Portugal Place Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Portugal Place Health Centre on 7 September 2016. Overall the practice is rated as good.

Our key findings were as follows:

- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Although it was not always clear what action had been taken to improve safety in the practice, and prevent a reoccurrence of incidents and significant events.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Many patients were unhappy with the appointments system; managers were aware of this and were taking action to improve access.
- 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 proactively sought feedback from staff and patients, which they acted on.
- There were effective arrangements in place to ensure all staff received training appropriate to their role.
- Staff throughout the practice; and the other external agencies based in the same building, worked well together as a team.

The area where the provider should make improvements is:

- Take steps to ensure that learning from significant events is identified and appropriate action taken to reduce the risk of similar incidents occurring in the future.
- Take action to ensure that the refrigerators used to store vaccines are serviced in line with manufacturer's guidelines.
- Develop arrangements for identifying patients who are carers so they can be offered appropriate care and support.

Summary of findings

- Take steps to improve the system for investigating and responding to complaints, including providing advice on what to do if the complainant was unhappy with the response to their complaint.

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.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. However, it was not always clear what action had been taken to improve safety in the practice, and prevent a reoccurrence of incidents and significant events.

There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. One of the clinical rooms was carpeted; managers told us they had plans to replace the carpet with suitable flooring.

Effective staff recruitment practices were followed and there were enough staff to keep patients safe. Disclosure and Barring Service (DBS) checks had been completed for all staff employed since 2014. A decision had been taken not to carry out retrospective checks on existing (clinical and non-clinical) staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 95.8% of the points available. This was above the national average of 94.7%. Information about patients' outcomes was used to make improvements. The practice used an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices.

Patients' needs were assessed and care was planned and delivered in line with current legislation. There were designated leads for clinical areas, they attended relevant training and kept up to date with new guidance, then cascaded that to colleagues. A number of clinical protocols had been devised; which incorporated NICE and local guidelines. These were reviewed regularly and were available to all clinical staff.

Arrangements had been made to support clinicians with their continuing professional development. Staff had received training appropriate to their roles. There were systems in place to support

Summary of findings

multi-disciplinary working with other health and social care professionals in the local area. The district nursing team and health visitors were based in the same building so there was regular informal communication.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about support groups and services was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality. Some patients commented that they felt their conversations with the receptionist could be overheard. Managers were aware of this issue and had tried several options to reduce the risks.

The National GP Patient Survey published in July 2016 showed satisfaction scores on consultations with doctors and nurses were broadly in line with national averages. Results showed that 95% of respondents had confidence and trust in their GP, the same as the national average; 100% said they had confidence and trust in their nurse, compared to the national average of 97%. However, some scores were slightly below average, for example, 88% said the nurse was good at treating them with care and concern compared to the national average of 91%.

There was no specific written information available for carers to ensure they understood the various avenues of support available to them. Patients were invited to register as a carer when they registered with the practice. Staff told us the clinical staff would ask those patients who they considered may have been carers but there were no plans to reach out to the wider practice population.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had good facilities and was well equipped to treat patients and meet their needs. Extended hours surgeries were offered every Wednesday and Thursday evening; appointments with GPs and nurses were available outside of normal working hours.

However, the practice's scores in relation to access in the National GP Patient Survey were below average. The most recent results (published in July 2016) showed 80% (compared to 85% nationally and 86% locally) of respondents were able to get an appointment or speak to someone when necessary. The scores on the ease of getting through on the telephone to make an appointment were also below average (60% of patients said this was easy or very easy, compared to the national average of 73% and a CCG average of

Summary of findings

79%). Some of the patients we spoke with also expressed dissatisfaction at the appointments system. Managers were aware of patients' views on access and had carried out a detailed review of capacity and demand. New ways of working had been implemented to improve access; this included employing a nurse practitioner and increasing the number of telephone consultations available.

The practice had a system in place for handling complaints and concerns but this was not always effective. We looked at six complaints received in the last 12 months. Many of the responses did not give the complainant advice on what to do if they were unhappy with the response to their complaint.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. There was a clear and documented vision for the practice. Staff understood their responsibilities in relation to the practice aims and objectives. There was a well-defined leadership structure in place with designated staff in lead roles. Staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which they acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

There was a focus on continuous learning and improvement at all levels within the practice. New ways of working had been implemented to improve access. Staff were involved in making improvements to the practice.

