Oxford Terrace and Rawling Road Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection of Oxford Terrace and Rawling Road on 17 October 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- The practice carried out clinical audit activity.
- Feedback from patients about their care was comparable with local and national averages. Patients reported that they were treated with compassion, dignity and respect. Patient feedback in relation to access was better than local clinical commissioning group and national averages.
- Patients were able to access same day appointments. Pre-bookable appointments were available within acceptable timescales.
- The practice had a number of policies and procedures to govern activity, which were reviewed and updated regularly.
- The practice had proactively sought feedback from patients and implemented suggestions for improvement and made changes to the way they delivered services in response to feedback.
- The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring effectiveness and had achieved an overall result which was higher than local and national averages.
- Information about services and how to complain was available and easy to understand.
- They had a clear vision in which quality and safety was prioritised. The strategy to deliver this vision was regularly discussed and reviewed.
- The practice had developed an in-house Complex Care Team to care for frail and elderly patients in their own home or care home and prevent unnecessary admission to hospital. Comprehensive care plans were in place for high risk, housebound and care home

Summary of findings

patients. Dedicated administrative support was attached to the team and ensured that the team were aware of relevant patients and that their care and treatment was discussed and reviewed at weekly multi-disciplinary team meetings.
- They had obtained funding to pilot the employment of a practice based occupational therapist on a secondment basis for 19 hours per week. The aim of this role was to optimise the health and wellbeing of frail older people through timely targeted intervention.
- The practice employed primary care navigators to advise and support patients and carers with any social need that maybe affecting their health including maintaining independence and social inclusion.

We saw several areas of outstanding practice:

- They had developed a self-help group for young people with type 1 diabetes in the area. A young person with the condition had been appointed as the project coordinator and the practice had employed a diabetes specialist nurse. The aim was to engage young people in managing their condition through the use of electronic information and telecommunication technologies which would allow long distance communication between a patient and a clinician. The practice had been awarded second place in the Bright Ideas in Innovation Awards 2016 for improving services for young children with type 1 diabetes.
- The practice had recruited a number of volunteer practice health champions (volunteers who work with GP practices to improve services and to help meet the health needs of patients in their community) and together they had developed a number of social clubs and events for their patients to aid social inclusion. They had also hosted a lunch on Christmas Day for vulnerable or socially isolated patients and hosted tea dances for people with long term conditions and for armed forces veterans to promote self-care and social inclusion.

However, there were also areas where the provider must make improvements. Importantly, the provider must:

- Implement a comprehensive checking process to ensure there are no out of date emergency medicines or equipment held on the premises.
- Ensure all patient group directions (PGDs) are signed in line with recommended guidance.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

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. Risks to patients were assessed and well managed.

Lessons were shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, and verbal or written apologies.

The practice was clean and hygienic and, with the exception of checking and recording staff immunity status for all staff, good infection control arrangements were in place. However, we were not assured that the arrangements for managing medicines in the practice minimised risks to patients. This was because we found out of date emergency medicine and equipment. In addition, there were gaps in the logs used to checked and monitor the expiry dates and stock control of emergency medicines and vaccinations.

Comprehensive staff recruitment and induction policies were in operation. However, not all non-clinical staff had undertaken a Disclosure and Barring Service (DBS) checks and there was no risk assessment in place detailing why this had not felt to be necessary. Chaperones were available if required and staff who acted as chaperones had undertaken appropriate training and a DBS check.

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 comparable with local clinical commissioning group (CCG) and national averages. The practice

Summary of findings

used the QOF as one method of monitoring effectiveness and had attained 97.8% of the points available to them for 2015/16 compared to the local clinical commissioning group (CCG) average of 96.9% and national average of 95.4%.

Achievement rates for cervical screening, influenza vaccination and the majority of childhood vaccinations were comparable with local and national averages. For example, at 79%, the percentage of women aged between 25 and 64 whose notes recorded that a cervical screening test had been performed in the preceding five years was below the CCG average of 81% and national average of 82%. Childhood immunisation rates for the vaccinations given to two year olds ranged from 81.5% to 94.5% (compared to the CCG range of 64.7% to 93.5% and national average of 73.3% to 95.1%). For five year olds this ranged from 73.8% to 92.9% (CCG range 90.1% to 97.4% and national average 81.4% to 95.1%).

There was evidence of clinical audit activity and some improvements to patient care and outcomes as a result of this. However, not all of the audits we saw had led to improvements.

Staff received annual appraisals and were given the opportunity to undertake both mandatory and non-mandatory training. All newly employed staff were allocated a mentor for the first three months of their employment.

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. However, we were able to overhear conversations taking place in the consultation rooms at the branch surgery.

Results from the National GP Patient Survey published in July 2016 were comparable with local and national averages in respect of providing caring services. For example, 84% 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%) and 93% said the last nurse they saw or spoke to was good at listening to them (CCG average 93% and national average was 91%). Results also indicated that 88% of respondents felt the last GP they

Summary of findings

saw or spoke with treated them with care and concern (CCG average 88% and national average of 85%). 89% of patients felt the nurses treat them with care and concern (CCG average 93% and national average 91%).

We observed a strong patient-centred culture where staff had been motivated and empowered to offer kind and compassionate care. The practice proactively identified carers and ensured they were offered an annual health check, influenza vaccination and signposted to appropriate advice and support services. At the time of our inspection they had identified 489 of their patients as being a carer (approximately 3.1% of the practice patient population).

The practice had appointed primary care navigators to help ensure that a patient's social as well as medical needs were being met. This included supporting carers, armed forces veterans and other vulnerable patients. They had also appointed a large number of volunteer practice health champions who were actively involved in arranging in arranging a number of social groups and activities for patients.

