

Central Surgery

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?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Central Surgery on 5 April 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- Risks to patients were assessed and well managed.
- Outcomes for patients who use services were good.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.
- Patients said they were able to get an appointment with a GP when they needed one, 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 a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team.
- The practice carried out a survey of staff in January 2016 using the CQC key questions.
- The practice was aware of and complied with the requirements of the duty of candour.
- The practice were innovative and moving towards further improvements to elderly care, young people and promoting self-care.

We saw one area of outstanding practice which included:

Summary of findings

- The practice were one of the leading practices in the area for providing a substance misuse service to patients. One of the GP partners had a clinical interest in this area and was the lead on this for the practice with two other GPs, a recovery worker and an administrative member of staff and the practice pharmacist. The practice had 51 patients they provided opiate substitute medication to and 35 who were in GP shared care. The practice had carried out a repeat audit on substance misuse patients attending for review. The purpose was to set goals for reviews and to review prescribing with set review appointments as it was felt that this group of patient struggled to access appointments appropriately. They also wanted to ensure they were receiving the appropriate support. The criteria was set for 80% of all of the patients to be reviewed every year. The findings of the re-audit found that 88% of the patients had

been seen by their GP at three month review stage rather than twelve month stage (previously 49%). The practice also implemented regular meetings to discuss these patients and encouraged them to have a named GP to deal with individual prescriptions.

The areas where the provider should make improvements are:

- Consider specific training for the infection control lead nurse and carry out a more comprehensive infection control audit.
- Consider carrying out a risk assessment as to why some administration staff did not have a DBS check.
- Consider a risk assessment around the emergency medicines which were available in the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

The practice had a good process in place for recording and investigating significant events which resulted in audits to review safety systems in the practice. This resulted in changes in clinical practice which improved patient care. There were infection control arrangements in place and the practice was clean and hygienic. However, the infection control audit was not comprehensive. Appropriate recruitment checks had been carried out for staff. There were systems and processes in place for the safe management of medicines. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services.

Data showed that the practice was performing highly when compared to practices nationally; they had achieved 100% of the total number of points available to them, which was above the England average of 94.8% and the local clinical commissioning group (CCG) average of 94.4%.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. These were initiated because of clinical priorities, significant events, complaints or GPs areas of interest. The GPs had specialist clinical interests which meant patients could receive in-house consultation with practice experts and other practices could refer their patients, which cut down waiting times in secondary care.

Staff worked with multidisciplinary teams. There was evidence of appraisals for all staff. We saw staff received appropriate training.

Good



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also

Good



Summary of findings

saw that staff treated patients with kindness and respect, and maintained confidentiality. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified.

Patients said they could make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was in line with local and national averages.

The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.

Good



Are services well-led?

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

The leadership, governance and culture were used to drive and improve the delivery of high-quality person centred care. The practice had a clear vision with quality and safety as its top priority. Their quality improvement policy was titled 'Good- Better – Best'. The practice had a five year strategic plan. They also had yearly plans. The current yearly plan set out quality improvements which were planned.

The practice had very good governance arrangements that supported improvement. For example, the practice had a good process in place for recording and investigating significant events which resulted in audits to review safety systems in the practice which required significant organisation and management.

The practice had clear processes to monitor all aspects of the service, identify any risks and areas for improvements and review the success of any improvements implemented.

The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events. The provider was aware of and complied with the requirements of the duty of candour.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was above local clinical commissioning group (CCG) average (98.9%) and above the England average (97.9%).

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, patients at high risk of hospital admission and those in vulnerable circumstances had care plans in place, this included patients receiving palliative care. The practice were in the process of developing risk assessments for those at risk of falls and for frailty.

The practice was responsive to the needs of older people, including offering home visits. The practice offered longer appointments for patients over the age of 75 as a result of a survey of patients and they had a named GP. Prescriptions could be sent to any local pharmacy electronically.

The practice had recruited a new GP, to carry out an initiative with the Royal College of General Practitioners (RCGP) to improve care for older patients. One of the practice's quality improvement areas led by one of the GP partners was elderly care.

The practice were the lead for one residential care home in the area. One of the GPs visited there every two weeks. Age UK held clinics in the surgery.

The practice maintained a palliative care register and end of life care plans were in place for those patients it was appropriate for. They offered immunisations for pneumonia and shingles to older people.

Good



People with long term conditions

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

The practice had a register of patients with long term conditions which they monitored closely for recall appointments. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively.

