

Crowhall Medical Group

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection at Crowhall Medical Group on 15 March 2016. Overall the practice is rated as good.

- There was an open and transparent approach to safety and there was a good system for reporting and recording significant events. The staff team took the opportunity to learn from these events.
- The practice had a clear vision to deliver high quality care and promote good outcomes for their patients.
- Staff demonstrated a strong commitment to supporting patients to live healthier lives and were actively taking steps to achieve this.
- Outcomes for patients were . Data from the Quality and Outcomes Framework (QOF) showed that patient outcomes in the clinical and public health indicators were above average, when compared to the local clinical commissioning group (CCG) and England averages.

- Staff recruitment checks had not always been carried out effectively.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. Although some staff had not completed all of the required training for their role, arrangements had been made for them to do so.
- Staff had developed strong and effective working relationships with other healthcare colleagues, to help make sure the needs of vulnerable patients, and patients with complex health conditions, were met. The support clinical staff had provided to one of the care homes they supported had helped to significantly reduce admission rates to the local hospital, and contacts with the out-of-hours and community nursing teams.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their treatment. Information about the services provided by the practice and how to complain, was available and easy to understand.
- The practice was well equipped to treat patients and meet their needs.

The areas where the provider must make improvement are:

- Ensure that required pre-employment checks are carried out and that there is documentary evidence to confirm this.

There were areas of practice where the provider needs to make improvements. The provider should:

- Review the need for GPs not to carry a range of emergency medicines for use in acute situations, when on home visits. Keep a written record of what the review considered and the outcome.
- Ensure fire safety drills are carried out regularly, and that staff complete fire safety training, in line with the practice's fire safety policy.
- Put in place a formal system for updating the practice's clinical guidelines.
- Ensure regular infection control audits are carried out.
- Keep a log of the checks staff carry out to make sure emergency medicines are within their expiry date.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

There was an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. Overall, the practice had good safeguarding arrangements that helped to keep children and vulnerable adults safe. Individual risks to patients had been assessed and were well managed. The practice was clean and hygienic and infection control arrangements were satisfactory. The premises were satisfactorily maintained and equipment was safe to use. However, staff recruitment checks had not always been carried out consistently. Also, it was not possible to verify that all staff had completed training in fire safety, infection control and the use of the Mental Capacity Act. Regular infection control audits had not been carried out.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services.

Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed well in obtaining 99.6% of the total points available to them, for providing recommended care and treatment to their patients. This was 4.1% above the local clinical commissioning group (CCG) average and 4.9% above the England average. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. However, the practice did not have a formal system for updating their clinical guidelines. Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. Staff worked well with other health and social care professionals to help ensure patients' needs were met. All staff were actively engaged in monitoring and improving quality and outcomes for patients. Staff had completed a range of clinical audits and used these to improve patient outcomes.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

Patients' emotional and social needs were seen as being as important as their physical needs, and there was evidence of a strong, person-centred culture. The practice demonstrated a caring and responsive approach to patients and their individual needs. Patients told us they were treated with compassion, dignity and respect, and they felt well looked after. Information for patients about the range of services provided by the practice, was available and easy to understand. Staff had made very good arrangements to help patients and their carers cope emotionally with their care and treatment. Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction with the quality of GP and nurse consultations was either above, or broadly in line with, the local clinical commissioning group (CCG) and national averages.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. A range of services were offered by staff, and staff were actively taking steps to further improve the care and treatment they provided to patients with long-term conditions. The practice worked closely with local health and social care professionals to plan how services were provided, in order to ensure they met patients' needs and offered flexibility, choice and continuity of care. The patients we spoke with, as well as most of those who completed CQC comment cards, expressed no concerns about telephone access or access to appointments. The results of the NHS National Patient Survey of the practice, published in January 2016, showed patient satisfaction levels relating to telephone access and practice opening times, were broadly in line with the local CCG and national averages. However, patient satisfaction levels were lower with regards to appointment availability. The practice provided suitable facilities and they were appropriately equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Good



Are services well-led?

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

Overall, there was evidence of good governance arrangements. These included the carrying out of evidence based assessments, the allocation of lead roles to staff to help promote good clinical leadership, and the holding of regular meetings to share information and to manage patient risk. All meetings were minuted and these were available to staff. However, there were some aspects of the practice's governance arrangements that could be improved. All of

Good



Summary of findings

the staff we spoke to were aware of the practice's vision, were proud to work for the practice and had a clear understanding of their roles and responsibilities. There was a clear leadership structure and staff felt very well supported by the GPs and the practice manager. Regular clinical, practice, nursing and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. The practice actively sought feedback from patients via surveys and their patient participation group. There was a strong focus on, and commitment to, continuous learning and improvement, at all levels within the practice.

