addresses.

The practice had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Are services well-led?

Good

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

Management lead through learning and improvement

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

Staff from the practice also attended the monthly CCG protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The management team met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared these with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

The practice manager met monthly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and CCG meetings. One of the issues which was under review was how the health community could work together to improve arrangements for discharges from hospitals. They also attended learning events and shared information from these with the other GPs in the practice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Information specified in Schedule 3 of the Health & Social Care Act 2008 in respect of people employed for the purposes of carrying on a regulated activity was not available (Regulation 21 (b)). Arrangements were not in place to check that people employed for the purposes of carrying on a regulated activity were registered with professional bodies (Regulation 21 (c)).