Flexible appointments, including extended opening hours and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review.

Good



Summary of findings

The nurse practitioner was trained in spirometry interpretation and the health care assistants were trained in performing spirometry.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, performance for related indicators for patients with COPD were above the national average (100% compared to 96% nationally). The practice had increased the number of patients with COPD who had care plans by 92% from September 2014 to September 2015 (23 to 297).

Families, children and young people

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, accident and emergency visits were screened for harm factors. Childhood immunisation rates were in line with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 100%, compared to the CCG averages of 84% to 99% and for five year olds from 90% to 98%, compared to CCG averages of 91% to 100%.

The practice's uptake for the cervical screening programme was 81.9%, which was in line with the national average of 81.8%. Appointments were available outside of school hours and the premises were suitable for children and babies. Child immunisations were carried out on Wednesday afternoons between 1:30 and 4pm.

The practice had made young people one of their quality improvement areas. They were working with the local youth parliament to make the practice 'youth friendly'.

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).

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 which included appointment booking, test results and ordering repeat prescriptions. They had the highest electronic access in the CCG area at 25%. There was a full range of health

Good



Summary of findings

promotion and screening that reflected the needs for this age group. Flexible appointments were available as well as extended opening hours. A 'winter pressures surgery' was available which was shared with other practices on a Saturday during winter months.

People whose circumstances may make them vulnerable

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability.

The practice were one of the leading practices in the area for providing a substance misuse service to patients. One of the GP partners had a clinical interest in this area and was the lead on this for the practice with two other GPs, a recovery worker and an administrative member of staff and the practice pharmacist. The practice had 51 patients they provided opiate substitute medication to and 35 who were in GP shared care. The practice had carried out a repeat audit on substance misuse patients attending for review. The purpose was to set goals for reviews and to review prescribing with set review appointments as it was felt that this group of patient struggled to access appointments appropriately. They also wanted to ensure they were receiving the appropriate support. The criteria was set for 80% of all of the patients to be reviewed every year. The findings of the re-audit found that 88% of the patients had been seen by their GP at three month review stage rather than twelve month stage (previously 49%). The practice also implemented regular meetings to discuss these patients and encouraged them to have a named GP to deal with individual prescriptions.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children, there were safeguarding summaries for staff in all consulting rooms. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There were 270 patients on the carer's

Outstanding



Summary of findings

register which is 1.86% of the practice population. Carer's packs with written information was available for carers to ensure they understood the various avenues of support available to them. Staff were aware to try and identify carers and offer help and support.

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).

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. They carried out advanced care planning for patients with dementia. All clinicians were trained in dementia screening. 91% of patients identified as living with dementia had received an annual review in 2014/15 (national average 84%). The practice also worked together with their carers to assess their needs. Dementia friends training was available to all staff.

The practice maintained a register of patients experiencing poor mental health and recalled them for regular reviews. They told them how to access various support groups and voluntary organisations, such as talking therapies. Performance for mental health related indicators was better than the national average. For example, 97.9% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months 2014/15 compared to the national average of 88.4%.

Good



Summary of findings

What people who use the service say

We spoke with nine patients on the day of our inspection, which included two members of the practice's patient participation group (PPG).

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included brilliant and good. They told us staff were nice and they received a good service.

We reviewed 34 CQC comment cards completed by patients prior to the inspection. 29 of the cards were wholly positive. Common words used to describe the practice were excellent, very good and nice. Five of the cards, although they gave positive feedback, mentioned that sometimes it was difficult to obtain an appointment with the GP of their choice.

The latest GP Patient Survey published in January 2016 showed that scores from patients were mostly above or in line with national and local averages. The percentage of patients who described their overall experience as good was 100%, which was above the local clinical commissioning group (CCG) average of 87% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 83% (local CCG average 81%, national average 79%).
- 95% said the GP was good at listening to them compared to the local CCG average of 92% and national average of 89%.

- 90% said the GP gave them enough time compared to the local CCG average of 89% and national average of 87%.
- 90% said the nurse was good at listening to them compared to the local CCG average of 92% and national average of 91%.
- 91% said the nurse gave them enough time compared to the local CCG average of 93% and national average of 92%.
- 81% said they found it easy to get through to this surgery by phone compared to the local CCG average 82%, national average 73%.
- 79% described their experience of making an appointment as good compared to the local CCG average 78%, national average 73%.
- Percentage of patients who find the receptionists at this surgery helpful – 86% (local CCG average 89%, national average 87%).