Summary of findings

The six population groups and what we found

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

Older people

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

Nationally reported data showed the practice had performed well in providing recommended care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had obtained 100% of the total Quality and Outcomes Framework (QOF) points available to them, for providing recommended clinical care to patients who had cancer. This was 3.6% above the local clinical commissioning group (CCG) average and 2.1% above the England average. Patients over 75 years of age had a named GP who was responsible for their care. Emergency care had been put in place for patients considered to be at high risk of an unplanned admission into hospital. The practice had developed strong links with a local support organisation for older people and had recently been successful in obtaining funding, to set up a project aimed at supporting older people to socialise and exercise. Weekly clinics were held at the two care homes supported by the practice, in line with national priorities to enhance the health of people living in care homes. The support provided to one of these care homes had helped to significantly reduce admission rates to the local hospital, and contacts with the out-of-hours and community nursing teams.

Good



People with long term conditions

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

Nationally reported data showed the practice had performed well in providing recommended care and treatment, for the clinical conditions commonly associated with this population group. For example, the practice had achieved 100% of the total QOF points available to them, for providing recommended clinical care to patients diagnosed with diabetes. This was 8% above the local CCG average and 10.8% above the England average. Staff had adopted the 'Year of Care' approach, as their model for providing personalised care to this group of patients. Patients received appropriate support and education to help them manage any long-term conditions they had. Staff had identified those patients with the most complex needs and put care plans in place to help reduce unplanned emergency admissions into hospital.

Good



Summary of findings

Families, children and young people

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

Nationally reported data showed the practice had performed well in providing recommended care and treatment for this group of patients. For example, the QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them, for providing contraceptive services. This was 3.7% above the local CCG average and 3.9% above the England average. The practice provided a range of services for families and younger patients, including contraceptive advice and child health advice and support. The practice provided families with access to a full programme of childhood immunisations. Publicly available information showed they had performed well in delivering these immunisations. For example, the nationally reported data that was available to us showed that the immunisation rates, for 16 of the 17 childhood immunisations, were over 90%. The data available to us also showed the practice's uptake of cervical screening was higher, at 83.01%, than the national average of 81.83%. A good range of health promotion leaflets was available in the patient waiting area, including information about the practice being breastfeeding friendly. A good level of information was also provided on the practice's website. Monthly multi-disciplinary safeguarding meetings were held where the needs of vulnerable children and their families were discussed. All staff had completed safeguarding training that was relevant to their roles and responsibilities.

Good



Working age people (including those recently retired and students)

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

Nationally reported data showed the practice had performed well in providing recommended care and treatment for this group of patients. For example, the QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them, for providing care and treatment to patients who had chronic kidney disease. This was 4.6% above the local CCG average and 5.3% above the England average. The practice had assessed the needs of this group of patients and had developed their services to make sure they were accessible, flexible and provided continuity of care. The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of this group of patients. NHS health checks were offered to help promote the wellbeing of patients aged between 40 and 75 years of age.

Good



Summary of findings

People whose circumstances may make them vulnerable

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

There were good arrangements for meeting the needs of vulnerable patients. Systems were in place to help reduce unplanned emergency admissions into hospital. The practice maintained a register of patients with learning disabilities which they used to ensure these patients received an annual healthcare review. Extended appointments were offered to enable this to happen. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns. Staff actively collaborated with other health and social care professionals to meet the needs of vulnerable patients. The practice informed vulnerable patients, including those with addictions, about how to access various support groups and voluntary organisations. The practice had good arrangements in place for supporting the large group of patients who misused substances who were registered with them. Clinical staff worked in partnership with the local drug and alcohol recovery service to help ensure their patients' needs were met. Good arrangements had been made to meet the needs of patients who were also carers. Monthly multi-disciplinary meetings were held to review the needs of patients with palliative or end of life needs.

Good



People experiencing poor mental health (including people with dementia)

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

There were good arrangements for supporting patients with mental health needs. The QOF data, for 2014/15, showed the practice had performed well by obtaining 100% of the overall points available to them, for providing recommended care and treatment to these patients. This was 7.3% above the local CCG average and 7.2% above the England average. Of those patients with the mental health conditions covered by the QOF, 91.4% had had their care reviewed, face-to-face, in the preceding 12 months. This was 17.5% above the local CCG average and 14.2% above the England average. Patients with mental health needs were offered an annual health review and were provided with advice about how to access various support groups and voluntary organisations. Clinical staff carried out opportunistic dementia screening and completed care plans, to help make sure patients with dementia received appropriate support and treatment. The QOF performance of the practice in relation to patients with dementia was also very good. For example,

Good



Summary of findings

92.9% of patients who had been diagnosed with dementia had had their care reviewed, face-to-face, in the preceding 12 months. This was 11.5% above the local CCG average and 15.2% above the England average.