With the support of the practice volunteer practice health champions were involved in arranging a number of social groups and activities including a knitting club, craft fairs, walking club and tea dances for armed forces veterans and patients with long term conditions,

The practice also hosted a lunch on Christmas Day for socially isolated and vulnerable patients which was attended by clinical and non-clinical staff members and their families. There was also a process in place to ensure identified patients unable or unwilling to attend the lunch received a phone call on Christmas day.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

Both the main and branch surgeries had good facilities and were well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised and identified themes arising from them.

The practice's performance in relation to access in the National GP Patient Survey was better than local and national averages. For example, the most recent results (July 2016) showed that 83% of patients found it easy to get through to the surgery by phone (CCG average 79%, national average 73%) and 87% were able to get an appointment (CCG average 85% and national average 85%).

Summary of findings

The practice was able to demonstrate that they continually monitored the needs of their patients and responded appropriately. The practice had become involved in a number of initiatives to improve services. For example, the had recruited 39 Practice Health Champions (volunteers who work with GP practices to improve services and to help meet the health needs of patients in their community) who were involved in arranging a number of social groups and activities including a knitting club, craft fairs, walking club and tea dances for armed forces veterans and patients with long term conditions. They had also developed a complex care team, transformed their nursing team and appointed an older persons specialist nurse and occupational therapist to coordinate the care of frail and elderly patients. The practice was able to demonstrate that the appointment of an older person's specialist nurse had led to a reduction in unplanned admissions to hospital and A&E attendances for older people.

The practice implemented suggestions for improvements and made changes to the way they delivered services as a consequence of feedback from patients. For example, they had improved telephone access, reviewed GP and nurse appointment availability and improved the management of long term conditions for their patients.

The practice used social media regularly as a way of keeping in touch with their patients and free Wi-Fi was available in the surgery.

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.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

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. The practice had a strategic development plan which identified their future aims and objectives. This included improving patient experience, improving access for hard to reach groups, working with community pharmacies, joint commissioning and continually managing demand and capacity.

The provider was aware of and complied with the requirements of the Duty of Candour regulation. The GP and practice manager

Summary of findings

encouraged a culture of openness and honesty. 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. They had an active and involved patient participation group. They also had a large group of volunteer practice health champions who worked with the practice to improve services and to help meet the health and social needs of patients in their community.

There was a strong focus on continuous learning and improvement at all levels and the practice were involved in a number of initiatives and research programmes to improve services for patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported Quality and Outcomes Framework (QOF) data for 2015/16 showed the practice had achieved good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients experiencing heart failure, hypertension and osteoporosis.

The practice had developed an in-house Complex Care Team to care for frail and elderly patients in their own home or care home and prevent unnecessary admission to hospital. Comprehensive care plans were in place for high risk, housebound and care home patients. The GPs operated a ward round approach to visiting patients in their linked care homes. For the two larger care homes these visits were carried out in conjunction with an older person's specialist nurse employed by the practice. The practice had purchased lap tops for GPs to ensure they were able to access and update patient's notes whilst on ward rounds or home visits.

The practice had been successful in obtaining funding to pilot the employment of a practice based occupational therapist on a secondment basis for 19 hours per week. The aim of this role was to optimise the health and wellbeing of frail older people through timely targeted intervention.

The practice employed primary care navigators. This role involved a holistic approach to ensuring a patient's medical and social needs were referred or signposted to appropriate support services.

People with long term conditions

Good

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

Home visits and longer appointments and home visits were available when needed. Longer appointments were routinely offered to patients with complex needs or those requiring an interpreter. The practice's computer system was used to flag when patients were due for review and the practice had implemented an effective recall system. Patients with multiple long term conditions were offered an annual comorbidity (multiple conditions) review whenever possible in their birthday month.

Summary of findings

The practice had carried out a review and transformation of their nursing team to improve access to appointments and the management of long term conditions. This had resulted in an additional 280 nursing appointments per week being created releasing the equivalent of 8 GP sessions.

The QOF data for 2015/16 showed that they had achieved good outcomes in relation to the conditions commonly associated with this population group. For example:

- The practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with asthma.
- The practice had obtained 99.2% of the points available to them in respect of hypertension

The practice had been proactive in the development of a self-help group for young people with type 1 diabetes in the area. A young person with the condition had been appointed as the project coordinator and the practice had employed a diabetes specialist nurse. The aim was to engage young people in managing their condition through the use of electronic information and telecommunication technologies which would allow long distance communication between a patient and a clinician. The practice had been awarded second place in the Bright Ideas in Innovation Awards 2016 for improving services for young children with type 1 diabetes.

The practice hosted a tea dance for patents with long term conditions which was attended by approximately 250 patients and funded by a local university who were carrying out research into supported self-care.

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 processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as health visitors.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Data available for 2014/15 showed that the practice childhood immunisation rates for the vaccinations given to two year olds

Summary of findings

ranged from 85.1% to 94.5% (compared to the CCG range of 64.7% to 93.5% and national average of 73.3% to 95.1%). For five year olds this ranged from 73.8% to 92.9% (compared to CCG range of 90.1% to 97.4% and national average of 81.4% to 95.1%).

At 79%, the percentage of women aged between 25 and 64 whose notes recorded that a cervical screening test had been performed in the preceding five years was comparable with the CCG average of 81% and national average of 82%.

Pregnant women were able to access a full range of antenatal and post-natal services at 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 met. The main surgery was open from 8am to 7.30pm on a Monday and Thursday (appointments from 8.30am to 7.20pm), from 8am to 6.30pm on a Tuesday, Wednesday and Friday (appointments from 8.30am to 6pm) and from 9am to 12 midday on a Saturday (appointments from 9am to 11.50am). The branch surgery was open from 8am to 6pm on a Monday to Friday (appointments from 8.30am to 6pm). Patients registered with the practice were also able to access pre bookable appointments with a GP at one of three local health centres from 8am and 8pm on a weekday and 9am to 2pm on a weekend.

The practice offered sexual health and contraception services, travel advice, childhood immunisation service, antenatal services and long term condition reviews. They also offered new patient and NHS health checks (for patients aged 40-74).