Summary of findings

The six population groups and what we found

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

Older people

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, all patients over the age of 75 had a named GP. Patients at high risk of hospital admission and those in vulnerable circumstances had care plans.
- The practice was responsive to the needs of older people and offered home visits and urgent appointments for those with enhanced needs.
- A palliative care register was maintained and the practice offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of admission to hospital were identified as a priority.
- Longer appointments and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively.
- Patients had regular reviews to check health and medicines needs were being met.
- For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Performance in the Quality and Outcomes Framework (QOF) for peripheral arterial disease (a circulatory problem) indicators was above the national average (100% compared to 96.7% nationally). For example, the percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet was being taken was 96.5%, compared to the national average of 92.7
- QOF performance for asthma related indicators was below the national average (82.1% compared to 97.4% nationally). For example, the percentage of patients with asthma who had had an asthma review in the preceding 12 months that included an

Summary of findings

assessment of asthma control using the 3 RCP questions was 65.7%, compared to the national average of 75.3%. However, action had been taken, including further training for clinicians and the implementation of a new protocol on dealing with suspected asthma in the under 16s. Data, provided by the practice, for 2015/2016 showed that performance had improved and the practice had achieved all of the points available for the asthma related indicators.

Families, children and young people

Good

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

- The practice had identified the needs of families, children and young people, and put plans in place to meet them.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies. The practice hosted open access baby clinics every week.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice's uptake for the cervical screening programme was 80.6%, which was slightly below the CCG average of 83.1 and the national average of 81.8%.
- Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice.

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 and flexible. Extended hours surgeries were offered on Wednesday and Thursday evenings until 8pm for working patients who could not attend during normal opening hours.
- The practice offered a full range of health promotion and screening which reflected the needs for this age group. Patients could order repeat prescriptions and book appointments on-line.

Summary of findings

- Additional services were provided such as health checks for the over 40s and travel vaccinations.

People whose circumstances may make them vulnerable

Good

The practice is rated as requires improvement 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.
- Patients with learning disabilities were invited to attend the practice for annual health checks and were offered longer appointments, if required.
- The practice had effective working relationships with multi-disciplinary teams in the case management of vulnerable people.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.
- The practice had a comprehensive system for recording child safeguarding concerns; there was a shared electronic document which was regularly reviewed and updated by the health visiting team.
- There was no specific written information available for carers to ensure they understood the various avenues of support available to them. Patients were invited to register as a carer when they registered with the practice. Staff told us the clinical staff would ask those patients who they considered may have been carers but there were no plans to reach out to the wider practice population.

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 worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Care plans were in place for patients with dementia.
- Patients experiencing poor mental health were sign posted to various support groups and third sector organisations.
- The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

Summary of findings

What people who use the service say

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

We reviewed two CQC comment cards which had been completed by patients prior to our inspection.

Patients were generally complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. However, some patients were unhappy with the appointments system.

The National GP Patient Survey results published in July 2016 showed some scores were below local and national averages. There were 105 responses (from 269 sent out); a response rate of 39%. This represented 0.9% of the practice's patient list. Of those who responded:

- 87% said their overall experience was good or very good, compared with a clinical commissioning group (CCG) average of 88% and a national average of 85%.
- 60% found it easy to get through to this surgery by phone, compared with a CCG average of 79% and a national average of 73%.
- 83% found the receptionists at this surgery helpful, compared with a CCG average of 90% and a national average of 87%.
- 80% were able to get an appointment to see or speak to someone the last time they tried, compared with a CCG average of 86% and a national average of 85%.
- 91% said the last appointment they got was convenient, compared with a CCG average of 93% and a national average of 92%.
- 69% described their experience of making an appointment as good, compared with a CCG average of 77% and a national average of 73%.
- 69% usually waited 15 minutes or less after their appointment time to be seen, compared with a CCG average of 72% and a national average of 65%.
- 57% felt they don't normally have to wait too long to be seen, compared with a CCG average of 64% and a national average of 58%.

Areas for improvement

Action the service SHOULD take to improve

Take steps to ensure that learning from significant events is identified and appropriate action taken to reduce the risk of similar incidents occurring in the future.

Take action to ensure that the refrigerators used to store vaccines are serviced in line with manufacturer's guidelines.

Develop arrangements for identifying patients who are carers so they can be offered appropriate care and support.

Take steps to improve the system for investigating and responding to complaints, including providing advice on what to do if the complainant was unhappy with the response to their complaint.

Portugal Place Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Portugal Place Health Centre

Portugal Place Health Centre is registered with the Care Quality Commission to provide primary care services. It is located in the town of Wallsend, Tyne and Wear.