Summary of findings

What people who use the service say

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 15 completed comment cards. We also spoke with two members from the practice's patient participation group. The majority of patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us staff were caring and helpful. They also said they were treated with respect and dignity, and that the premises were always kept clean and tidy. However, two patients told us they had experienced difficulties obtaining an appointment.

Results from the NHS GP Patient Survey of the practice, published in January 2016, showed patient satisfaction levels with the quality of GP and nurse consultations were either above, or broadly in line with, local clinical commissioning group (CCG) and national averages. Patient satisfaction levels relating to telephone access and practice opening times, were broadly in line with the local CCG and national averages. However, patient satisfaction levels were lower with regards to appointment availability. Of the patients who responded to the survey:

- 93% said they had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%.
- 88% said the GP was good at listening to them. This was just below the local CCG average of 91% and in line with the national average.

- 87% said the GP gave them enough time. This was just below the local CCG average of 89% and in line with the national average.
- 87% said the last GP they spoke to was good at treating them with care and concern, compared to the local CCG average of 88% and the national average of 85%.
- 99% said they had confidence and trust in the last nurse they saw. This was above the local CCG average of 98% and the national average of 97%.
- 94% said the last nurse they spoke to was good at treating them with care and concern, compared to the local CCG average of 92% and the national average of 91%.
- 89% said their last appointment was convenient. This was just below the local CCG and national averages of 92%.
- 76% said they found it easy to get through on the telephone, compared to the local CCG average of 78% and the national average of 73%.
- 75% said they were able to get an appointment to speak or see someone the last time they tried. This was below the local CCG and national averages of 85%.

(324 surveys were sent out. There were 116 responses which was a response rate of 36%. This was 1.9% of the practice population.)

Areas for improvement

Action the service **MUST** take to improve

Ensure that required pre-employment checks are carried out and that there is documentary evidence to confirm this.

Action the service **SHOULD** take to improve

- Review the need for GPs not to carry a range of emergency medicines for use in acute situations, when on home visits. Keep a written record of what the review considered and the outcome.
- Ensure fire safety drills are carried out regularly, and that staff complete fire safety training, in line with the practice's fire safety policy.
- Put in place a formal system for updating the practice's clinical guidelines.

Summary of findings

- Ensure regular infection control audits are carried out.
- Keep a log of the checks staff carry out to make sure emergency medicines are within their expiry date.

Crowhall Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor.

Background to Crowhall Medical Group

Crowhall Medical Group is a medium sized practice providing care and treatment to approximately 6,678 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of NHS Newcastle Gateshead Clinical Commissioning Group (CCG). Life expectancy for patients is lower than the local CCG and England averages. The practice serves an area where deprivation is higher than the local CCG and England averages.

We visited the following location as part of the inspection:

- Crowhall Medical Group, Felling Health Centre, Stephenson Terrace, Felling, Gateshead, Tyne and Wear, NE10 9QG.

Crowhall Medical Group is located in purpose built health centre and provides patients with access to ground floor treatment and consultation rooms. (The building also accommodates a second practice and other community based healthcare services.) The practice offers a range of chronic disease clinics, as well as services aimed at promoting patients' health and wellbeing. There are four GP partners (one male and three female.) The practice submitted an application shortly after the inspection to remove the male GP from the partnership as he had recently left the practice. (We were told patients wishing to

see a male clinician would be referred to the local service providing out-of-hours care and treatment.) The practice has a practice manager, two practice nurses (one of whom is a nurse prescriber), two healthcare assistants (one of whom is also a phlebotomist), and a team of administrative and reception staff. The practice was in the process of recruiting a third nurse, who would also act as a nurse manager.

The practice's opening hours are:

Monday: 7:30am to 6:30pm.

Tuesday, Wednesday and Thursday: 7:30am to 6pm.

Friday: 8am to 6pm.

GP appointment times were:

Monday: 7:30am to 6:20pm.

Tuesday, Wednesday and Thursday: 7:30am to 5:50pm.

Friday: 8am to 5:50pm.

Information about how to access urgent out-of-hours care is available on the practice's website and in its patient information leaflet. When the practice is closed patients can access out-of-hours care via the Northern Doctors Urgent Care Limited service, and the NHS 111 service.

Why we carried out this inspection

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

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 March 2016. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed comment cards where patients shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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).

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

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting and recording significant events. Staff had identified and reported on 12 significant events during the previous 12 months. All of these incidents had also been reported to the local clinical commissioning group (CCG) via the Safeguard Incident and Risk Management System (SIRMS). (This 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). The sample of records we looked at showed the practice had managed such events consistently and appropriately. Significant events were reviewed immediately to look at what could be done to prevent them from happening again. In addition, quarterly meetings were held to review lessons learned, and to look for any common themes or patterns. Staff were clear about their responsibilities in relation to reporting such concerns. Copies of significant event reports could be accessed by all staff on the practice intranet system. The practice's approach to the handling and reporting of significant events ensured that the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

The practice had a system for managing and responding to safety alerts. All safety alerts, including those covering medicines, were received by the practice manager, and then forwarded to relevant staff, to enable appropriate action to be taken. The practice manager had recently set up a central log of all alerts received, and of the actions taken in response.

