Thornfield Medical Group

Inspection report

Molineux Street
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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 location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Good** ●
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as Outstanding overall. (Previous rating October 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Thornfield Medical Group on 3 October 2018. This was as part of our ongoing inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- There was a truly holistic approach to assessing, planning and delivering care and treatment to people who used the service. Quality improvement was at the heart of any changes made by the practice. New evidence based techniques were used to support the delivery of high quality care.
- They ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff were committed to working collaboratively, people who had complex needs were supported to receive coordinated care and there were innovative and effective ways to deliver more joined up care to patients.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with patients was used to do so.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice had helped to make links with patients who may be most vulnerable of being excluded from good access to primary medical services.
- The practice took a systematic approach to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- The practice planned for a sustainable future, and innovated to support sustainability and provision of good quality care. Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. There were strong governance arrangements which supported safe innovation and continual improvement.

We saw areas of outstanding practice:

- Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. They were proactive in responding to the needs of the patients to help reduce health inequalities. They understood the challenges faced by patients in a very deprived area and put in place strategies to support improved outcomes for patients. For example, staff were consistent in supporting people to live healthier lives through a targeted proactive approach to health promotion and prevention of ill health. They had reduced non-elective admissions to hospital for patients with chronic obstructive pulmonary disease (COPD) by 12.5%. They had captured the individualised needs of patients who had undergone gender reassignment, experienced gender dysphoria or identified as non-binary, including future health screening needs. The practice had linked with people who were most vulnerable of exclusion from good access to primary medical services. They had supported patients to become familiar with the practice and how primary care works with a visit by young people with autism and participating in a national children's TV programme.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to Thornfield Medical Group

The Care Quality Commission (CQC) registered Thornfield Medical Group to provide primary care services to around 19,500 patients from two locations:

- Molineux Street Byker, Newcastle Upon Tyne, Tyne and Wear, NE6 1SG
- Branch Surgery: Shieldfield Health Centre, Stoddard Street, Shieldfield, Newcastle upon Tyne, Tyne and Wear, NE2 1AL

We visited both sites as part of this inspection.

Thornfield Medical Group provides care and treatment to around 19,500 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of the NHS Newcastle Gateshead clinical commissioning group (CCG).

The practice was in the process of negotiating terms on new premises for the main surgery at the time of the inspection. However, final terms were yet to be agreed and planning had yet to identify a firm date for a move.

The practice has four GP partners (three females and one male) and ten salaried GP's and a business manager. Additionally, the practice employs two pharmacists (one male and one female), an advanced nurse practitioner (female), a mental health practitioner (male), four nurses and six healthcare assistants. There are 30 members of the administration team and one further member of the management team. The practice is a teaching practice.

The NHS 111 service and Vocare Limited (known locally as Northern Doctors Urgent Care) provide the service for patients requiring urgent medical care out of hours.

Information from Public Health England placed the area in which the practice is located in the second most deprived decile. In general, people living in more deprived areas tend to have a greater need for health services. Average male life expectancy at the practice is 76.3 years, compared to the national average of 79.2 years. Average female life expectancy at the practice is 80.9 years, compared to the national average of 83.2 years.

86.5% of the practice population were white, 1.6% were mixed race, 8.5% were Asian, 2.4% were black and 1.1% were other races.

We checked and confirmed the practice had displayed the most recent CQC ratings legibly and conspicuously both on their practice website and in the practice premises.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their role 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

In May 2015, we said the practice should improve the security arrangements within the reception area. In October 2018, we found security arrangements had improved. The door to this area was always locked and staff held keys to allow them appropriate access.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and had taken action to support good antimicrobial stewardship in line with local and national guidance.
- The practice had achieved a reduction in opioid prescribing in 11 patients prescribed the highest doses of opioids alongside other medicines. These medicines put patients at higher risk of respiratory depression. They had achieved a total reduction of 395mg per day of morphine equivalent in these patients (an average reduction of 36mg per day per patient).
- There were effective protocols for verifying the identity of patients during remote or online consultations.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Good

Are services safe?