The practice provides services to around 11,700 patients from one location: Portugal Place, Wallsend, Tyne and Wear, NE28 6RZ. We visited this address as part of the inspection. The practice has eight GP partners (five female and three male), one salaried GP (female), a trainee GP (male), a nurse manager, a nurse practitioner and three practice nurses (all female), a healthcare assistant, a practice manager, and 21 staff who carry out reception and administrative duties.

The practice is a training practice and one of the GPs is an accredited GP trainer. At the time of the inspection there was one trainee GP working at the practice.

The practice is part of North Tyneside clinical commissioning group (CCG). The age profile of the practice population is broadly in line with CCG and national averages. Information taken from Public Health England placed the area in which the practice is located in the fourth more deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

The practice is located in a purpose built two storey building. All patient facilities are on the ground floor. There is on-site parking, a disabled WC, wheelchair and step-free access.

Opening hours are between 8am and 6pm on Mondays, Tuesdays and Fridays and between 8am and 8pm Wednesday and Thursday, appointments are available at all times during opening hours. Patients can book appointments in person, on-line or by telephone.

A duty doctor is available each afternoon until 6.30pm.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

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

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)

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG).

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

We carried out an announced visit on 7 September 2016. We spoke with eight patients and 12 members of staff from the practice. We spoke with and interviewed five GPs, the nurse manager, the nurse practitioner, the practice manager and four staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed two CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events, but this did not provide sufficient assurance that learning was identified to reduce the risk of similar incidents occurring in the future.

- Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Incidents were also reported on the local cross primary and secondary care Safeguard Incident and Risk Management System (SIRMS).
- The practice carried out some analysis of the significant events.

Staff told us they were encouraged to report incidents. We reviewed safety records, incident reports and minutes of meetings where these were discussed. However, it was not always clear what action had been taken to improve safety in the practice, and prevent a reoccurrence of such events. For example, there had been an error in prescribing the incorrect medicine to a patient. This was resolved but it was not clear what action had been taken to prevent it happening again. In other cases, there were significant events in relation to baby immunisations and a delayed diagnosis. It was unclear whether the practice protocols and procedures had been reviewed or what learning had been taken from the incidents.

The practice informed us that their system for recording, discussing, actioning and reviewing significant events had recently been overhauled. The new forms included sections on 'suggestions to prevent recurrence' and 'actions to be taken'.

We discussed the process for dealing with safety alerts with the practice manager and some of the clinical staff. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Alerts were disseminated by the deputy practice manager to the GPs to decide what action should be taken to ensure continuing patient safety, and mitigate risks. The alerts were then passed on to relevant staff and discussed at the clinical governance meetings.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice had a comprehensive system for recording child safeguarding concerns; there was a shared electronic document for each child with a safeguarding concern, which was regularly reviewed and updated by the health visiting team. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three, and the nurses to level two.
- In most areas appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead; they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. However, one of the clinical rooms was carpeted; National guidelines state 'carpets should not be used in treatment and minor surgery rooms. The flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant.' Managers told us they were aware of the issue and they had plans to replace the carpet with suitable flooring.

Good

Are services safe?

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Regular medicines audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (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). However, the practice was unable to provide evidence that the refrigerators used to store vaccines had been serviced in line with manufacturer's guidelines. They told us the correspondence relating to the refrigerators was with the practice accountants so they were not aware of servicing requirements. After the inspection the practice told us that the refrigerators had been added to the list of equipment to be recalibrated systematically.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- Recruitment checks were carried out and the three files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice policy was to carry out Disclosure and Barring Service (DBS) checks for all staff employed since 2014 (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). A decision had been taken not to carry out retrospective checks on existing (clinical and non-clinical) staff.
- Notices in the consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role; however, as they were long-standing members of the team not all had received a DBS check.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with posters throughout the building. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and childrens' masks. 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. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

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. Staff had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet patients' needs.
- There were designated leads for clinical areas, they attended relevant training and kept up to date with new guidance, then cascaded that to colleagues. The practice had devised a comprehensive set of clinical protocols; which incorporated NICE and local guidelines. The protocols were held centrally on a shared drive for all staff to access; this ensured consistency of care.
- The practice monitored that these guidelines were followed through risk assessments, audits and through discussion at the regular educational meetings.

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 95.8% of the total number of points available, which was above the England average of 94.7%.

At 7.2%, the clinical exception reporting rate was below the England average of 9.2% (the QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where medicines cannot be prescribed due to a contraindication or side-effect).