Overview of safety systems and processes

The practice had a range of systems and processes in place which helped to keep patients and staff safe and free from harm. However, staff recruitment checks had not always been carried out effectively. Also, it was not possible to verify that all staff had completed training in fire safety, infection control and the use of the Mental Capacity Act. Regular infection control audits had not been carried out.

We looked at the recruitment files for four staff. Appropriate indemnity cover was in place for all clinical staff and checks

had been made to ensure they continued to be registered with their professional regulatory body. References had been obtained for all four staff to make sure they had performed satisfactorily, in their most recent period of employment. Disclosure and Barring Service (DBS) checks had been carried out on three of the staff. However, there was no documentary evidence available to confirm that a DBS check had been completed for one of the nurses. (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 vulnerable adults). Employment history information had been obtained for all four staff. Confirmation of the clinical staff's qualifications had been obtained, as part of the pre-employment checks carried out to confirm they were registered with their professional regulatory body. However, the provider had not obtained copies of their professional qualifications. Also, there was no documentary evidence the provider had obtained proof of identity for two of the clinical staff, although both of these staff had NHS SMART Cards, and these are only issued once full identity checks have been completed.

There were procedures and systems in place for monitoring and managing risks to patient and staff safety. The practice had arranged for all clinical equipment to be serviced and calibrated, to ensure it was safe and in good working order. All electrical equipment had been checked to make sure it was safe to use. We checked the premises and identified no health and safety concerns. A general health and safety risk assessment had been completed within the last 12 months, and had been regularly reviewed. Staff were in the process of completing a Control of Substances Hazardous to Health risk assessment. A fire risk assessment had been completed in the previous 15 months. Fire drills were completed by NHS Property Services for the Health Centre building in which the practice was located. However, we found that a fire drill had not been completed since November 2012. The provider took immediate action, on the day of the inspection, to address this shortfall. We received confirmation shortly following the inspection that a fire drill had been carried out by NHS Property Services. We were able to confirm that most staff had completed fire safety training. However, three staff had not completed this training. The practice manager told us they would take immediate action to address this.

There was a structured and managed approach to maintaining cleanliness, and we found that the practice

Are services safe?

was clean and tidy throughout. One of the recently appointed nurses had taken on the role of infection control lead, and arrangements had been made for this person to attend advanced training in May 2016 to help them carry out this role effectively. There were infection control protocols in place which staff followed in the practice. Most staff whose records we looked at had received infection control training. However, we were unable to confirm this for one member of the clinical team. An infection control audit had not been carried out during the previous 12 months. However, we received confirmation, immediately after the inspection that a comprehensive audit had been carried out. We saw actions had been identified and timescales attached. A legionella risk assessment had been carried out, in January 2016, to help protect patients from the health risks posed by these bacteria. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

The practice's chaperone arrangements helped to protect patients from harm. Staff who acted as chaperones were trained for this role and had undergone a DBS check. The chaperone service was advertised on a poster displayed in the patient waiting area.

There were policies and procedures for safeguarding children and vulnerable adults. Staff told us they were able to easily access these. A designated GP acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to their colleagues. Staff demonstrated they understood their safeguarding responsibilities and most had received safeguarding training relevant to their role. For example, the GPs had completed level three child protection training. Although a small number of staff had not completed adult safeguarding training, arrangements had been made to make sure they completed this training. Clinical staff were proactive in taking action when they identified that patients in their care might not be receiving the best possible care. Staff maintained an up-to-date log of all of the children on the child protection register, to ensure clinical staff took this into account during consultations. All of these children were clearly identified on the practice's clinical records system. Staff had limited contact with the health visitor team. Health visitors were invited to safeguarding meetings, but rarely attended.

The arrangements for managing medicines, including emergency drugs and vaccines, helped to keep patients

safe. Staff were able to access medicines management support from the pharmacist attached to the practice. The provider was currently considering whether to employ a pharmacist to assist them with medicines management. There was a clear audit trail for the authorisation and review of repeat prescriptions. Alerts had been placed on the clinical IT system to ensure that patients prescribed high-risk medicines were monitored. There was also a clear audit trail for the management of information received from other services, including information about changes made to patients' information following their discharge from hospital. Prescription pads were securely stored to reduce the risk of mis-use or theft. Suitable arrangements had been made to store and monitor vaccines. These included carrying out daily temperature checks of the vaccine refrigerators and keeping appropriate records. None of the information we looked at before the inspection indicated that the practice's prescribing data was an outlier when compared to other local practices.