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

In the May 2015 CQC inspection we said the practice should review the arrangements for recording significant events, as they were not all logged centrally. Records did not clearly identify if an apology had been made to the person, where appropriate.

In October 2018, we found the practice had addressed this concern. There was a central log of all significant events. This was kept on a shared drive so staff could access the lessons learned and identified improvements. Where patients were affected by an event or incident, the practice informed them and apologised.

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.
- The practice reviewed all deaths and serious diagnoses to see if they could have improved the care and treatment offered. Where appropriate, they considered cases through the significant events process, to ensure they were capturing any learning and implementing improvements to the care and treatment provided to patients.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

Effective needs assessment, care and treatment

There was a truly holistic approach to assessing, planning and delivering care and treatment to people who used the service. New evidence based techniques were used to support the delivery of high quality care.

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may have been vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice carried out group consultation sessions for patients, including statins seminars and osteoporosis clinics. Informal feedback from patients was they liked this approach, as they gained more from the sessions as someone else asked a question they had not thought to ask.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The practice followed the 'Year of Care' approach to helps patients to manage their own long-term condition.
- The practice had tailored the service it offered to patients with asthma. This included delivering group asthma clinics for children and young people during the summer holidays. The practice pharmacist also offered review appointments on a Saturday to encourage people who worked to attend for review. Identifying patients who failed to attend reviews and had used more than 12 inhalers a year. These patients were referred to a community pharmacy where the pharmacist could carry out a review when the patient collected their prescription. This had helped reduce the number of patients who had not received a review from 33 to 13.
- The practice had reviewed the use of antibiotic rescue packs for patients with chronic obstructive pulmonary disease (COPD). They monitored those patients prescribed rescue packs for exacerbation of symptoms, for example, due to onset of chest infections. Where appropriate the patients were referred to hospital consultants or community matrons for review, including review of inhaler use. The practice had increased the issue of rescue packs from 48 patients in 2016/17 to 84 in 2017/18. This was whilst maintaining the antibiotic prescribing rates, which were below the CCG average. This approach had resulted in a 12.5% reduction in non-elective admissions to hospital for COPD year on year, since this work started. The latest monthly data to August 2017 showed a further reduction to 7%.
- The practice had reviewed the care of patients who used stoma products. The purpose of this work was to check the patients had the correct fitting devices and give them some support. Of the 25 patients reviewed, 13 had not had their stoma care reviewed by a specialist nurse for at least two years. The most frequent issues reported by patients were leakage and sore skin. As a result of the reviews, interventions included advice on accessory usage, stopping the usage of some products and making adjustments.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

Good

Are services effective?

- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice's performance on quality indicators for long term conditions was in line with averages when compared to local and England averages.

Families, children and young people:

- The practice was above the 90% target rate for all childhood immunisations. They were also above the World Health Organisation target of 95% for three out of the four groupings for childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice offered group asthma clinics during the summer holidays and Saturday clinics for children and young people to encourage uptake. This had led to an overall reduction in the number of patients who had failed to attend review appointments. Overall, this had helped reduce the number of patients with asthma who had not received a review from 33 to 13.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 62.3%, which was below the 80% coverage target for the national screening programme. This compared to the CCG average of 70.9% and the national average of 72.1%. We spoke with the practice about the action they were taking to understand and improve their performance. They told us they offered appointments on a Saturday to support uptake from patients who worked. They also offered opportunistic screening and had built in flexible appointments into their schedule to facilitate this. They had accessed patient leaflets in a range of languages to help target hard to reach groups including those patients whose first language was not English. This included the large population of refugees registered with the practice.
- The practice's uptake for breast and bowel cancer screening was lower than the national average.
- The practice had worked with the local Healthwatch team identify and address barriers to cancer screening and had put in place improvements to encourage uptake. This included ensuring where an interpreter was required, this was recorded in the patient's record. Where an interpreter was booked a leaflet about the screening programme was sent to the patient in their preferred language. Information leaflets were available in a range of languages.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had carried out 189 in 2015/16 and 26 in 2018/19 so far.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice reviewed all deaths and serious diagnoses to see if they could have improved the care and treatment offered. For example, they had contacted a local mental health organisation for advice and improved the information available to signpost patients to sources of support, following a patient suicide. They had implemented improvements to the service offered following two serious case reviews.
- The practice held a register of patients living in vulnerable circumstances including homeless people, refugees and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice offered annual health checks to patients with a learning disability. Following a serious case review the practice had improved their approach to provision of annual health checks. This included all medicine reviews for patients with learning disabilities carried out face to face. There was a dedicated administrative lead for this area of work who had ongoing contact with patients to build relationships. Patients were sent a birthday card to maintain good