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. The practice communicated with patients using social medial and free Wi-Fi access was available to patients in the practice waiting room. Pre bookable telephone consultations were available with a GP. Email consultations were available on request.

The practice had implemented a 24 hour per day/seven day per week service called patient partner which would enable patients to book, cancel and rearrange appointments using an automated telephone service.

People whose circumstances may make them vulnerable

Good

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

Summary of findings

The practice held a register of patients living in vulnerable circumstances, including 137 patients who had a learning disability. Patients with a learning disability were offered an annual health check and flu immunisation which were available as a home visits if required.

The practice had established 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 identified proactively identified carers and ensured they were offered appropriate advice and support and an annual health check and flu vaccination. They had identified 489 of their patients as being a carer (approximately 3.1% of the practice patient population).

The practice were actively engaged in identifying armed forces veterans who were then offered appropriate support in accessing relevant services by the practice primary care navigator. The practice had also hosted a tea dance for this group of patients as a way of combating possible social isolation. At the time of our inspection the practice had identified 53 patients as being an armed forces veteran.

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).

QOF data for 2015/16 provided by the practice showed that they had achieved the maximum score available for caring for patients with dementia and depression and for those with a mental health condition. The practice had a high prevalence of patients with dementia which was partly attributed to providing care for eight care homes in the area.

Patients were supported by the primary care navigator in accessing various support groups and third sector organisations, such as local wellbeing and psychological support services. As a result of primary care navigator involvement the practice were able to demonstrate an increase in the number of patients being screened and assessed for dementia. This had led to the practice being awarded first place in the Bright Idea in Innovation Awards 2015 for improving dementia care through care navigation and social prescribing.

Summary of findings

What people who use the service say

The results of the National GP Patient Survey published in July 2016 showed patient satisfaction was mixed. Of the 302 survey forms distributed, 105 were returned (a response rate of 35%). This represented approximately 0.7% of the practice's patient list. For example, of the patients who responded to their survey:

- 83% found it easy to get through to this surgery by phone compared to a CCG average of 79% and a national average of 73%.
- 87% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85%, national average 85%).
- 83% described the overall experience of their GP surgery as fairly good or very good (CCG average 88%, national average 85%).
- 68% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 80%, national average 78%).
- 80% said their GP was good at explaining tests and treatment (CCG average 88%, national average 86%)
- 89% said the nurse was good at treating them with care and concern (CCG average 93%, national average 91%)

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received a total of 48 comment cards (25 for Oxford Terrace and 23 for Rawling Road) which were consistently positive about the standard of care received. The respondents stated that they found the surgery clean and hygienic and that they were confident they would receive good treatment. Words used to describe the practice and its staff included friendly, helpful, professional, respectful, excellent, sympathetic, first class and fabulous.

We spoke with 11 patients during the inspection, four of whom were members of the practice patient participation group. All 11 said they were happy with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

- Implement a comprehensive checking process to ensure there are no out of date emergency medicines or equipment held on the premises.
- Ensure all patient group directions (PGDs) are signed in line with recommended guidance

Outstanding practice

- They had developed a self-help group for young people with type 1 diabetes in the area. A young person with the condition had been appointed as the project coordinator and the practice had employed a diabetes specialist nurse. The aim was to engage young people in managing their condition through the use of electronic information and telecommunication technologies which would allow long distance communication between a patient and a clinician. The practice had been awarded second place in the Bright Ideas in Innovation Awards 2016 for improving services for young children with type 1 diabetes.
- The practice had recruited a number of volunteer practice health champions (volunteers who work with GP practices to improve services and to help meet the health needs of patients in their community) and together they had developed a number of social clubs and events for their patients to aid social inclusion. They had also hosted a lunch on Christmas Day for

vulnerable or socially isolated patients and hosted tea dances for people with long term conditions and for armed forces veterans to promote self-care and social inclusion.

Oxford Terrace and Rawling Road Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team also consisted of a a second CQC inspector, a GP specialist advisor and a practice nurse specialist advisor.

Background to Oxford Terrace and Rawling Road Medical Group

Oxford Terrace and Rawling Road Medical Group provides care and treatment to approximately 15,311 patients from the Dunston, Dunston Hills, Teams, Team Valley, Chowdene, Harlow Green, Wrekenton, Beacon Lough, Leam Lane, Heworth, Felling, Mount Pleasant, Sheriff Hill, Windy Nook, Deckham and Bensham areas of Gateshead, Tyne and Wear. The practice is part of the NHS Newcastle Gateshead Clinical Commissioning Group (CCG) and operates on a Personal Medical Services (PMS) contract.

The practice provides services from the following addresses, which we visited during this inspection:

Main surgery:

1 Oxford Terrace

Bensham

Gateshead

Tyne and Wear

NE8 1RQ

Branch surgery:

1 Rawling Road

Bensham

Gateshead

Tyne and Wear

NE8 4QS

The main surgery is located in a large, converted ex-residential property. All reception and consultation rooms are fully accessible for patients with mobility issues. On street parking is available nearby.

The branch surgery is located in purpose built premises. All reception and consultation rooms are fully accessible for patients with mobility issues. An on-site car park is available.

The main surgery is open from 8am to 7.30pm on a Monday and Thursday (appointments from 8.30am to 7.20pm), from 8am to 6.30pm on a Tuesday, Wednesday and Friday (appointments from 8.30am to 6pm) and from 9am to 12 midday on a Saturday (appointments from 9am to 11.50am). The branch surgery is open from 8am to 6pm on a Monday to Friday (appointments from 8.30am to 6pm). Patients registered with the practice were also able to access pre bookable appointments with a GP at one of three local health centres from 8am and 8pm on a weekday and 9am to 2pm on a weekend.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Gateshead Community Based Care Limited (known locally as GatDoc).

Detailed findings

Oxford Terrace and Rawling Road Medical Group offers a range of services and clinic appointments including childhood health and immunisation service, long term condition reviews, minor surgery, travel advice, contraception and sexual health.