There were suitable arrangements for planning and monitoring the number and mix of staff to meet patients' needs. Non-clinical staff had been trained to carry out all reception and administrative roles, to help ensure the smooth running of the practice. Although the practice had a full complement of GPs at the time of the inspection, recruitment was underway to find cover for a GP post that would shortly become vacant. There were no nurse vacancies. However, the practice was considering recruiting a third nurse, who would take on responsibilities for managing the nursing team. Locum GP staff were rarely used. A locum pack was available for new locum GPs where required.

Arrangements to deal with emergencies and major incidents

There were good arrangements for dealing with emergencies and major incidents. An instant messaging system on the computers in all the consultation and treatment rooms, alerted staff to any emergency. Emergency medicines were stored securely in an area of the practice accessible to all staff. The GPs told us they did not carry any medicines, for use in an emergency, when carrying out home visits. We were told the clinical team had assessed whether they needed to do this, and had judged that, given their proximity to local healthcare services, this was not required. However, there was no written record of this assessment. There was a system in place for carrying

Are services safe?

out regular checks of the emergency medicines. This was known by staff, and they confirmed these were carried out. When we checked the emergency medicines, we found all were within their expiry date and were fit for use. However, staff had not kept a log of the checks they carried out.

Staff had completed basic life support training, to help them respond appropriately in an emergency. They had access to a defibrillator which was stored in the patient waiting area in Felling Health Centre. (Staff from both practices located in the building were able to access the defibrillator.) Checks were carried out by NHS Property

Services to ensure the defibrillator was maintained in good working order. However, a log of these checks was not available at the time of our visit. We saw evidence that the provider had tried to access this information through contact they had had with NHS Property Services, to assure themselves that the required checks were being carried out. The practice had a business continuity plan for emergencies, such as a power failure. The plan had been reviewed to make sure it was up-to-date and reflected relevant guidance. It was available to all staff on the practice's IT system.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including the National Institute for Health and Care Excellence (NICE) best practice guidelines, and regional care pathway templates. Clinical staff were able to access these via the practice's intranet system. However, there was no formal system for updating new guidelines.

Management, monitoring and improving outcomes for people

Outcomes for patients were consistently good. The practice participated in the Quality and Outcomes Framework (QOF) scheme. (This is intended to improve the quality of general practice and reward good practice.) Staff used the information collected for the QOF, and their performance against national screening programmes, to monitor and improve outcomes for patients. The QOF data, for 2014/15, showed the practice had performed well in obtaining 99.6% of the total points available to them. (This was 4.1% above the local Clinical Commissioning Group (CCG) average and 4.9% above the England average.) Examples of good QOF performance included the practice obtaining:

- 100% of the total points available to them, for providing recommended clinical care to patients who had asthma. This was 3.4% above the local CCG average and 2.6% above the England average.
- 100% of the total points available to them, for providing recommended clinical care to patients who had atrial fibrillation. This was 0.4% above the local CCG average and 1.5% above the England average.
- 100% of the total points available to them, for providing recommended clinical care to patients with diabetes. This was 8% above the local CCG average and 10.8% above the England average.

The practice's clinical exception reporting rate, for the 2014/15 QOF year, at 12.5%, was 3.6% above the local CCG average and 3.3% above the England average. (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.) We discussed this with clinical staff who told us

that, in the main, this was due to the high numbers of frail care home residents on their registers of patients with long-term conditions and end-of-life needs. Evidence obtained during the inspection indicated that the 'call and recall system' used by the practice was effective and efficient, and there were good internal processes in place. Where patients required reviews of their needs, these were taking place. For example, 87% of patients with cancer, who had been diagnosed within the preceding 15 months, had had a patient review recorded as occurring within six months of diagnosis. This was 5% above the local CCG average and 6.9% above the England average. With regards to patients with dementia, 92% had had a face-to-face review within the preceding 12 months. This was 11.5% above the local CCG average and 15.2% above the England average.

Staff were proactive in carrying out clinical audits to help improve patient outcomes. We looked at one of the full clinical audits that had been carried out during the previous 24 months. This was relevant, showed learning points and evidence that staff had considered how they could further improve their practice. The audit had considered the potential complications following the fitting of specific contraceptive devices, and whether there were low infection and perforation rates when these procedures were carried out. The follow-up audit showed that the clinical procedures for fitting contraceptive devices worked well, and that there were very low rates of infection and no incidents of perforation. The audit had indicated that an information leaflet should be prepared and shared with patients undergoing such procedures to help promote better infection control. There were plans in place to complete this piece of work.