These results were based on 134 surveys that were returned from a total of 318 sent out; a response rate of 42.1% and 0.9% of the overall practice population.

The practice carried out a survey of patients in October 2015 and with the agreement of staff and the patient reference group (PRG) an action plan was drawn up. The action plan included actions regarding patient waiting times for getting through to the surgery on the telephone, review of the waiting room experience for patients and patients receiving letters unnecessarily.

The nursing team also carried out a survey of 10 patients who had a cervical smear carried out at the surgery.

Areas for improvement

Action the service SHOULD take to improve

- Consider specific training for the infection control lead nurse and carry out a more comprehensive infection control audit.
- Consider carrying out a risk assessment as to why some administration staff did not have a DBS check.
- Consider a risk assessment around the emergency medicines which were available in the practice.

Summary of findings

Outstanding practice

- The practice were one of the leading practices in the area for providing a substance misuse service to patients. One of the GP partners had a clinical interest in this area and was the lead on this for the practice with two other GPs, a recovery worker and an administrative member of staff and the practice pharmacist. The practice had 51 patients they provided opiate substitute medication to and 35 who were in GP shared care. The practice had carried out a repeat audit on substance misuse patients attending for review. The purpose was to set goals for reviews and to review prescribing with set review

appointments as it was felt that this group of patient struggled to access appointments appropriately. They also wanted to ensure they were receiving the appropriate support. The criteria was set for 80% of all of the patients to be reviewed every year. The findings of the re-audit found that 88% of the patients had been seen by their GP at three month review stage rather than twelve month stage (previously 49%). The practice also implemented regular meetings to discuss these patients and encouraged them to have a named GP to deal with individual prescriptions.

Central Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a second CQC inspector.

Background to Central Surgery

Central Surgery provides Primary Medical Services to the town of South Shields. The practice provides services from one location, Cleadon Park Primary Care Centre, Prince Edward Road, South Shields, Tyne and Wear, NE34 8PS. We visited this address as part of the inspection.

The surgery is located in purpose built premises which are shared with the local library. There is step free access at the front of the building and all facilities are on the ground floor with full disabled access. There is a large car park to the rear of the surgery including dedicated disabled parking bays.

The practice has five GP partners and eight salaried GPs. Six are female and seven male. The practice is a training practice who have GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme). There are two nurse practitioners, three practice nurses and three healthcare assistants. There is a practice manager, assistant practice manager, IT manager, and part-time pharmacist. There are fifteen reception and administration staff.

The practice provides services to approximately 14,500 patients of all ages. The practice is commissioned to provide services within a Personal Medical Services (PMS) contract with NHS England.

The practice is open from 8am until 7pm Monday and Tuesdays. 8am until 6pm Wednesday to Friday and there are extended hours on a Saturday morning from 8am until 12:45pm.

Consulting times with the GPs and nurses are from 8:30am to 12:30pm weekdays, then 2pm to 6:50pm on Mondays and Tuesdays and 2pm until 5:50pm Wednesday to Friday. There are pre booked appointments with the practice nurse on Saturday morning from 8:30am until 12:30pm.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited.

Information taken from Public Health England placed the area in which the practice was located in the third least deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The average male life expectancy is 77 years and the female is 82. The average male life expectancy in the CCG area is 77 and nationally 79. The average female life expectancy in the CCG area is 81 and nationally 83. The percentage of patients with a long-standing health condition is higher than the national average (practice population is 59% compared to a national average of 54%). The proportion of patients who are in paid work or full-time employment or education is 53.8% compared to the CCG average of 54.6% and the national average of 61.5%.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 5 April 2016.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.

Are services safe?

Our findings

Safe track record and learning

There was a good system in place for reporting and recording significant events. The practice manager was responsible for their collation. They maintained a schedule of these, there had been 66 in the last 12 months. One of the GP partners also oversaw the process and there was an audit process of them. Where incidents and events met the threshold criteria, these were also added to the local CCG Safeguarding Incident & Risk Management System (SIRMS). The incident recording form supported the recording of notifiable incidents under the duty of candour. (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 also kept its own log of the incident. These were scored according to risk. They were discussed at weekly clinical or administration meetings or both if appropriate. We reviewed safety records, incident reports and minutes of meetings where these were discussed.

Significant event analysis was carried out quarterly to look at common themes that the practice could learn from. Action points were taken from this and also good practice was celebrated. Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident.