The practice consists of:

- Five GP partners (four male and one female)
- Six salaried GPs (three male and three female)
- Two nurse practitioners (both female)
- Four practice nurses (all female)
- Four health care assistants (all female)
- 28 non-clinical members of staff including a practice manager, assistant practice manager, operational services manager, registrations clerk, medical secretaries, practice administrators, finance administrator, IT support assistants, recall clerk, data coding administrators, complex care administrator, receptionists and cleaners.

The practice is a training practice and is involved in teaching and training GP registrars, medical students, student nurses, nurse associates and trainee pharmacists. It is also a 'research ready' practice and as such is committed to encouraging staff and patients to become involved in primary care research.

The average life expectancy for the male practice population is 76 (CCG average 77 and national average 79) and for the female population 81 (CCG average 81 and national average 83).

At 52.3%, the percentage of the practice population reported as having a long standing health condition was lower than the CCG average of 56.9% and national average of 54%. Generally a higher percentage of patients with a long standing health condition can lead to an increased demand for GP services. The percentage of the practice population recorded as being in paid work or full time education is 46.2% (CCG average 60.5% and national average 61.5%). Deprivation levels affecting children and adults were higher than the local CCG average and national averages.

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- 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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 October 2016. During our visit we spoke with a mix of clinical and non-clinical staff including the GPs, the practice nurse, the practice manager, assistant practice manager, operational services manager, finance administrator, data

Detailed findings

coding administrator, secretary, recall clerk and receptionists. We spoke with 11 patients, four of whom were members of the practice patient participation group and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 48 Care Quality Commission (CQC) comment cards that had been completed by patients and looked at the records the practice maintained in relation to the provision of services. We also spoke to attached staff that worked closely with, but were not directly employed by, the practice.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Staff were well aware of their roles and responsibilities in reporting and recording significant events.

The practice had systems in place for knowing about notifiable safety incidents and actively identified trends, themes and recurrent problems. They had recorded 82 internal and external significant events from 1 September 2015 to 30 September 2016. Significant events were regularly discussed and analysed at clinical and practice meetings and appropriate action taken. For example, the practice had recorded a significant event where a GP had requested the district nursing team to carry out an electrocardiogram (ECG) on a housebound patient but was informed that the district nursing team were unable to carry out this task .As a result the practice had identified a gap in service delivery and now deliver an in-house electrocardiogram service.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. Trends and themes were identified and the practice regularly recorded relevant significant events and safeguarding incidents on the local clinical commissioning group's (CCG) Safeguard Incident and Risk Management System (SIRMS). The SIRMS system enables GPs to flag up any issues via their surgery computer to a central monitoring system, so that the local CCG can identify any trends and areas for improvement. A system was in place to ensure patient safety alerts were cascaded to relevant staff and appropriate action taken.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, an apology if appropriate and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had systems, processes and practices in place which generally kept patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice held regular multi-disciplinary meetings to discuss vulnerable patients. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The clinical staff were trained to level three in children's safeguarding.
- Chaperones were available if required. Staff who acted as a chaperone had all received appropriate training and 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).
- Not all non-clinical staff had undertaken a DBS check. Nor was there a risk assessment in place detailing why this had not been felt to be necessary.
- The practice maintained appropriate standards of cleanliness and hygiene and we observed the premises to be clean and tidy. An effective cleaning schedule was in place and infection control audits were carried on a six monthly basis. A comprehensive infection prevention and control policy was in place.
- An effective system was in place for the collection and disposal of clinical and other waste.
- We reviewed the personnel files of staff members and found that appropriate recruitment checks had been undertaken for all staff prior to employment. Good induction processes were in place for staff. All newly appointed staff were allocated a mentor for the first three months of their employment.
- The provider was aware of and complied with the requirements of the Duty of Candour regulation. The GP and practice manager encouraged a culture of openness and honesty.
- A process was in place to ensure that patient safety alerts were disseminated to clinical staff for consideration and action. However, there was no process in place to ensure that relevant action had been taken.
- Patient group directions (PGDs) and patient specific directions (PSDs) had been adopted by the practice to allow nurses and health care assistants to administer medicines in line with legislation. PGDs and PSDs allow

registered health care professionals, such as nurses, to supply and administer specified medicines, such as vaccines, without a patient having to see a doctor. However, not all of the PGDs we looked at were appropriately signed including those for meningococcal, shingles, rotavirus and influenza immunisations.

We were not assured that the arrangements for managing medicines, including emergency drugs and vaccinations in the practice kept patients safe. For example:

- We found an out of date item of emergency medicine. We were told that the emergency medicines were checked on a weekly basis but the last check recorded on the checklist was dated 2 August 2016. In addition, there was no record of the emergency medicines being checked between 4 March 2016 and 15 July 2016.
- We found some out of date equipment, including the adult pads for use with the defibrillator, latex gloves, butterfly cannulas, plasters and skin cleaning swabs.
- The equipment cleaning schedule did not include the spirometer or nebuliser
- Practice staff did not have access to a spillage kit to deal with vomit. Spillage kits were available for blood and bodily fluids.
- Medicines stored in refrigerators needed to be moved away from the sides to allow the circulation of air.
- The log for recording the stock of vaccines was not kept up to date. There was no evidence of any logs from February 2015 to May 2016 or for July 2016. The log for August 2016 did not include running totals for some of the vaccines.
- Records indicated the inbuilt thermometer showed that the temperature of one of the refrigerators used to store vaccines had risen to 10.1°C at 3.40pm on 25 May 2016 (recommended guidance states that temperatures must not fall below 2°C or above 8°C). The practice had checked the fridge data logger (a separate device used to record the fridge temperature on an hourly basis) the following day which showed that the actual maximum temperature the fridge had reached was 8°C. However, the practice were unable to provide us with full details for the refrigerator temperatures that day, evidence of the practice taking action to ensure which temperature recording was correct (by way of calibration of the fridge) or of the practice taking advice from NHS England (screening and immunisation team) on whether any of the vaccines could have been compromised.
- The practice had developed a staff screening and immunisation policy in October 2016 and they were in the process of checking staff immunity and immunisation status. However, a protocol was in place dictating that only staff who had been vaccinated against Hepatitis B should take responsibility for cleaning any spillages of blood or bodily fluids.