In addition, the practice also participated in local audits initiated by the local CCG. For example, staff had carried out an audit to identify whether they had breached the two-week-wait cancer referral rule, during the previous 12 months. Staff had looked at the reasons for the breaches identified, to determine whether they had any responsibility for them, and what could be done in the future to avoid them.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff made use of e-learning training modules and in-house training, to help them keep up-to-date with their mandatory training. Although most

Are services effective?

(for example, treatment is effective)

staff had received the training they needed to carry out their roles and responsibilities, there were gaps in some of the records we looked at. The practice manager had already made plans to address these. Training completed included protecting vulnerable children and basic life support. Nursing staff had completed additional training, to help them meet patients' needs, including for example, training in child immunisations and cervical screening. Staff had received an annual appraisal of their performance and the GPs received support to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment. The information included patients' medical records and test results. Staff shared NHS patient information leaflets, and other forms of guidance with patients, to help them manage their long-term conditions. All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and the emergency services. Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005). When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome. However, there was no evidence that three clinical staff had completed MCA training. Arrangements had been made to provide these staff with appropriate training.

Health promotion and prevention

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. Patients had access to appropriate health assessments and checks. These included health

checks for new patients and NHS health checks for people aged between 40 and 74 years. There were suitable arrangements for making sure a clinician followed up any abnormalities or risks identified during these checks.

The practice had a comprehensive screening programme. For example, the QOF data showed they had performed well by obtaining 100% of the overall points available to them for providing cervical screening services. This was 1.8% above the local CCG average and 2.4% above the England average. The data showed the practice's uptake of cervical screening was higher, at 83.01%, than the national average of 81.83%. The QOF data showed the practice had protocols that were in line with national guidance. These included protocols for the management of cervical screening, and for informing women of the results of these tests. The practice had also performed well by obtaining 100% of the overall points available to them, for providing contraceptive services to women in 2014/15. This was 3.7% above the local CCG average and 3.9% above the England average.

Patients were also supported to stop smoking. For example, the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. Nationally reported QOF data, for 2014/15, showed the practice had performed very well by obtaining 99.7% of the overall points available to them, for providing recommended care and treatment to patients who smoked. This was 4.7% above the local CCG average and 4.9% above the England average. The data also showed that, of those patients aged over 15 years who smoked, 99.5% had been offered support and treatment during the preceding 24 months. This was 2.1% above the local CCG average and 2.3% above the England average.

The practice offered a full range of immunisations for children. Publicly available information showed they had performed well in delivering childhood immunisations. For example, the nationally reported data that was available to us showed that the immunisation rates for 16 of the 17 childhood immunisations were over 90%. Rates for the vaccinations given to under two year olds ranged from 82.1% to 94.6%, compared to the CCG averages of between 81.3% and 97% and, for five year olds from 91.2% to 97.1%, compared to the CCG averages of between 89.1% and 97%.

Are services caring?

Our findings

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to, provide flexibility, choice and continuity of care. Examples of the practice being responsive to and meeting patients' needs included:

- Providing all patients over 75 years of age with a named GP who was responsible for their care. Care and admissions avoidance plans had been put in place for patients considered to be at high risk of an unplanned admission into hospital. The practice had recently been awarded funds to hold two extra clinical sessions per month, to allow GPs to carry out visits to housebound patients aged over 75 years. Patients discharged from hospital had their needs reviewed within three days. The practice had developed strong links with the Gateshead Older Peoples' Assembly. As a result of this relationship, representatives from the Assembly had held information sessions in the practice's waiting area. Patients were also signposted to classes held by the Assembly. The practice had successfully bid for funds to set up, in collaboration with the Assembly, a 30-week programme of tea dances for older people living in the Gateshead area. (The aim of the programme is to help combat loneliness and provide opportunities for older people to exercise.) In addition to this, staff worked with a local Primary Care Navigator, referring older patients who they considered would benefit from additional care and support. Staff also referred patients needing extra support to a national organisation for older people.
- Staff had worked hard to develop good working relationships with the two care homes they were responsible for. Weekly clinics were held at both care homes in line with national priorities to enhance the health of people living in care homes. There was evidence that the work undertaken by the GPs to support the staff working in one of these care homes, by providing advice and training, had helped significantly reduce emergency admission rates, and contacts with the out-of-hours and community nursing teams. This included providing staff from the care home with training in how to carry out observations and manage minor ailments.
- Effective arrangements for meeting the needs of patients with long-term conditions. In 2014, the practice had participated in a local pilot project, to help set up a 'call and recall' system for patients with long-term conditions (LTCs). One outcome of this project was the development of a master template for reviewing the needs of patients with LTCs which linked in with the practice's clinical IT system. The practice had later adopted the new 'call and recall' system and set up systems and processes to support its effective operation. Where patients failed to respond to an initial request to make an appointment, a system was in place which ensured there was further contact with them.
- Providing a range of services for families and younger patients, including family planning and contraceptive advice. Following the birth of their child, new mothers received a letter of congratulations. This letter also explained the registration process for their new baby, and information about how to make appointments for the eight week baby health check, immunisations and post-natal reviews. The practice provided families with access to a full programme of childhood immunisations. A good range of health promotion leaflets was available in the patient waiting area, including information about the practice being breastfeeding friendly. There was a good process in place for monitoring information coming into the practice about at-risk children. Staff had devised a spreadsheet which they updated as new information was received about children subject to a child protection plan.
- Providing services which met the needs of patients experiencing poor mental health. Staff maintained a register of patients with mental health needs, so this could be taken into account during any consultation held with them. Patients with mental health needs were offered an annual health review and were provided with advice about how to access various support groups and voluntary organisations. A high proportion of patients on the mental health register had received an annual review during the 2014/15 Quality and Outcomes Framework year. Patients were able to access 'talking therapies' and in-house counsellor sessions were also provided. Staff had received training from the local challenging behaviour team and Gateshead Talking