relationships with them. Since the practice had introduced the new recall process, they had carried out 69 annual health checks for patients with learning disabilities, of the 142 patients on the register. So far of those invited, one patient had declined a health check. The practice told us they planned to discuss this case as a team to decide on next steps. The practice planned to invite the remaining patients before their birthday month to support good uptake levels for annual health checks

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice's performance on quality indicators for mental health was below local and national averages. We spoke with the practice about this, who told us they had taken over another local practice within the last few years and had been working to improve the numbers of patients with mental health conditions who had been reviewed, who had transferred. We looked at provisional QOF data provided by the practice for 2017/18, which had not yet been published or verified. This showed there was year on year improvement.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2016/17 showed the practice had achieved 98.6% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was higher than the local CCG average of 97.7% and the national average of 95.6%. (QOF is a system intended to improve the quality of general practice and reward good practice.)

We asked the practice to provide us with unpublished and, therefore, unverified, QOF data for 2017/18. This showed the practice had a forecast achievement of 556.01 of the 559 (99.5%) of the points available.

- The overall clinical exception-reporting rate was 10.1% in comparison to a CCG average of 10.2% and a national average of 9.6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) Of the 15 clinical exception rates, six were over 10% (These were coronary heart disease; stroke and transient ischaemic attack; chronic obstructive pulmonary disease; cancer; diabetes mellitus; depression). We discussed this with the practice and found the practice were taking appropriate action to encourage uptake of appropriate care and treatment and were taking action to reduce exception reporting.
- The practice used information about care and treatment to make improvements. Quality improvement was at the heart of any changes made by the practice. For example, the practice had carried out an audit to ensure they had captured the individualised needs of patients who had undergone gender reassignment, experienced gender dysphoria or identifying as non-binary.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Good

Are services effective?

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- In September 2018, the practice had hosted training on spirometry for healthcare assistants, including those from other local practices, so they could support their practice nursing teams with reviews of long-term conditions. (Spirometry is a test used to help diagnose and monitor certain lung conditions.) The training included an inhaler technique session provided by the practice pharmacist.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. Staff were committed to working collaboratively, people who had complex needs were supported to receive coordinated care and there were innovative and effective ways to deliver more joined up care to patients.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- The practice worked with a number of partners to improve the service offered and health outcomes for patients. For example, they had worked with the local Healthwatch team to support patients' uptake of cancer screening. They had worked with the stoma care services to improve satisfaction with stoma products. They had supported healthcare assistant to develop skills in spirometry, including those who worked at other local practices.

Helping patients to live healthier lives

Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with patients was used to do so.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- The practice was engaged in the 'Newcastle Can' project to support patients to maintain a healthy weight. They also delivered 'healthy plate' dietary advice clinics, provided by the practice health care assistants. There was an ongoing training programme for healthcare assistants in weight management (under and overweight patients) to help address the national public health agenda on obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Good

Are services effective?

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's National GP Patient Survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- Results from the National GP Patient Survey we reviewed showed patients had similar levels of satisfaction for questions about their involvement in planning and making decisions about their care and treatment to local and national averages.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, as outstanding for providing responsive services.

We also rated the population groups, people with long-term conditions; families, children and young people; and, people whose circumstances may make them vulnerable as outstanding.