We were subsequently contacted by the practice manager post inspection who informed us that staff had worked late the same day as our inspection to ensure that an action plan had been put in place immediately to address the issues identified. This included arranging the signing of patient group directions and putting steps in place to ensure there was a more robust system in place for managing medicines and equipment.

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 and staff were aware of their roles and responsibilities in relation to this. Staff had received fire safety training; fire alarms were tested on a weekly basis and fire evacuation drills carried out annually.
- The practice had a variety of other risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The last legionella risk assessment carried out in respect of the main surgery at Oxford Terrace had been undertaken in April 2016 and no concerns were identified. The last assessment of Rawling Road had been carried out in 2010 when it was identified that the premises required a new boiler and heating system. As this would have a cost implication of approximately £6,000 and the practice were in the process of applying for funding to renovate and extend the premises they had been advised by the local clinical commissioning group not to carry out this work at present. In the meantime they had made suitable arrangements to ensure the risk of legionella was minimised as far as possible.

Requires improvement

Are services safe?

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Annual leave was planned well in advance and staff had been trained to enable them to cover each other's roles when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage.
- The practice had arrangements in place to respond to emergencies and major incidents. Emergency medicines were easily accessible and all staff knew of their location. A defibrillator and oxygen were available on the premises. However, some of the emergency medicines and equipment we checked were out of date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care 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 held twice yearly NICE meetings as well as regular practice and multi-disciplinary team meetings which were an opportunity for clinical staff to discuss clinical issues and patients whose needs were causing concern.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The results for 2015/16 showed the practice had achieved 97.8% of the total number of points available to them compared with the clinical commissioning group (CCG) of 96.9% and the national average of 95.4%.

The 2015/16 data showed that at 12% their overall clinical exception rate was slightly high when compared to the local CCG average of 9.7% and national average of 9.8%. The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. The practice were able to explain that this was due to their merger with another practice and taking on a number of care home patients with multiple and complex long term conditions in 2013. They were also able to demonstrate a year on year reduction in their clinical exception rate since 2013. For example, the practice had a clinical exception rate of 15.2% for patients with chronic obstructive pulmonary disease in 2014/15. This had reduced to 14.7% in 2015/16 and was currently showing as 8.8% for 2016/17. The clinical exception rate for patients with chronic heart disease was 11.4% in 2014/15. This had reduced to 9.9% in 2015/16 and was running at 5.4% for 2016/17.

- The 2015/16 QOF data showed that they had obtained the maximum points available to them for 16 of the 19 QOF indicators, including asthma, cancer, dementia and heart failure. For the three other indicators the practice had still scored above local and national averages.

At 33.8% the number of emergency admissions to hospital for patients with long term conditions was higher than the national average of 20.5% for the period 1 April 2015 to 31 March 2016. However, the practice was able to demonstrate that this was improving. For example, they had carried out a project to look at access to GP appointments and the management of long term conditions. This had led to a review and restructure of the nursing team which had resulted in a reduction in unplanned hospital attendances and admissions by 12%. This had been attributed to the creation of an additional 280 nurse appointments per week which, in turn, had created the equivalent of 8 additional GP sessions.

The practice carried out clinical audit activity with the aim of improving patient's outcomes. Clinical audit evidence provided by the practice included a two cycle audit to ensure that thepractice was coding new diagnosesof chronic kidney disease (CKD) accurately so that patients' could receive appropriate care. However, we were not assured that this audit had led to improvements following the second cycle of the audit as it would appear that a large number of patients were notbeingrequested to havefollow up blood tests in order to make the diagnosis of CKD and patient records were not beingcoded for CKD whentestshad confirmed the diagnosis.We also saw evidence of audits looking at antimicrobial stewardship and audits to improve QOF performance. For example, the practice had carried out a review to determine why they had very few patients on their osteoporosis register and that patients with fragility fractures were being appropriately supported. We felt that clinical audit activity in the practice was limited and the practice could have had a more effective programme of clinical audit activity.

The practice manager also told us of a number of other quality improvement audits carried out by the practice. For example, they had carried out a referrals audit which had led to an increase of 40% in the number of referral letters being sent to their medical secretaries for action. They had

Good

Are services effective?

(for example, treatment is effective)

also reviewed their GP documentation handling process which has led to a reduction of 80% over the first six months. All of this had resulted in GP clinical productivity and less pressure.

The practice had developed protocols which were regularly reviewed and updated to govern the treatment of a number of conditions. For example, we saw protocols governing the use of injections to treat osteoporosis in post-menopausal women, the remit of diabetic reviews and the prescribing of disease modifying anti rheumatoid drugs.

We also saw evidence of the practice effectively monitoring their prescribing and compliance with the prescribing engagement scheme. A review of prescribing for the period April to June 2016 had shown that:

- They were prescribing a higher amount of antibacterial items than the CCG average. This was attributed to having a larger list size than the majority of other practices in the CCG area and a significant number of care home patients.
- The practice was a lower than average prescriber of non-steroidal anti-inflammatory drugs (NSAIDs)
- They were performing well in relation to the prescribing of antibiotics.

The practice had a record of patients prescribed medicines that required regular monitoring such as warfarin (an anticoagulant). They also had a palliative care register and discussed the needs of palliative care patients at quarterly multi-disciplinary team meetings.

Effective staffing

The staff team included GPs, nurses, health care assistants, managerial, administrative and cleaning staff. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, health and safety, infection control, information governance, safeguarding and appropriate clinical based training for clinical staff.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (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 nursing team were supported in seeking and attending continual professional development and training courses and attended locality practice nurse meetings.

The practice had a staff appraisal system in operation which included the identification of training needs and development of personal development plans.

