Talbot Medical Centre

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 Talbot Medical Centre on 6 October 2016. Overall the practice is rated as good. We have rated the population group of families, children and young people outstanding.

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.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below local clinical commissioning group (CCG) and national averages. However the practice were able to demonstrate that data for the 2015/16 period which were not yet published had improved to 96.3 from 88.5% in 2014/15.
- 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.
- The practice had reviewed their appointment system, following feedback from patients and staff.
- 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.

Summary of findings

- The practice was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice;

- The practice were the first organisation in South Tyneside to be awarded the Change for Life young people's award. This is an NHS organisation dedicated to the health and well-being of the public. In addition, the practice carried out work with young people to improve their awareness of what general practice can offer and their rights regarding access and consent. This involved giving a lesson to year eight pupils at a local secondary school. This was delivered by GPs, nurses and NHS staff. At the start of the lesson 38% of students knew what confidentiality meant and at the end 96% felt they knew the meaning. 14% at the start of the lesson knew there was no age limit to see a GP or nurse on their own, by the end 82% knew this. The practice put forward a paper to the CCG Informal Executive committee to see if this work could be offered to all young people in South Tyneside involving other practices as well as theirs.

The areas where the provider should make improvements are:

- Carry out regular comprehensive infection control audits.
- Produce a consent policy which complies with the guidance from The General Medical Council.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Nationally reported data did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.

Lessons were shared to make sure action was taken to improve safety in the practice. We found significant events were recorded, investigated and learned from.

The practice was clean and hygienic and good infection control arrangements were in place, although infection control audits were not carried out.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. However, there was no risk assessment in place for the medicines carried by GPs for home visits.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

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

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below local clinical commissioning group (CCG) and national averages. The practice were able to demonstrate that they had achieved 88.5% of the points available to them for 2014/15. This was below the England average of 94.8% and the local clinical commissioning group (CCG) average of 95.6%. The practice explained that this was lower than local and national averages due

Summary of findings

to a major change to GP staffing during the period QOF results covered. Information provided by the practice for the 2015/16 period which were not yet published showed that the overall score had improved to 96.3%.

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

Staff received annual appraisals and were given the opportunity to undertake both mandatory and non-mandatory training. However, there was no overall record of all staff training to ensure that all staff received the correct training appropriate for their role.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Results from the National GP Patient Survey published in July 2016 were comparable with local CCG and national averages in respect of providing caring services. For example, 96% of patients who responded to the survey said the last GP they saw or spoke to was good at listening to them (CCG average 91% and national average 89%).

The practice identified carers and ensured they were signposted to appropriate advice and support services. At the time of our inspection they had identified 167 of their patients as being a carer (approximately 2% of the practice patient population).

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice was able to demonstrate that they continually monitored the needs of their patients and responded appropriately. For example, the practice had carried out work with young people to improve their awareness of what general practice can offer and their rights regarding access and consent. This involved giving a lesson to year eight pupils at a local secondary school.

The practice had good facilities and was well equipped to treat patients and meet their needs. There were specialist clinics provided for example, minor surgery, including dedicated clinics for joint injections, intrauterine device (IUD also known as coil) fitting and

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removal service and travel vaccinations. Sexually transmitted infection screening was offered which included blood tests for blood borne viruses. The practice offered the C card service to patient aged between 14-25 years where they could receive free condoms.

Information about how to complain was available and evidence showed that the practice responded quickly to issues raised and identified themes arising from them.

Over the past two years the practice had systematically reviewed their performance on access to appointments. Telephone appointments and triage for appointments and home visits had been introduced. The role of the nurse practitioner and health care assistant had been enhanced to free up time for the GPs.

Patients we spoke with said they generally could obtain an appointment when they needed one but sometimes there was a two week wait for routine appointments.

Are services well-led?

Good

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

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

The practice had undergone a great deal of change in the last two to three years. As a result practice development plans were put in place. Leadership roles within the practice were developed from this. The practice succeeded in achieving its aims for example, the recruitment of new GPs and improvement of services provided.

There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. There were GP leads for clinical and non-clinical areas.

The provider was aware of and complied with the requirements of the duty of candour regulation. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.