Are services responsive to people's needs?

(for example, to feedback?)

Therapies, to help them engage better with patients with mental health needs. Double appointments were provided to help ensure clinicians could properly assess and put arrangements in place to meet their needs.

The practice had effective arrangements for meeting the needs of patients with dementia. Clinicians were proactive in carrying out dementia screening, where they thought patients were at risk of developing dementia. Arrangements were also in place to identify these patients on the practice's clinical IT system, to help make sure staff knew who they were, so they could provide appropriate care and treatment. A high proportion of patients on the dementia register (92%) had received an annual review during the 2014/15 Quality and Outcomes Framework year.

- Providing services which met the needs of patients who were vulnerable. Monthly multi-disciplinary meetings were held to review the needs of patients with palliative or end of life needs. The practice maintained a register of patients with learning disabilities to help ensure they were able to target appropriate services to this group of patients. Patients received a personal telephone call inviting them to attend for their annual review. For female patients, this included the carrying out of opportunistic cervical screening and the provision of contraceptive advice. The practice had a small number of patients who were homeless. Clinical staff told us any potential safety issues regarding these patients were addressed during consultations and, where needed, patients were signposted to local social care services.

The practice had good arrangements for meeting the needs of patients who were involved in substance misuse. A member of the GP team held lead clinical responsibilities for this group of patients, and maintained an overview of each person's medication and ongoing care and support needs. Clinical staff also worked in partnership with the local drug and alcohol recovery service, to help ensure their patients' needs were met.

- Developing services to meet the needs of working patients. The practice was proactive in offering online services, as well as a full range of health promotion and screening, to make it easier for working patients to obtain convenient care and treatment. There was a

daily, early morning clinic and, on two days a week, a lunch-time surgery was also provided. NHS health checks were offered to help promote the wellbeing of patients aged between 40 and 75 years of age.

- Making reasonable adjustments which helped patients with disabilities and those whose first language was not English, to use the practice. For example, all consultation and treatment rooms were located on the ground floor. There was a disabled toilet which had appropriate aids and adaptations. A hearing loop system was available to help improve accessibility for hearing impaired patients. The ground floor waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. Patients using wheelchairs were able to access the building via a ramp at the front of the health centre. A section of the reception desk had been lowered to make it easier for these patients to speak with staff.

At the time of the inspection, staff were making preparations to register a small number of refugees that had been allocated to their practice. Staff were in the process of reviewing their access to interpretation services, to ensure that they would be sufficient to help them meet the needs of this group of patients. They were also working with the Tuberculosis (TB) screening nurse support nurse to help identify potential health needs. One of the GPs also provided medical reports for asylum seekers registered with the practice on a voluntary basis. They had completed 60 such reports in five years.

Access to the service

The practice's core opening hours were:

Monday: 7:30am to 6:30pm.

Tuesday, Wednesday and Thursday: 7:30am to 6pm.

Friday: 8am to 6pm.

GP appointment times were:

Monday: 7:30am to 6:20pm.

Tuesday, Wednesday and Thursday: 7:30am to 5:50pm.

Friday: 8am to 5:50pm.

The practice website provided good information about how to access appointments. Patients were able to access 'book on the day' appointments, as well routine

Are services responsive to people's needs?

(for example, to feedback?)

appointments which could be booked in advance. Following the practice's 2015 patient survey results, more 'book on the day' appointments had been made available at busier times of the week, as well as an increase in the availability of such appointments throughout the week. A GP led triage system had also been implemented in 2015, for patients requesting access to same-day urgent care. Double appointments could be booked for patients requiring a lengthier consultation. Patients were also able to access urgent, out-of-hours care and treatment, at two sites in the Gateshead area.