The data showed:

- Performance for peripheral arterial disease (a circulatory problem) indicators was above the national average (100% compared to 96.7% nationally). For example, the percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet was being taken was 96.5%, compared to the national average of 92.7
- Performance for mental health related indicators was better than the national average (94.7% compared to 92.8% nationally). For example, the percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months was 100%, compared to the national average of 91%.
- Performance for asthma related indicators was below the national average (82.1% compared to 97.4% nationally). For example, the percentage of patients with asthma who had had an asthma review in the preceding 12 months that included an assessment of asthma control using the 3 RCP questions was 65.7%, compared to the national average of 75.3%.

However, action had been taken, including further training for clinicians and the implementation of a new protocol on dealing with suspected asthma in the under 16s. Data, provided by the practice, for 2015/2016 showed that performance had improved and the practice had achieved all of the points available for the asthma related indicators.

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 a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings. This included an audit of patients diagnosed with diabetes who were housebound, to ensure appropriate health checks were carried out. An initial audit was carried out which showed that foot screening checks had been carried out for 58% of patients. Action was taken and further staff were trained to carry out such checks. A further audit cycle was carried out and this showed an improvement, in that 86% of patients had received the checks.

The practice used an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices. Information about patients' outcomes was used to make

Good

Are services effective?

(for example, treatment is effective)

improvements. For example, referrals to secondary services had been reduced; where appropriate more patients were treated within the practice, which was more convenient and efficient.

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 safeguarding, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updates for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

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. The practice had devised comprehensive guidelines for staff to follow, for example, when reviewing patients' hospital discharge letters.

All relevant information was shared with other services in a timely way, for example when people were referred to other services. 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. The district nursing team and health visitors were based in the same building so there was regular informal communication. Staff told us they worked well together and regularly shared information. We saw evidence that formal multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

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 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 recorded the outcome of the assessment.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice. For example:

- 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.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 80.6%, which was slightly below the CCG average of 83.1% and the national average of 81.8%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. 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 comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two

Good

Are services effective?

(for example, treatment is effective)

year olds ranged from 97.4% to 100%, compared to the CCG averages of between 97.3% and 98.8%) and for five year olds from 96.6% to 100%, compared to the CCG averages of between 92.2% and 98.3%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. 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 helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

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

We spoke with eight patients during our inspection. Most patients told us they were satisfied with the care provided by the practice and said their dignity was respected. Some patients commented that they felt their conversations with the receptionist could be overheard. Managers were aware of this issue and had tried several options to reduce the risks; a sign was in place at the reception desk asking patients' to stand back to give other patients' privacy.

Results from the National GP Patient Survey, published in July 2016, showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. However, scores were variable, with some below average. For example, of those who responded:

- 95% said they had confidence and trust in the last GP they saw, compared to the clinical commissioning group (CCG) average of 96% and the national average of 95%.
- 85% said the last GP they spoke to was good at treating them with care and concern, compared to the CCG average of 89% and the national average of 85%.
- 100% said they had confidence and trust in the last nurse they saw, compared to the CCG average of 98% and the national average of 97%.
- 88% said the last nurse they spoke to was good at treating them with care and concern, compared to the CCG average of 92% and the national average of 91%.
- 83% said they found the receptionists at the practice helpful, compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the July 2016 National GP Patient Survey we reviewed showed most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Scores were broadly in line with averages. For example, of those who responded:

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

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. There were no notices in the reception areas informing patients this service was available. However, when patients registered with the practice they were asked if

they needed an interpreter; this was then noted in their medical record. Managers told us they previously had information on display and would ensure this was replaced.
- Information leaflets were available in easy read format.

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. For example, there were leaflets with information about a men's group, a 'knit and natter' group and a work club.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all patients who were also carers; 90 patients (0.8% of the practice list) had been identified as carers. They were referred for social services support if appropriate. There was no specific written information available for carers to ensure they understood the various avenues of support available to them. Patients were invited to register as a carer when they registered with the practice. Staff told us the clinical staff would ask those patients who they considered may have been carers but there were no plans to reach out to the wider practice population.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the local clinical commissioning group (CCG) to secure improvements to services where these were identified. For example, the practice was the 'hub' as part of a local pilot for Christmas opening; this involved sharing patient data from practices in the Wallsend area (with the consent of patients) and provided convenient access to GP services.

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

- The practice offered evening clinics every Wednesday and Thursday until 8pm for patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability and those speaking through an interpreter.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities and translation services available.
- Telephone consultations were available each day.
- Appointments could be booked online, in person, on the telephone.