The practice sought feedback from staff and patients, which it acted on. There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice was responsive to the needs of older people, including offering home visits. All patients over the age of 75 had a named GP. If the patient was over the age of 75 the practice had a policy that they would ring the patient back if there was a request for an urgent appointment within 2 hours. There was a proactive search of the over 75s who did not attend the practice regularly to offer health checks or visit if appropriate. Prescriptions could be sent to any local pharmacy electronically.

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. Age UK attended the influenza clinics held to give energy and benefits advice to patients.

The practice had quarterly palliative care meetings and clinicians meet informally daily to discuss patients for whom they had concerns. This included palliative care / end of life patients and allowed the practice to be responsive to patient's needs as they arose.

People with long term conditions

Good

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

The practice had a register of patient with long term conditions which they monitored closely for recall appointment for health checks. 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.

Care plans were in place for the practice's most vulnerable 2% of patients at high risk of hospital admission including patients with long term conditions. The practice nurse led on the chronic disease reviews and self-care and management was encouraged and supported. Spirometry was carried out in the practice.

Summary of findings

Families, children and young people

Outstanding ☆

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

The practice had good arrangements were in place to safeguard adults and children from abuse. There was a monthly child safeguarding meetings and clinicians met informally on a daily basis to discuss patients for whom they had concerns, this included safeguarding concerns. We were provided with examples of follow up action from these meetings. For example, from the child safeguarding meeting there was a follow up of children who had not attended primary or secondary care appointments.

The practice were the first organisation in South Tyneside to be awarded the Change for Life young people's award. This is an NHS organisation dedicated to the health and well-being of the public. The practice in addition carried out work with young people to improve their awareness of what general practice can offer and their rights regarding access and consent. This involved giving a lesson to year eight pupils at a local secondary school. This was delivered by GPs, nurses and NHS staff. At the start of the lesson 38% of students knew what confidentiality meant and at the end 96% felt they knew the meaning. 14% at the start of the lesson knew there was no age limit to see a GP or nurse on their own, by the end 82% knew this. The practice put forward a paper to the CCG Informal Executive committee to see if this work could be offered to all young people in South Tyneside involving other practices as well as theirs.

Letters were sent to patients when the attained the age of 14 explaining more about the practice, for example, making appointments, confidentiality and young carers information.

Immunisation rates were comparable with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to five year olds ranged from 96% to 99%, compared to CCG averages of 81% to 95%.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 82%.

Specialist Clinics were provided which included intrauterine device (IUD also known as coil) fitting and removal service. Sexually transmitted infection screening was offered which included blood tests for blood borne viruses. The practice offered the C card service to patient aged between 14-25 years where they could receive free condoms.

Mother and baby clinics were offered by the health visiting team in the same building as the practice. Child immunisations were carried out by making an appointment with the practice nurse. Appointments were available outside of school hours; all children

under the age of two where a request was made for a same day appointment were given one, this would be as an extra for a GP if none were available. The premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. There was a full range of health promotion and screening that reflected the needs for this age group.

Flexible appointments were available as well as extended opening hours.

People whose circumstances may make them vulnerable

Good

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

The practice had a register of patients with a learning disability. The nurse practitioner recently began to offer reviews in the home for patients. This was primarily aimed at patients with dementia and learning disabilities. The visit would include compiling a personalised care plan and would cover health needs, ensure all reviews were up to date, carer's assessment, referrals to other services as necessary, emergency care plan and consent to share information with other agencies.

The practice offered an enhanced drug and alcohol worker service and worked with a local drug and alcohol treatment service.

The practice had good arrangements in place to safeguard adults and children from abuse. There was a quarterly vulnerable adult safeguarding meeting. Community health care staff, for example, health visitor and school nurse attended along with the local integrated care team. We were provided with examples of follow up actions from these meetings. For example, where elderly patients in poor living conditions were referred to social services for assessment.

The practice had identified a carer's lead in the last year who was a member of the reception team. The local carers association had given a presentation to staff regarding carers support in May 2016.