The practice carried out a safety audit to assure the safety and appropriateness of their prescribing of DMARDs to patients. DMARDs are disease-modifying-anti-rheumatic drugs and they need to be prescribed carefully, with detailed monitoring because they are drugs with significant risk of serious side effects. These medicines are prescribed for conditions such as rheumatoid arthritis. The audit was carried out following significant events regarding these medications in 2013/14. Audits were carried out for the following two years which resulted in an improvement in prescribing safety. The practice implemented a new policy and protocols, redesigned pathways and had involvement with consultants. There was then a patient survey a year later which showed improved understanding of the policy. This example shows the practice was using a significant event to examine its processes and learn from its outcomes and taking active steps to ensure safety for patients in the future.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and national safety alerts. The practice manager managed the dissemination of national patient safety alerts to appropriate staff.

Overview of safety systems and processes

The practice could demonstrate its safe track record through having systems in place for safeguarding, health and safety, including infection control, and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Two of the GPs were the leads for safeguarding adults and children. There were safeguarding summaries for staff in all consulting rooms. Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of. There was a monthly safeguarding meeting at the practice and all safeguarding concerns were also discussed at clinical meetings. Accident and emergency reports were screened for to look for patterns of attendance indicating an increased risk of safeguarding issues. Community health care staff, for example, health visitor and school nurse attended the meetings. Staff demonstrated they understood their responsibilities and had all received safeguarding children and adult training relevant to their role. All GPs and nurses in the practice had received level three safeguarding children training.
- There was a notice on the television information screens in the waiting area to advise patients that they could request a chaperone, if required, the receptionist could describe the procedure for this. The three healthcare assistants and two receptionists had been trained for this role. They had all received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy, patients commented positively on the cleanliness of the practice. One of the practice nurses was the

Are services safe?

infection prevention and control lead; they had been infection prevention and control lead previously in a hospital setting however they had not received recent infection prevention and control lead training. There were infection prevention and control policies, including a needle stick injury policy. Regular hand hygiene audits had been carried out and where actions were raised these had been addressed. There had been regular infection prevention and control checks but no in depth audit. There was a legionella risk assessment which the business manager had obtained from the landlord.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording and handling.). Blank prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacist who was also employed by the practice three hours per week. There were bi-monthly meetings regarding prescribing and the whole practice team had received training on repeat prescriptions, this had led to a fall of general prescribing significant events from nine in quarter one of 2015 to none in quarter one in 2016.
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We looked at recruitment checks for both staff and GPs and saw that checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. There was no documented rationale as to why some administration staff did not have a DBS check. We saw that the clinical staff had medical indemnity insurance.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a

health and safety policy and risk assessment. The assistant practice manager showed us records of a health and safety monthly walk around the premises which they carried out where they checked for any hazards room by room. They had been specifically trained in health and safety and had carried out in-house training for staff. The practice had fire risk assessments in place. Staff had received fire training and we saw there were annual fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. The practice had previously carried out capacity and demand audits and knew what their minimum number of staff should be to cover appointments. There were rotas for clinical and administration staff which went up to a year in advance. There was a policy on absences such as holidays for staff to follow. The practice had only used long term locum cover in recent years to cover for long term absences such as maternity cover. The GPs and staff were able to cover absences between them.

Arrangements to deal with emergencies and major incidents

All staff received basic life support training and there were emergency medicines available in the practice. However, the emergency medicines held did not contain all of the suggested list of emergency drugs for GP practices as outlined in the Drugs and Therapeutics Bulletin in 2005. The practice had a defibrillator available on the premises and oxygen. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

The practice had a business continuity plan in place for major incidents such as building damage. The plan included emergency contact numbers for staff and was updated on a regular basis.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The staff kept themselves up to date via clinical meetings. This information was used to develop how care and treatment was delivered to meet patient needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The data showed:

The latest publicly available data from 2014/15 showed the practice had achieved 100% of the total number of points available to them, with a clinical exception reporting rate of 12.4%. The QOF score achieved by the practice in 2014/15 was above the England average of 94.8% and the local clinical commissioning group (CCG) average of 94.4%. The clinical exception rate was above the England average of 9.2% and the CCG average of 9.5%. We saw the clinical exception process was fully audited.