We looked at staff cover arrangements and identified that there were sufficient staff on duty when the practice was open. Holiday, study leave and sickness were covered in-house and a buddy system was in place amongst the GPs to ensure test results and discharge information were dealt with appropriately and in a timely manner. The GP partners rotated their lead roles every two years to ensure they all gained experience in the various roles. The practice did not use locum GPs.

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 investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary meetings took place on a regular basis and that care plans reviewed and updated. Comprehensive care plans were in place for housebound and frail elderly patients as well as for those residing in care homes. These were developed with the involvement of the patient, family members and carers and included decisions on end of life care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Good

Are services effective?

(for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including Mental Capacity Act 2005. GPs had undertaken Mental Capacity Act and Deprivation of Liberty Standards training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Practice staff told us that where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurses assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients requiring palliative care, carers and those with a long-term and mental health condition or learning disability.

Vaccination rates for 12-month and 24-month old babies and five-year-old children were comparable with CCG averages. For example, data available for the 2015/16 period showed that childhood immunisation rates for the vaccinations given to two year olds ranged from 85.1% to 94.5% (compared with the CCG range of 64.7% to 93.5% and national range of 73.3% to 95.1%). For five year olds this ranged from 73.8% to 92.9% (compared to CCG range of 90.1% to 97.43% and national average of 81.4% to 95.1%)

At 79%, the percentage of women aged between 25 and 64 whose notes recorded that a cervical screening test had been performed in the preceding five years was comparable with the CCG average of 81% and national average of 82%.

Patients had access to appropriate health assessments and checks. This included health checks for patients aged over 75, NHS health checks for patients aged between 40 and 74 and new patient health checks. Since April 2016 the practice had carried out 66 over 75 health checks, 185 NHS health checks and 601 new patient health checks (this represented approximately 63% of the patients who had joined the practice since April 2016). The practice carried out appropriate follow-ups where abnormalities or risk factors were identified. Information such as NHS patient information leaflets was also available.

The practice produced a regular newsletter which gave patients information on a variety of health related topics, social opportunities and practice updates. They also used social media as a way of keeping patients up to date.

The practice had recognised that they had the largest list of substance misuse patients in shared care of any practice in the local area. Four of the practice GPs had undertaken training on the treatment of substance misuse with the Royal College of General Practitioners. Practice GPs had been written the current substance misuse shared care enhanced service criteria and had included in this a quality component based on blood borne virus testing, immunisation and provision of contraception. The practice was able to demonstrate that they had exceeded targets in relation to this. Another practice GP, who had been the chair of a local drugs related deaths enquiry group, had initiated a system where patients were given training and a medicine to take home to block the effects of opioids. The practice reported that this incentive had significantly reduced the rate of drug related deaths in the Newcastle and Gateshead area.

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 and that they 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 to prevent conversations taking place in these rooms being overheard. However, our inspector found that some consultations taking place in the branch surgery could be overheard. The practice manager explained post inspection that normally a television in the waiting room would prevent conversations from being overheard until refurbishment of the premises was completed. However, the television was out of order on the day of the inspection.
- Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

We received 48 completed CQC comment card which were very complimentary about the caring nature of the practice. We also spoke with 11 patients during our inspection, four of whom were members of the practice patient participation group. They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the National GP Patient Survey (published in July 2016) showed patient satisfaction was comparable with local and national averages in respect of being treated with compassion, dignity and respect. For example:

- 96% 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%.
- 88% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% 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%.
- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 82% of patients 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 we spoke with 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey showed patient satisfaction was lower than, or comparable with local and national averages in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 84% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 86% said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 80% 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%.
- 74% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national averages of 82%.
- 93% said the last nurse they spoke to was good listening to them compared to the CCG average of 93% and the national average of 91%.
- 93% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

The practice had access to a translation service for patients who did not have English as a first language. They had a hearing loop at both the main and branch surgery and patients who were deaf or blind were automatically given a 20 minute appointment.

Good

Are services caring?

Patients with a learning disability were offered an annual influenza immunisation and health check which were available as a home visit if preferred. The practice held a register of 137 patients recorded as living with a learning disability.

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.

The practice identified carers and ensured they were offered an annual health check and influenza vaccination. The practice primary care navigators ensured that carers were signposted to appropriate advice and support services as well as social activities hosted by practice health champions. The practice computer system alerted clinicians if a patient was a carer. At the time of our inspection they had identified 439 of their patients as being a carer (approximately 3.1% of the practice patient population).

We observed a strong patient-centred culture where staff had been motivated and empowered to offer kind and compassionate care.

The practice had appointed primary care navigators to help ensure that a patient's social as well as medical needs were being met. They had also employed a Health and Wellbeing Co-ordinator and a large number of volunteer practice health champions who were actively involved in arranging a number of social groups and activities for patients and in developing effective community engagement. The initiatives they had been involved in included hosting a lunch on Christmas Day for socially isolated and vulnerable patients which was also attended by clinical and non-clinical members of staff and their families. A process had been in place to ensure patients unable or unwilling to attend the lunch received a phone call on Christmas Day. The practice manager told us that the work the practice had carried out in relation to social prescribing and in supporting socially isolated patients and those at high risk of admission to hospital had been used by the National Social Prescribing Network as an outstanding exemplar and presented at the Houses of Parliament in March 2016. Health Education England had also used the process the practice had developed to inform their own workforce developments.

Patients known to have experienced bereavement were sent a condolence card. Patients recently discharged from hospital were contacted by a member of the in house complex care team within three days of discharge to ensure appropriate support was in place and to review care plans if appropriate.

The practice has received recognition both locally and nationally for their innovative and caring work and been awarded a number of awards. This has included improving dementia care through care navigation and social prescribing, improving patient experience through the use of practice health champions and the work of their complex care team and frailty nurse.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of their local population and planned services accordingly. Services took account of the needs of different patient groups and helped to provide flexibility, choice and continuity of care.