Summary of findings

The practice had 167 patients identified as a carer (2% of the overall practice population) and the lead member of staff was in the process of contacting the carers personally to offer support. They had spoken to 64 patients so far. The practice had two separate carers packs, one for patients in general and the other for young carers which set out the definition of a carer, the type of support available and the details of the practice carer's lead. This information was available in the waiting area of the practice.

People experiencing poor mental health (including people with dementia)

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The practice maintained a register of patients experiencing poor mental health and recalled them for regular reviews. In house counselling was available. They told them how to access various support groups and voluntary organisations. Performance for mental health related indicators was better than national average. (95.7% compared to 92.8% nationally).

They carried out advanced care planning for patients with dementia. This included discussions about the future, usually in their own homes, with their carers present. 89% 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. The practice had in the waiting area an example of 'twiddle mitts' which were knitted or crocheted hand muffs with interesting items with textures attached, sensory items, such as button and beads, which were for patients with dementia. The practice staff had been collecting items and making these for the local community.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection, which included speaking to a member of the practice's patient participation group (PPG) by telephone.

All patients, except one, we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included fabulous, lovely and good. They told us staff were friendly and helpful and they received a good service. Patients said they generally could obtain an appointment when they needed one, but sometimes there was a two week wait for routine appointments.

We reviewed 21 CQC comment cards completed by patients prior to the inspection. The cards completed were positive except one. Common words used to describe the practice included, excellent, caring, helpful and good.

The latest GP Patient Survey published in July 2016 showed that scores from patients were variable when compared to national and local averages. The percentage of patients who described their overall experience as good was 88%, which was in line with the local clinical commisioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- 69% said they would recommend their GP surgery (local CCG average 79%, national average 78%).
- 96% said the GP was good at listening to them compared to the local CCG average of 91% 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%.
- 86% said the nurse was good at listening to them compared to the local CCG average of 93% and national average of 91%.
- 90% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 76% said they found it easy to get through to this surgery by phone compared to the local CCG average 79%, national average 73%.
- 60% described their experience of making an appointment as good compared to the local CCG average 77%, national average 73%.
- Percentage of patients who find the receptionists at this surgery helpful – 84% (local CCG average 89%, national average 87%).

These results were based on 122 surveys that were returned from a total of 294 sent out; a response rate of 41% and 1.5% of the overall practice population.

Areas for improvement

Action the service SHOULD take to improve

- Carry out regular comprehensive infection control audits.
- Produce a consent policy which complies with the guidance from The General Medical Council.

Outstanding practice

- The practice were the first organisation in South Tyneside to be awarded the Change for Life young people's award. This is an NHS organisation dedicated to the health and well-being of the public. In addition, the practice carried out work with young people to improve their awareness of what general practice can offer and their rights regarding access and consent. This involved giving a lesson to year eight pupils at a local secondary school. This was delivered by GPs, nurses and NHS staff. At the start of the lesson 38% of students knew what confidentiality meant and at the end 96% felt they knew the meaning. 14% at the start

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of the lesson knew there was no age limit to see a GP or nurse on their own, by the end 82% knew this. The practice put forward a paper to the CCG Informal Executive committee to see if this work could be offered to all young people in South Tyneside involving other practices as well as theirs.

Talbot Medical Centre

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 Talbot Medical Centre

Talbot Medical Centre provides Primary Medical Services to the central area of the town of South Shields. The practice provides services from one location; Stanley Street, South Shields, Tyne and Wear, NE34 0BX. We visited this address as part of the inspection.

The surgery is located in a purpose built premises. 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 car parking at the side of the surgery including dedicated disabled parking bays and also street parking.

The practice has five GP partners and one salaried GP. Four are female, who are part-time and two are male who are both full time; there are 33 sessions per week. The practice teaches stage one, two, three and five medical students. There are two nurse practitioners and two practice nurses. There is a practice manager, assistant practice manager and seven administration and nine reception staff of which some are part-time.

The practice provides services to approximately 8,200 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) contract with NHS England.

The practice is part of South Tyneside clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the second most deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice population had similar numbers of patients comparable with the national average other than patients between the ages of 30 and 44 where there were less than the average number of patients.

The practice is open from 8.30am and until 6pm Monday, Thursday and Friday. There is extended opening hours on Tuesday and Wednesday evenings until 7.30pm. The practice is closed at weekends.