The data showed:

- Performance for diabetes related indicators was above the national average (100% compared to 89.2% nationally). For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 92.4%, compared to a national average of 88.3%. The percentage of patients on the diabetes register who had an influenza immunisation was 98.7%, compared to a national average of 94.5%.
- Performance for asthma related indicators was above the national average (100% compared to 97.4% nationally). For example, the percentage of patients on

the asthma register who had an asthma review within the preceding 12 months that included an assessment of asthma control was 78.6%, this compared to a national average of 75.4%.

- The practice performed well on the percentage of patients with atrial fibrillation with CHADS2 score of 1, who were currently treated with anticoagulation drug therapy or an antiplatelet therapy. (Atrial fibrillation is an irregular and often rapid heart rate that commonly causes poor blood flow to the body. A CHADS2 score rates the risk for patients with atrial fibrillation based on identified major stroke risk factors.) The practice had achieved 100% in this indicator, compared to an average of 98.4% nationally.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was above the national average (100% compared to 96% nationally). The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding twelve months was 96.1% which was better than the national average of 89.9%.
- Performance for mental health related indicators was above the national average (100% compared to 92.8% nationally) For example, 97.9% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. This compared to a national average of 88.5%.
- Performance for dementia indicators was above the national average (100% compared to 94.5% nationally). The percentage of patients diagnosed with dementia whose care was reviewed in a face-to-face review within the preceding 12 months was better than the national average at 90.5% (compared to a national average of 84.0%).

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment outcomes for people. We saw examples of full completed audits which had been carried out in the last year. This included audits regarding minor surgery, cervical smear testing, bisphosphonates, which is a medication which slows down or prevents bone damage and an audit on blood pressure control.

The practice had carried out a repeat audit on substance misuse patients attending for review. This was an area of specific interest for the practice. The purpose was to set goals for reviews and to review prescribing with set review

Are services effective?

(for example, treatment is effective)

appointments. The criterion was set for 80% of these patients to be reviewed every year. The findings of the re-audit found that 88% of the patients had been seen by their GP at three month review stage rather than twelve month stage (previously 49%).

The GPs had specialist clinical interests; for example, dermatology, musculoskeletal problems, substance misuse, diabetes, ophthalmology and ear, nose and throat (ENT). Patients could receive in-house consultation with practice experts and other local practices could refer their patients which cut down waiting times in secondary care.

The practice had the contract for the carrying out of cryosurgery from the CCG. They provided the service to their own patients and to patients referred to this service from other practices within the CCG area. They had carried out 466 procedures in 2015, with no complaints received regarding the service. The minor surgery contract the practice had from the CCG had a dedicated practice nurse and health care assistant. The waiting time for minor surgery in the CCG area was in excess of 12 weeks in 2012. In the 2015/16 year this was down to 2 weeks due to the practice obtaining the contract and getting through the work. In a recent survey 94% (17 out of 18 patients) gave the service an excellent rating.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and responsibilities of their job role. There was also an up to date locum induction pack at the practice, although locum cover was rarely used. There was also a specific GP who was the supervisor/mentor for new GPs in the practice and there was a full induction process for them.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. Non-clinical staff had received an appraisal within the last twelve months. They told us they felt supported in carrying out their duties. The practice nurses were appraised by the nurse practitioner who was then appraised by a GP partner.

- All GPs in the practice had received their 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.) The salaried GPs also received in house appraisals.
- Staff received training that included: fire procedures, health and safety awareness basic life support, and information governance awareness. All staff had received safeguarding children and adults training. The practice manager told us staff had received equality and diversity training however this was not formally recorded. Clinicians and practice nurses had completed training relevant to their role.
- The practice was a training practice for trainee doctors. Two of the GPs are GP trainers.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

The practice nursing team and administration staff organised the co-ordination of health checks for those patients with long-term conditions, mental health conditions, a learning disability and carers.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. Multi-disciplinary team meetings took place monthly, we saw minutes of the meetings. Care plans were routinely reviewed and updated. Unplanned hospital admissions were routinely reviewed.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements, including the Mental Capacity Act 2005. When providing

Are services effective?

(for example, treatment is effective)

care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was

81.9%, which was in line with the national average of 81.8%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates were in line with CCG/ national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 100%, compared to the CCG averages of 84% to 99% and for five year olds from 90% to 98%, compared to CCG averages of 91% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the healthcare assistant or the GP or nurse if appropriate. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients; both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We reviewed 34 CQC comment cards completed by patients prior to the inspection. Twenty-nine of the cards were wholly positive. Common words used to describe the practice were excellent, very good and nice.