- There were longer appointments available for anyone who needed them.
- Home visits were available for older patients, housebound patients and patients who would benefit from these.
- People could access appointments and services in a way and time that suited them.
- The practice had developed an in-house Complex Care Team to care for frail and elderly patients in their own home or care home and prevent unnecessary admission to hospital. Comprehensive care plans were in place for high risk, housebound and care home patients. Dedicated administrative support was attached to the team and ensured that the team were aware of relevant patients and that their care and treatment was discussed and reviewed at weekly multi-disciplinary team meetings.
- The practice had appointed an older persons specialist nurse in 2013 whose role was to achieve continuity of care for elderly patients with complex health and social care needs. The practice was able to demonstrate that 94 housebound patients with an average age of 85 years had been referred to the nurse during the first eight months and that this had resulted in a 54% reduction in the number of unplanned admissions to hospital and A&E attendances for their older patients.
- They had also obtained funding to pilot the employment of a practice based occupational therapist on a secondment basis for 19 hours per week. The aim of this role was to optimise the health and wellbeing of frail older people through timely targeted intervention.
- The practice employed primary care navigators to advise and support patients and carers with any social need that maybe affecting their health including maintaining independence and social inclusion.This included supporting carers, armed forces veterans and other vulnerable patients through signposting to appropriate support services and social prescribing. The practice manager told us that in the first three months of appointing primary care navigators they had been instrumental in ensuring additional numbers of patients had been screened and assessed for dementia, added to their carers and veterans registers, had a care plan and were offered an NHS Health Check where approriate. In addition, the primary care navigators were responsible to contacting patients following discharge from hospital which had resulted 86 patients being referred to various social prescribing initiatives during the first three months.
- They had developed a self-help group for young people with type 1 diabetes in the area. A young person with the condition had been appointed as the project coordinator and the practice had employed a diabetes specialist nurse. The aim was to engage young people in managing their condition through the use of electronic information and telecommunication technologies which would allow long distance communication between a patient and a clinician. The practice had been awarded second place in the Bright Ideas in Innovation Awards 2016 for improving services for young children with type 1 diabetes.
- The practice was part of a GP federation with a number of other local GP Practices and was committed to sharing services and responsibility for delivering high quality patient focused services for the communities the practices served. This had included supporting single handed GP member practices to improve care navigation for the over 75s, leading a project on triaging support services for patients with complex health needs and using any spare GP capacity to support other practices.
- Patients registered with the practice were also able to access pre bookable GP appointments at three local health centres up to 8pm weekdays and on weekends as part of a local extended hour's provision.
- There were disabled facilities and translation services available. The practice had a hearing loop at the main and branch surgeries.
- All patient facilities were easily accessible to patients with a mobility issue.
- The practice offered online services to book appointments and request repeat prescriptions.
- The practice regularly used social media as a forum to keep patients up-to-date with practice developments and health related news. They had involved two of their

patients with substance misuse issues in setting up and administering one of their social media sites. The practice felt this promoted self-help, better engagement and confidence building

- The practice had recently installed an automated telephone system to enable patients to book appointments 24 hours per day/seven days per week. The system gave patients the option to choose whether they wanted to see a male, female or particular GP. This enabled receptionists to have more time to deal with requests for repeat prescriptions and test results rather than restricting patients to a certain time to call.
- With the involvement of Practice Health Champions (volunteers who work with GP practices to improve services and to help meet the health needs of patients in their community) the practice had been instrumental in developing a number of social clubs and events for their patients. This included a weekly knitting/crochet group, weekly walking group and seasonal craft fairs. There were 39 health champions who met on a weekly basis and were known as 'Friends of Oxford Terrace'.
- The practice hosts a lunch on Christmas day for vulnerable or socially isolated patients who were identified by the primary care navigators and third sector organisations working with the practice (36 patients attended the lunch on Christmas day 2015). The lunch and gifts for patients was funded by donations from local companies.
- They had also hosted a tea dance for 250 patients with long term conditions funded by a local university who were carrying out research into supported self-care. They had also organised a tea dance for armed forces veterans.

We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings. As a result the practice and its staff had received recognition and been rewarded nationally for a number of initiatives.

Access to the service

The main surgery was open from 8am to 7.30pm on a Monday and Thursday (appointments from 8.30am to 7.20pm), from 8am to 6.30pm on a Tuesday, Wednesday and Friday (appointments from 8.30am to 6pm) and from 9am to 12 midday on a Saturday (appointments from 9am to 11.50am). The branch surgery was open from 8am to 6pm on a Monday to Friday (appointments from 8.30am to 6pm). Patients registered with the practice were also able to access pre bookable appointments with a GP at one of three local health centres from 8am and 8pm on a weekday and 9am to 2pm on a weekend.

Results from the National GP Patient Survey (July 2016) showed that patients' satisfaction with how they could access care and treatment was comparable or better than local and national averages. For example:

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and the national average of 76%.
- 83% 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%.
- 75% of patients described their experience of making an appointment as good compared to the CCG average of 76% and the national average of 73%.
- 82% of patients said they usually waited less than 15 minutes after their appointment time compared to the CCG average of 68% and the national average of 65%.
- 87% were able to get an appointment to see or speak to someone the last time they tried compared with the CCG and national averages of 85%.
- 67% felt they didn't normally have to wait too long to be seen compared with the CCG average of 60% and national average of 58%.

Patients we spoke to on the day of the inspection and those who completed CQC comment cards reported that they were able to get an appointment within an acceptable timescale. We looked at appointment availability during our inspection and found that routine GP appointment was available at both the main and branch surgery five working days later. An appointment with a nurse was available three working days later at the branch surgery and four working days later at the main surgery. Staff told up that appointments could be booked a minimum of four weeks in advance and that availability was reviewed on a daily basis.

Listening and learning from concerns and complaints

The practice had an effective system in place for monitoring, dealing with and responding to complaints.