Consulting times with the GPs and nurses range from 8.45am – 11.50am and 2.20pm – 5:40pm. On extended opening days consulting times run to 7.15pm.

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

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.

Detailed findings

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 6 October 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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. The practice manager was responsible for their collation. There had been nine recorded for the year 2015/16, an annual review of these had taken place. There were thirteen so far for the year 2016/17. The practice manager said that recently the practice had improved their incident reporting system and made staff more aware which had led to more reports. Significant events were discussed at the practice clinical meeting or administration meeting if more appropriate.

Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident. They gave us examples of feedback from recent incidents. This included an incident where an appointment for a secondary care consultation had been given to the wrong patient. This led to a review of the process for this and staff were required to check dates of birth and identification before appointments were booked.

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).

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.

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.

- The practice had good arrangements in place to safeguard adults and children from abuse. There was a weekly child safeguarding meeting at the practice and a quarterly vulnerable adult safeguarding meeting. Community health care staff, for example, health visitor and school nurse attended both of these the meetings and the local integrated care team attended the vulnerable adult meetings. We were given several examples of the appropriate interaction and actions following these meetings, for example, from the child safeguarding meeting there was a follow up of children who had not attended primary or secondary care appointments.
- Safeguarding policies reflected relevant legislation and local requirements and 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 practice GP partners were the leads for safeguarding adults and children. Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of. Staff demonstrated they understood their responsibilities and had all received safeguarding children training relevant to their role. Both safeguarding leads had received level 3 safeguarding children training.
- There was a notice displayed in the waiting area and in the clinical rooms advising patients that they could request a chaperone if required. The practice nurses and some of the reception staff carried out this role. They had received chaperone training and all who carried out chaperoning duties had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Further reception staff had been trained to be chaperones but were awaiting their DBS check before commencing chaperoning duties.
- 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 infection control lead. They had attended a recent link practitioner training course for infection control and had carried out hand hygiene training with staff. There were infection control policies, including a needle stick injury policy. Sharps bin receptacles were available in the consultation rooms and those we looked at had been signed and dated by the assembler. Clinical waste was appropriately handled. There was a legionella risk assessment. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

Good

Are services safe?

However, there were no arrangements for carrying out regular comprehensive infection control audits which would have reduced the risk of Healthcare Associated Infections (HCAI's).

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording and handling.). Prescription pads were securely stored and there were systems in place to monitor their use. 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. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We sampled recruitment files for both staff and GPs and saw that appropriate 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. 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 which had been carried out by an external contractor. The practice manager told us they also carried out regular checks of the building. The practice had fire risk assessments in place. The fire equipment was checked every week. There had been six monthly fire drills which were documented and we were shown an email which confirmed staff were due to attend fire safety training in November 2016. 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 of staff and mix of staff needed to meet patients' needs. The practice occasionally used locum cover. There were rotas in place for GP and administration staff cover.

Arrangements to deal with emergencies and major incidents

We saw records to confirm staff had received appropriate basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However, the oxygen cylinder was out of date. The practice immediately ordered another cylinder and we saw an email from the supplier to confirm this was to be delivered the next working day. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. There was no risk assessment in relation to the medicines carried in the GPs bags.

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.

Good

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 and educational 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 latest publicly available data from 2014/15 showed the practice had achieved 88.5% of the total number of points available to them, with a clinical exception reporting rate of 5%. The QOF score achieved by the practice in 2014/15 was below the England average of 94.8% and the local clinical commissioning group (CCG) average of 95.6%. The clinical exception rate was below the England average of 9.2% and the CCG average of 8.9%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

We asked the practice about the number of QOF points being lower than the local and national averages and they said this was due to a major change to GP staffing during the period QOF results covered. Information provided by the practice for the 2015/16 period which were not yet published showed that the overall score had improved to 96.3% and the clinical exception rate for this period was 6.6%

The data showed:

- Performance for diabetes related indicators was below the national average (63.5% compared to 89.2% nationally) for 2014/15. However, data provided by the practice for the 2015/16 year showed an improvement to the data which made up these figures. For example, the percentage of patients whose glycatedhaemoglobin was 64mmoll or less in the preceding 12 months for 2014/15 was 64.5%; this had improved to 74% for the 2015/16 year.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were below the national average (88.7% compared to 96% nationally). However, data provided by the practice for the 2015/16 year showed an improvement to the data which made up these figures. For example, the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding twelve months was 74%, for the 2014/15 year, this had improved to 96% for the 2015/16 year.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We saw examples of twelve audits which had been carried out in the last year. This included audits regarding medication reviews for patients, a review of telephone triage and an audit of patients diagnosed with cancer. We saw in detail two fully completed audit cycles. This included an audit of gout, where NICE guidance recommended that uric acid levels should be below 300umol. Between the two audits there was an increase of 23.9% of patients having their levels tested (34.6% to 58.5%). The practice reminded clinicians that tests should be carried out and a re-audit was set for 2017. The nurses had carried out an audit of urine samples in June 2016 to reduce the practice of samples being handed into reception by patients for testing. This resulted in samples only being accepted following discussion or triage with a clinician.

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.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings.

Good

Are services effective?

(for example, treatment is effective)

Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. Non-clinical staff and nurses had received an appraisal within the last twelve months. They told us they felt supported in carrying out their duties.

- 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.
- We saw records of non-clinical staff training. This included: basic life support, safeguarding children and adults, medical terminology, training on the clinical computer system and information governance training. Staff were due to receive fire safety training and had been advised regarding health and safety awareness by the company which had provided the health and safety risk assessment to the practice. One of the nurses showed us an example of the training they had undertaken. There was no record of the GPs basic training, for example, fire, health and safety or basic life support, although we were assured this had been carried out. The practice manager advised they would look at having an overall record of all staff training to ensure that all staff received the correct training appropriate for their role.

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 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.
- Clinical staff used 'special notes' to record important information about vulnerable patients with complex needs, so this could be shared with out-of-hours emergency professionals in a timely manner.

Consent to care and treatment

The practice did not have a consent policy which covered minor surgery. Verbal consent only was obtained for this. The practice should produce a consent policy which covers the guidance from The General Medical Council, Consent: patients and doctors making decisions together (2008).

Staff including the GPs, nurses and some administration staff had received training in the Mental Capacity Act 2005. 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. The correct consent was considered for children and young people.

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 80%, which was comparable to the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were in line with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to children under one year old was 98%, compared to the CCG averages of 73% to 93% and for five year olds from 96% to 99%, compared to CCG averages of 81% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the healthcare assistant or the GP if appropriate. There was a proactive search of the over 75s who did not attend the practice regularly to offer health checks or visit if appropriate. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients; both attending at the reception desk and on the telephone. The practice used an electronic board to call patients; however the GPs personally came out of their consulting room when appropriate for example to call patients with hearing or visual problems.

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 21 CQC comment cards completed by patients prior to the inspection. The cards completed were positive except one. Common words used to describe the practice included, excellent, caring, helpful and good.

All patients we spoke with, except one, were satisfied with the care they received from the practice except one. Words used to describe the practice included fabulous, lovely and good. They told us staff were friendly and helpful and they received a good service.

Results from the national GP patient survey in July 2016 showed scores were just below the local and national averages for how patients were treated with compassion, dignity and respect. For example:

- 94% 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%.
- 95% 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%.
- 84% 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 above local and national averages. For example:

- 96% said the GP was good at listening to them compared to the CCG average of 91% 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%.
- 86% 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%.
- 90% said the nurse gave them enough time compared to the CCG average of 94% 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.

Patient and carer support to cope emotionally with care and treatment

The practice had a large amount of healthcare information on display in both clinical rooms and the waiting area of the practice. This included information regarding help for carers, mental health services and information for those at risk of domestic violence. There was information on sexual health in the patient toilets.

The practice had identified a carer's lead in the last year who was a member of the reception team. The local carers association had given a presentation to staff regarding carers support in May 2016. The practice had 167 patients identified as a carer (2% of the overall practice population) and the lead member of staff was in the process of contacting the carers personally to offer support. They had spoken to 64 patients so far. The practice had two separate carers packs, one for patients in general and the other for

Good

Are services caring?

young carers which set out the definition of a carer, the type of support available and the details of the practice carer's lead. This information was available in the waiting area of the practice.