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included brilliant and good. They told us staff were nice and they received a good service.

Results from the national GP patient survey in January 2016 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was in line with local and national satisfaction scores on consultations with doctors and nurses. For example:

- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 86% said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 92% and the national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 90% said the last nurse they spoke to was good listening to them compared to the CCG average of 92% and the national average of 91%.
- 91% said the nurse gave them enough time compared to the CCG average of 93% and the national average of 92%.

Staff told us that translation services were available for patients who did not have English as a first language. There were patient information leaflets available in the waiting room for patients in different languages. The practice had facilities in place to support deaf patients who attended the practice.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included information regarding talking therapies.

The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There were 270 patients on the carer's register which is approximately 2% of the practice population. Carer's packs with written information was available for carers to ensure they understood the various avenues of support available to them. Staff were aware to try and identify carers and offer help and support.

Staff told us that if families had suffered bereavement, depending upon the families wishes the GP would telephone or visit to offer support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Many of the staff had worked there for many years which enabled good continuity of care.

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The practice had recruited a new GP who was funded by the CCG, to carry out an initiative with the Royal College of General Practitioners (RCGP) to improve care for older patients. One of the practice's quality improvement areas led by one of the GP partners was elderly care.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. For example, the practice had identified its highest risk patients and had developed holistic care plans to meet their needs. The practice offered longer appointments for patients over the age of 75 and they had a named GP. The longer appointments were the result of a survey of patients which had identified a need for this. Prescriptions could be sent to any local pharmacy electronically.

The practice was the lead for one residential care home in the area. One of the GPs visited there every two weeks. Age UK held clinics in the surgery.

The practice had made young people one of their quality improvement areas. They were working with the local youth parliament to make the practice 'youth friendly'.

One of the GPs at the practice had a special clinical interest in substance misuse and had set up a separate service which had provided recovery for patients. They were the lead on this for the practice with two other GPs, a recovery worker and an administrative member of staff and the practice pharmacist. The practice had approximately 51 patients they provided care to for recovery from substance misuse.

The practice had a patient reference group (PRG) with approximately eight members who met monthly. The group helped the practice put measures in place to improve confidentiality at the reception desk. They had also discussed with the practice how to promote on-line

services and as a result information was included in the practice newsletter about this. The group had also helped the practice with their flu immunisation campaign and with the re-design of a letter to patients for reviews.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. For example;

- The practice offered extended opening hours on Monday and Tuesday evenings until 7pm and nurse appointments on a Saturday morning from 8:30am until 12:30pm.
- A 'winter pressures surgery' was available which was shared, on a Saturday, during winter months with other practices.
- Telephone consultations were available if required.
- Booking appointments with GPs and requesting repeat prescriptions was available online. They had the highest electronic access in the CCG area at 25%. Electronic prescription requests had increased from 9% in 2014 to 14% in 2016.
- Home visits were available for housebound patients or those who could not come to the surgery.
- Specialist Clinics were provided including minor surgery, joint injections and a cryosurgery service. (Cryosurgery is a type of surgery that involves the use of extreme cold to destroy abnormal tissues, such as tumours). The practice provided this service to 50% of South Tyneside practices.
- The practice provided travel vaccinations which included yellow fever.
- There were disabled facilities and translation services available.
- Child immunisations were carried out on Wednesday afternoons between 1:30 and 4pm.
- The practice produced a quarterly newsletter with topics and information such as patient participation group, holiday vaccinations and information for new patients.

Access to the service

The practice was open from 8am until 7pm Monday and Tuesdays. 8am until 6pm Wednesday to Friday and there were extended hours on a Saturday morning from 8am until 12:45pm.

Consulting times with the GPs and nurses were from 8:30am to 12:30pm weekdays, then 2pm to 6:50pm on

Are services responsive to people's needs?

(for example, to feedback?)

Mondays and Tuesdays and 2pm until 5:50pm Wednesday to Friday. There were pre booked appointments with the practice nurse on Saturday morning from 8:30am until 12:30pm.

There was an on-call GP on duty Monday to Friday, home visits were shared between the GPs on a morning and the on-call GP did these during the afternoon. Staff told us GP routine appointments were usually available in approximately two days. We looked at the practice's appointments system in real-time on the afternoon of the inspection. There was one routine appointment to see a GP in two hours. There were two routine appointments available three hours later.