The patients we spoke with, as well as most of those who completed CQC comment cards, expressed no concerns about telephone access or access to appointments. The results of the NHS National Patient Survey of the practice, published in January 2016, showed patient satisfaction levels relating to telephone access and practice opening times, were broadly in line with the local CCG and national averages. However, patient satisfaction levels were lower with regards to appointment availability. Of the patients who responded to the survey:

- 89% said their last appointment was convenient. This was just below the local CCG and national averages of 92%.

- 76% said they found it easy to get through on the telephone, compared to the local CCG average of 78% and the national average of 73%.
- 75% said they were able to get an appointment to speak or see someone the last time they tried. This was below the local CCG and national averages of 85%.
- 74% said they were satisfied with practice's opening hours, compared to the local CCG average of 79% and the national average of 75%.

Listening and learning from concerns and complaints

The practice had a good system in place for managing complaints. This included having a designated person who was responsible for handling any complaints and a complaints policy which provided staff with guidance about how to handle complaints. Information about how to complain could be accessed via the practice's website. A detailed complaints leaflet was available in the reception area. This advised patients how to escalate their complaint externally if they were dissatisfied with how the practice had responded. The practice had received seven complaints since June 2015. Information provided to us indicated these had been investigated and responded to appropriately. Complaints were discussed at the monthly staff meeting, so that opportunities for learning could be identified.

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 their patients. Information about the practice's commitment to providing patients with good quality care and treatment was available on their website and in their statement of purpose. Staff we spoke to were aware of the practice's commitment to providing good quality care, were proud to work for the practice and had a clear understanding of their roles and responsibilities.

Governance arrangements

Overall, there was evidence of good governance arrangements. These included the carrying out of evidence based assessments, the allocation of lead roles to staff to help promote good clinical leadership, and the holding of regular meetings to share information to manage patient risk. A forward plan of scheduled weekly meetings for 2016 was available. Each meeting covered a different area including, for example, palliative care patients, training, safeguarding and prescribing. Good arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice.

Clinical audits had been carried out and staff were able to demonstrate how these led to improvements in patient outcomes. The practice proactively sought feedback from patients using surveys. They also had an active patient participation group, which they encouraged to provide feedback on how services were delivered and what could be improved. The practice had performed consistently very well in the clinical and public health indicators covered by the Quality and Outcomes Framework (QOF). Members of the clinical team had been allocated lead responsibilities for overseeing the practice's QOF performance. However, the governance arrangements for making sure that staff had undergone the required pre-employment checks and completed the required training could be improved.

Leadership, openness and transparency

The GP partners and practice manager had a clear shared purpose, and they worked hard to deliver a quality service and to inspire and motivate staff. There was a clear leadership and management structure, and staff told us the

practice was well led and they felt well supported. The GPs, nurses and practice manager had the experience, capacity and capability to run the practice and ensure high quality compassionate care.

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

The practice encouraged and valued feedback from patients and staff. They had a small, well established, virtual patient participation group (PPG) which they consulted about possible improvements at the surgery. Plans were being made to hold face-to-face PPG meetings during 2016. Following feedback from their PPG, the practice had carried out a survey in 2015, after which they had made changes to their appointment system. These included providing more 'book on the day' appointments to help address the concerns raised by their patients. The survey had also been used to identify military veterans and carers, to help make sure these groups of patients were identified on the practice's clinical IT system, so that their specific needs could be met. Members of the PPG told us they felt staff welcomed their views and opinions, and used them to improve the practice. Information encouraging patients to participate in the practice's PPG was available on the practice website. However, we did not see any PPG information in the patient waiting area. Staff had also gathered feedback from patients through their Friends and Family Test survey.

The GP partners and practice manager valued and encouraged feedback from their staff. Arrangements had been made which ensured that all staff received an annual appraisal.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. For example, the practice provided placements for medical students to experience general practice as part of their training. Staff told us they were actively encouraged and supported to access relevant training. Clinical and quality improvement audits were carried out to help improve outcomes for patients. The practice was proactive in developing services to meet patients' needs. For example, they had recently secured funding to help them develop a programme of tea-dances for older people.

As part of their commitment to continuous improvement, one of the GPs acted as the primary care lead for the local

Are services well-led?

Good 

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

CCG, to help improve and develop the provision of primary care services to patients within the locality. The practice manager regularly attended local information and engagement events, to help make sure the practice kept up-to-date with what was happening within the locality. The practice proactively engaged with the Practice

Engagement Programme (PEP), and were taking steps to achieve objectives outlined in the PEP action plan. The latest PEP report confirmed that staff had attended training sessions provided by the local clinical commissioning group (CCG), as well as locality meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>The provider had failed to make sure that all of the required pre-employment checks had been consistently carried out.</p> <p>Regulation 19(1) and 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	