Staff told us that if families had suffered bereavement, one of the receptionists, who was the bereavement lead, if appropriate, would sent a bereavement card to the family which also told them they could contact the practice for support if needed.

Good

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. The practice had close links with the local community through the different multi-disciplinary meetings and groups the practice attended.

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The practice were working closely with other local practices as part of developing a local federation of GPs. (A Federation is a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local communities).

The practice were the first organisation in South Tyneside to be awarded the Change for Life young people's award. This is an NHS organisation dedicated to the health and well-being of the public. The practice in addition carried out work with young people to improve their awareness of what general practice can offer and their rights regarding access and consent. This involved giving a lesson to year eight pupils at a local secondary school. This was delivered by GPs, nurses and NHS staff. At the start of the lesson 38% of students knew what confidentiality meant and at the end 96% felt they knew the meaning. 14% at the start of the lesson knew there was no age limit to see a GP or nurse on their own; by the end 82% knew this. The practice put forward a paper to the CCG Informal Executive committee to see if this work could be offered to all young people in South Tyneside involving other practices as well as theirs. Letters were sent to patients when they attained the age of 14 explaining more about the practice, for example, making appointments, confidentiality and young carer's information.

The practice had a register of patients with long term conditions which they monitored closely for annual call and recall appointment for health checks. Care plans were in place for the practice's most vulnerable 2% of patients at high risk of hospital admission. The practice nurse led on the chronic disease reviews and self-care and management was encouraged and supported. Spirometry was carried out in the practice.

The practice had a register of patients with a learning disability and offered heath checks which were often carried out at home by the nurse practitioner.

The practice offered an enhanced drug and alcohol worker service and worked with a local drug and alcohol treatment service.

The nurse practitioner recently began to offer reviews in the home for patients. This was primarily aimed at patients with dementia and learning disabilities. The visit would include compiling a personalised care plan and would cover health needs, ensure all reviews were up to date, carer's assessment, referrals to other services as necessary, emergency care plan and consent to share information with other agencies.

The practice had in the waiting area an example of 'twiddle mitts' which were knitted or crocheted hand muffs with interesting items with textures attached, sensory items, such as button and beads, which were for patients with dementia. The practice staff had been collecting items and making these for the local community.

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;

- Telephone consultations were available if required
- Booking appointments with GPs and requesting repeat prescriptions was available online.
- Home visits were available for housebound patients or those who could not come to the surgery.
- Specialist Clinics were provided including minor surgery, including dedicated clinics for joint injections, intrauterine device (IUD also known as coil) fitting and removal service and travel vaccinations.
- Sexually transmitted infection screening was offered which included blood tests for blood borne viruses. The practice offered the C card service to patient aged between 14-25 years where they could receive free condoms.
- There were disabled facilities, hearing loop and translation services available.
- All patient services were accessible to patients with physical disabilities. Other reasonable adjustments were made and action was taken to remove barriers when people find it hard to use or access services.
- Mother and baby clinics were offered by the health visiting team in the same building as the practice. Child

Good

Are services responsive to people's needs?

(for example, to feedback?)

immunisations were carried out by making an appointment with the practice nurse. All children under the age of two where a request was made for a same day appointment were given one, this would be as an extra for a GP if none were available.

Access to the service

The practice was open from 8.30am and until 6pm Monday, Thursday and Friday. There was extended opening hours on Tuesday and Wednesday evenings until 7.30pm. The practice was closed at weekends.

Consulting times with the GPs and nurses ranged from 8.45am – 11.50am and 2.20pm – 5:40pm. On extended opening days consulting times ran to 7.15pm.

Over the last two years the practice had reviewed improving access to appointments for patients. Telephone appointments and triage for appointments and home visits had been introduced. This included enhancing the role of the nurse practitioner and health care assistant to free up time for the GPs.