Access to the service

The practice was open between 8am and 6pm Monday, Tuesday and Friday, and from 8am to 8pm every Wednesday and Thursday. GP clinics were staggered so appointments were available throughout opening hours.

Extended hours surgeries were offered every Wednesday and Thursday evening. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent on the day appointments were also available for people that needed them.

Results from the National GP Patient Survey, published in July 2016, showed that patient's satisfaction with how they could access care and treatment was generally below local and national averages. Patients we spoke with on the day also told us they found it difficult to get appointments when they needed them. For example:

- 81% of patients were satisfied with the practice's opening hours, compared to the CCG average of 78% and the national average of 76%.
- 60% of patients said they could get through easily to the surgery by phone, compared to the CCG average of 79% and the national average of 73%.
- 69% of patients described their experience of making an appointment as good, compared to the CCG average of 77% and the national average of 73%.
- 69% of patients said they usually waited 15 minutes or less after their appointment time, compared to the CCG average of 72% and the national average of 65%.

Managers were aware of patients' views on access and had carried out a detailed review of capacity and demand. New ways of working had been implemented to improve access; this included employing a nurse practitioner and increasing the number of telephone consultations available. This work was continuing; the practice was part of a local federation of practices and was piloting the use of an external consultancy firm to carry out a review of access. Many patients had commented that they had to telephone the practice at 8am to make an appointment; some told us they queued outside so they could make an appointment in person. The practice had made attempts to address this by promoting the use of the online services; we saw posters encouraging patients to register so they could book appointments online.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns but this was not in line with national guidelines and recommended best practice.

- There was a designated responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. Leaflets detailing the process were available in the waiting room and there was information on the practice's website.
- There was a complaints procedure in place, but this was not in line with recognised guidance and contractual obligations for GPs in England. There were no details about how to contact the Parliamentary and Health Service Ombudsman, which are routinely provided with complaint responses.
- Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at six complaints received in the last 12 months. Many of the responses did not give the complainant advice on what to do if they were unhappy with the response to their complaint. The NHS complaints policy states that the response 'should also include details of your right to take your complaint to the relevant ombudsman'.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision; 'Our vision is to provide the best clinical care for our patients from cradle to grave'. There was a strategy in place. This reflected the vision and values and was regularly monitored.

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.
- 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 and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions, although the processes for sharing learning from significant events could be improved. The practice informed us that their system for recording, discussing, actioning and reviewing significant events had recently been overhauled. The new forms included sections on 'suggestions to prevent recurrence' and 'actions to be taken'.

Leadership, openness and transparency

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure quality care. Staff told us the partners were approachable and always took the time to listen.

The provider was aware of and had systems in place to ensure compliance with the requirements of 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).This included support and training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. However, arrangements to respond to patient complaints could be improved.

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

- Staff told us that regular team meetings were held. There was a four week cycle of management team meetings; as well as nurse team and administrative team meetings.
- Staff were also supported to attend external training and networking, including attendance at nurse forums and local practice managers meetings.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. They said they felt confident in doing so and were supported if they did. We also noted that team 'Time In' sessions were held twice each year.
- Staff said they felt respected, valued and supported.
- Several staff also had lead roles across North Tyneside. For example, one of the GPs was CCG's medical director; and the practice manager was a director of the location federation of GP practices and the chair of the locality group.

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

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had been involved in discussions about access to appointments and how this could be improved.

The practice had also gathered feedback from staff through staff meetings, appraisals and general discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Managers encouraged all members of staff to identify opportunities to improve the service delivered by the practice. There was an 'ideas board' in the main office; staff were able to leave suggestions on the noticeboard; these were reviewed and implemented where appropriate. For example, one person had suggested all staff were provided with practice name badges; this was considered and the badges were ordered.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was part of local pilot schemes to improve outcomes

Are services well-led?

Good

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

for patients in the area. For example, the practice was the 'hub' as part of a local pilot for Christmas opening. Managers developed innovative data sharing agreements to enable access to other practice's patient records during this time.

New ways of working had been implemented to improve access; this included reviewing the skill mix within the team and employing a nurse practitioner. The nurse practitioner took the lead on supporting frail elderly and palliative care patients and supported the GPs by carrying out treatment for minor ailments. Managers were keen to further develop the skill mix and were considering employing an additional nurse practitioner.

Staff were involved in making improvements to the practice; the trollies used in the consultation rooms had been standardised so clinicians had easy access to equipment and practice guidelines.

The practice IT systems were continually reviewed; for example, a new template for recording significant events had recently been implemented.