We reviewed the CQC comment cards completed by patients prior to the inspection. Five of the cards, although they gave some positive feedback, mentioned that sometimes it was difficult to obtain an appointment with the GP of their choice. Patients we spoke with said they did not have difficulty obtaining an appointment to see a GP.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was higher or in line with local and national averages. For example;

- 85% of patients were satisfied with the practice's opening hours compared to the local CCG average of 80% and national average of 78%.
- 81% said they found it easy to get through to this surgery by phone compared to the local CCG average 82%, national average 73%.

- 79% patients described their experience of making an appointment as good compared to the local CCG average of 78% and national average of 73%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. This was also overseen by two of the GP partners.

We saw the practice had received five formal complaints in the last 12 months and these had been investigated in line with their complaints procedure. 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 clinical meetings or administration meetings. The minutes were emailed to staff and made available on the practice intranet.

The practice carried out an annual review of complaints and they looked for themes and trends. In the latest analysis they concluded there were no trends and there were no complaints in the last year as a result of delayed diagnosis.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice vision was to deliver quality care from the whole practice team. This was done by delegating roles, tasks and accountability to people and teams working in different areas. Their quality improvement policy was titled 'Good- Better – Best'. The practice knew they performed well but wanted to do better. They saw an essential part of this was the management team instilling a passion for quality improvement. Staff we spoke with talked about patients being their main priority.

The practice had a five year strategic plan. They also had yearly plans. The current yearly plan set out what quality improvement was planned, for example, further improvements to elderly care, young people and promoting self-care. They had a six monthly 'lifting their heads' planning meeting to assess how quality improvement was being achieved.

The practice also saw capacity and demand for appointments as a priority and had carried out some work in this area in previous years. The outcomes from this earlier quality improvement work can be seen on the practice's survey results under the caring and responsive sections.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

Governance and performance management arrangements were continually reviewed and reflected best practice. The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities, the GP partners were involved in the day to day running of the practice.
- There were clinical leads for areas such as safeguarding and prescribing. There were also leads for non-clinical issues such as information governance, training, and health and safety.
- The GPs had specialist clinical interests such as dermatology and joint injections.

- Practice specific policies were implemented and were available to all staff.
- Managers had a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- The practice had carried out its own audit of itself against the CQC key inspection questions.
- There were monthly audits looking at QOF performance.
- The practice had completed the NHS information governance toolkit which is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice had a good process in place for recording and investigating significant events which resulted in audits to review safety systems in the practice which required significant organisation and management.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff. The leaders at the practice were very much part of the team and motivated staff to succeed and decisions were made in a democratic way ensuring staff and patient views were respected and communicated well.

The provider was aware of and complied with the requirements of the Duty of Candour. Observing the Duty of Candour means that people who use services are told when they are affected by something that goes wrong, given an apology, and informed of any actions taken as a result. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were clinical meetings held every week and regular educational meetings for all clinicians which were minuted. There were multi-disciplinary meetings held monthly. The administration team had weekly meetings. There was a

Are services well-led?

Good 

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

partners meeting every other week and there were regular nurse meetings we saw comprehensive minutes of both meetings. There were whole practice meetings and training away days for staff.

The practice knew their priorities; they had plans in place for areas they needed to work on and knew in what areas they had improved.

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

The practice used innovative approaches to gather feedback from patients. They had gathered feedback from patients through a patient survey and formal and informal complaints received and the practice reference group (PRG). The practice had discussed the change in policy for the prescribing of a certain type of medicine as the patient reference group had raised concerns regarding why the policy had changed. The lead GP attended a PPG meeting to explain this to the members.

The practice had also gathered feedback from staff. The practice carried out a survey of staff in January 2016 using the CQC five key questions, for example using safe and asking questions to see if staff were clear about the importance of safety. There was a review of the survey and

an action plan put in place. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Opportunities for individual training were identified at appraisal. All staff were encouraged to identify opportunities for future improvements on how the practice was run. There were regular staff social events.

Continuous improvement

The practice had a quality improvement policy and talked of many improvements to services which were planned and included in their strategic plans. The practice were constantly innovating and had a good track record of improvements which included improvements to elderly care, young people and promoting self-care.

The practice patient list had grown by approximately 2,200 patients in the last two years. They were also looking at the possibility of being provider for another two practices where the GPs were considering retirement.

There was a focus on continuous learning and improvement within the practice. The practice had protected learning times both at the practice and at CCG organised events.