Patients we spoke with said they generally could obtain an appointment when they needed one but sometimes there was a two week wait for routine appointments. Two of the patients who completed CQC comment cards said that appointments did not run to time.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. There were routine appointments to see a GP in two weeks' time and telephone appointments available for the next week. The duty GP would ring back that day if a patient required an urgent appointment. If the patient was over the age of 75 the practice had a policy that they would ring the patient back if it was a request for an urgent appointment within 2 hours. All children under the age of two where a request was made for a same day appointment were given one, this would be as an extra for a GP if none were available.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment were variable compared to local and national averages. For example;

- 86% of patients were satisfied with the practice's opening hours compared to the local CCG average of 81% and national average of 76%.
- 76% patients said they could get through easily to the surgery by phone compared to the local CCG average of 79% and national average of 73%.
- 60% patients described their experience of making an appointment as good compared to the local CCG average of 77% 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.

We saw the practice had received three formal complaints in the last 12 months and two verbal complaints 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. The practice had carried out carried out an annual review of complaints.

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's had a mission statement to continually strive to provide the best quality, holistic health care where they were able, putting patients at the heart of what they did. Staff we spoke with talked about patients being their main priority.

The practice had undergone a great deal of change in the last two to three years. From this a practice development plan was developed for the period August 2014 to April 2016 and subsequently one for April 2016 to April 2018. Leadership roles within the practice were developed from this.

The development plan for 2014/16 set out objectives, for example to recruit new GPs in particular more female GPs. The practice achieved this in December 2015 by having a full complement of GPs including female GPs. There were also plans for improved sexual health services, improved patient access and improved support for those recently bereaved. These plans were achieved.

The development plan for 2016/18 includes carrying over plans from the previous plan, for example continually improving patient access. New aims were identified such as, to continue to work with third sector organisation, to become a research practice and to adopt lean working principles.

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

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. We were shown a document which set roles and responsibilities. There were GP lead roles for finance, governance, staff and nurses and patient participation.
- There were clinical leads for areas such as safeguarding, diabetes, mental health and palliative care.
- Practice specific policies were implemented and were available to all staff.
- Managers had an understanding of the performance of the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

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 provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There had been significant change to the GP partners in the last two to three years. The existing partners had worked tirelessly to ensure that the practice moved forward. Staff told us that changes had been positive and they had felt supported during this time.

There were clinical meetings held quarterly, a log was kept of actions from these meetings which included any significant events discussed, however there were no formal minutes of these. The practice was closed once a month over lunchtime for an hour and a half and a practice meeting was held. There were practice business meetings held monthly. We saw minutes of both meetings.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through formal and informal complaints received and the practice participation group (PPG). They had carried out an analysis which compared the results of the GP National Survey to monitor customer satisfaction, this showed that satisfaction had generally improved over a three year period. The practice had a 'positivity board' in the waiting area where they posted compliments, cards and gifts which were brought to the practice from patients.

Are services well-led?

Good

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

The practice had a patient participation group (PPG) with between six and ten members who met quarterly, one of the GPs chaired the meeting. We spoke with a member of the PPG. They told us the practice were open to suggestions from the group. The group had told the practice that they thought it would be a good idea to have a business card for patients with their named GP and information about the practice on it. The practice took this up and were in the process of having these made.

The practice had also gathered feedback from staff. There was a staff feedback document which had been compiled in 2015. This encouraged feedback from staff on what was working in the practice and areas for improvement. This was repeated in 2016. The practice had a staff bulletin which was published quarterly and gave staff information on for example, the influenza campaign and care navigators. There were regular events for staff including fund raising nights out and social events.

Continuous improvement

There was a culture of continuous improvement in the practice.

The practice had demonstrated development of services in recent years, this included sexual health screening, intrauterine device (IUD also known as coil) fitting and removal service and the practice offered the C card service to patients aged between 14-25 years where they could receive free condoms.

The practice had reviewed their appointment system to make improvements for patient access.

The practice had carried out work with young people to improve their awareness of what general practice can offer and their rights regarding access and consent. This involved giving a lesson to year eight pupils at a local secondary school.

The practice had protected learning times once a month both at the practice and at CCG organised events.

The practice taught stage 1, 2, 3 and 5 medical students at the practice and were hoping to be become 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).

The practice were working closely with other local practices as part of developing a local federation of GPs.