- Their complaints policy and procedures were in line with recognised guidance and contractual obligations

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

for GPs in England. This had been reviewed with the assistance of a patient who had made a complaint and had been invited to suggest ways to improve ways in which the practice dealt with complaints. As a result the practice now offered complainants an advocate to help them through the process. The patient had also delivered training to practice staff on a patient's perspective of making a complaint and how to respond appropriately.

- The operational service manager had been identified as lead for dealing with complaints.
- We saw that information was available in the reception area to help patients understand the complaints system.

The practice had recorded 50 complaints during the period 1 March 2015 to 31 March 2016 and a further 16 from 1 April 2016 to the date of our inspection. We found that these had been satisfactorily handled, dealt with in a timely way and lessons learned identified.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice vision was to deliver high quality care and promote good outcomes for patients

The practice had developed a 'shared purpose' with staff and patients. This included:

- Being open and transparent
- Providing the best possible and person centred care
- Being highly effective, safe and innovative
- Having a committed and inspired team
- Working with patients

The practice had a strategic development plan which identified their future aims and objectives. This included improving patient experience, improving access for hard to reach groups, working with community pharmacies, joint commissioning and continually managing demand and capacity.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure. Staff were aware of their own roles and responsibilities as well as the roles and responsibilities of others.
- Up to date practice specific policies were available for staff and were easily accessible
- Arrangements were in place to identify and manage risks and implement mitigating actions.
- There was evidence of some clinical audit activity which improved outcomes for patients. However, we felt the practice could have a more effective programme of clinical audit activity
- The practice continually reviewed their performance in relation to, for example the Quality and Outcomes Framework, referral rates and prescribing.

Leadership and culture

The GPs and practice management staff had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised high quality and compassionate care. The GP and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. However, we did feel that a lack of effective governance arrangements and management oversight had contributed to the issues identified within the safe domain in relation to medicines management.

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

- There was a schedule of regular GP, practice and multi-disciplinary team meetings which included discussions about palliative care, high risk and vulnerable patients.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. They also said they felt respected and valued.

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

The practice encouraged and valued feedback from patients, the public and staff. They proactively sought patients' feedback and engaged them in the delivery of the service.

- The practice had gathered feedback from patients through patient surveys, feedback and complaints received.
- The practice used their practice health champions to carry out patient surveys and told us that this had enabled them to invest the money they would have spent commissioning an external provider to do this elsewhere. A previous survey had revealed that 63.8% of respondents felt that they could get an appointment with a GP within 3 days; 65.8% felt they could get an appointment with a nurse within 3 days; 67.4% were satisfied with the practices management of long term conditions; 55.3% were able to speak to a GP or nurse without having to visit the surgery and 83% felt it was easy to get through to the practice on the phone. As a result the practice had identified a number of action points including improving telephone, IT, GP and nurse appointment access; improving long term condition management; undertaking research to understand patient needs and increasing awareness of self-care. Most identified actions had been completed with the

Are services well-led?

Good

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

exception of updating the website (due to a problem with the commissioning service) and moving to a four session per day GP appointment system which had been delayed due to changes in staffing.

- The practice had a patient participation group (PPG) consisting of six core members who met on a quarterly basis. The four members we spoke to during our inspection told us that their involvement included discussing proposed alterations to the branch surgery, updating the website, producing quarterly newsletters and reviewing patients surveys and anonymised complaints information. One of the PPG members also attended the local Patient User Carer Public Involvement (PUCPI) group.

Continuous improvement

The practice was committed to continuous learning and improvement at all levels. For example, the practice had realised that they were struggling to cope with appointment demand and subsequently the management of long term conditions and unplanned admission to hospital. They had therefore carried out at project to look at improving access and managing long term conditions effectively and efficiently. They found that a lot of GP appointments could actually be managed by the nursing team. A review and restructure of the nursing team subsequently took place and the tasks allocated to the nursing team became commensurate with their clinical grade. In addition, the appointment system was reviewed. As a result:

- An additional 280 nurse appointments were created per week releasing the equivalent of 8 GP sessions.
- The practice reduced unplanned hospital attendances and admissions by 12%
- Care planning improved.
- Management of long term conditions improved
- The practice were able to take on a further four linked care homes.

The practice were working with a researcher from a local university to carry out a two part study to consider how telephone communications between receptionists and patients could be improved to give patients better access to healthcare services and relieve pressure on GPs. The study involved the researcher randomly selecting and transcribing a large number of telephone conversations between receptionists and patients and interviewing staff. Aims identified included:

- Developing training for reception staff
- Educating patients regarding when to book a GP rather than a nurse/HCA appointment
- Developing a triage script to enable receptionists to signpost patients to the most relevant service
- Training reception staff as primary care navigators and develop more effective working relationships with support organisations

Phase one of the project had been completed with phase two and full implementation scheduled for 2017.

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The practice team was forward thinking and took part in local pilot schemes and initiatives to improve outcomes for patients in the area. This included:

- Appointing members of staff as primary care navigators to ensure there was a holistic approach to ensuring a patient's medical and social needs were met.
- Implementing a telephone system which would enable patients to book, cancel and rearrange appointments 24 hours per day and seven days per week using an automated telephone system.
- Working with other practices in the area to identify and implement new collaborative ways of working.

The practice were committed to the development of the services they offered and at the time of our inspection were in the process of applying for funding to extend and upgrade the branch surgery. They felt this would enable them to offer additional enhanced services.

The practice has received recognition both locally and nationally for their innovative work and been awarded a number of awards. This has included improving dementia care through care navigation and social prescribing, improving the management of long term conditions, improving patient experience through the use of practice health champions, the work of their complex care team and frailty nurse and improving services for children with type 1 diabetes..

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The practice was not taking adequate steps to ensure the proper and safe management of medicines. They did not have a robust process in place to check expiry dates of emergency medicines or equipment. Some emergency equipment was out of date. Not all patients group directions were appropriately signed. This was a breach of Regulation 12(1) Safe care and treatment.