We rated the population groups for older people; working age (including those recently retired and students); and, people experiencing poor mental health (including people with dementia) as good.

The practice was rated as outstanding for responsive because:

- There was a proactive approach to understanding the needs of different groups of people and to the delivery of care in a way that meets these needs and promotes equality. This included people who were in vulnerable circumstances or who had complex needs. For example, the practice had linked with people who were most vulnerable of exclusion from good access to primary medical services. They had supported patients to become familiar with the practice and how primary care works with a visit by young people with autism and participating in a national children's TV programme. They were building relationships with people with learning disabilities with invitation phone calls and birthday cards.
- The practice took a systematic approach to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. They worked with other organisations to help them meet the needs of patients, for example, to increase uptake of cancer screening, reduce falls through 'Staying Steady' education, improve stoma product care and be dementia friendly.
- They had identified and responded to the needs of patients, for example, by employing a mental health practitioner to reduce the risk of deterioration in mental health whilst patients waited for specialist mental health services. They had delivered group consultation clinics to increase uptake of preventative support and regular reviews for those who had or were at risk of developing long-term conditions. They had started to offer e-consultations to provide greater access to services for those who might find it difficult to attend appointments during normal working hours.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. They took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice had commenced some joint work with the local Healthwatch team to consider how they could best meet the needs of patients who were housebound.
- The practice worked collaboratively with NHS Newcastle Upon Tyne Hospital Foundation Trust, the local clinical commissioning group (CCG) and the Academic Health Science Network to identify patients with mild frailty at risk of falls to provide 'Staying Steady' education.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Are services responsive to people's needs?

- The practice carried out group consultation sessions for patients, including statins seminars, asthma atrial fibrillation and osteoporosis clinics. They were planning to also roll out group clinics for diabetes and COPD. Anecdotal feedback from these sessions was they were well liked by patients.
- The practice had worked with the local specialist stoma nurse to review the needs of patients who used stoma products. The purpose of this work was to check the patients had the correct fitting devices and give them some support. Of the 25 patients reviewed, 13 had not had their stoma care reviewed by a specialist nurse for at least two years. The most frequent issues reported by patients were leakage and sore skin. As a result of the reviews, interventions included advice on accessory usage, stopping the usage of some products and making adjustments.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had improved their approach to supporting mothers post birth in response to a serious care review. The practice improved their support by offering a one-week postnatal phone call to discuss early concerns and the opportunity for early intervention and support where needed.
- The practice participated in the Think Plan C-Card project helping to target information about sexual health advice and access to condoms for young people.
- The practice promoted the 'Little Orange book', a health education booklet for parents and guardians produced by the local CCG.
- The practice had been involved in filming a CBBC program aimed at showing children how GPs work.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- The practice offered a fast track for patients with symptoms of urinary tract infections to ensure treatment was provided quickly.
- The practice was part of a local initiative to provide fast and convenient access to advice and treatment for patients through a e-consultations. This signposted the patient to appropriate support via a webform and where appropriate collected details of a patient's symptoms and sent them to the patient's GP for a virtual consultation within 48 hours. This practice had just launched within the practice. At the time of the inspection, the practice had not had any patients use this service.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, refugees and those with a learning disability.
- The practice sent birthdays cards to patients with learning disabilities to support on-going good communication and encourage uptake of annual health checks. The practice maintained links with two supported housing schemes locally for patients with learning disabilities.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice worked with the local CCG, the Home Office and the local housing association to ensure refugee families had access to healthcare. Each refugee registered with the practice had an initial in-depth medical examination with a GP to identify physical and or mental health needs with appropriate follow up, where appropriate. The practice normally accommodated these at their quieter branch surgery to make it easier for patients who may be traumatised by their previous experiences. The practice worked with the local housing association to ensure patients were signposted to appropriate services and supported to adapt to the local area. Patients were referred to a local scheme delivered by a Primary Care Navigator (Primary care navigators help to connect vulnerable patients with

Are services responsive to people's needs?

care and support in the community, and provide direct nonmedical support, such as providing advice about benefit entitlement). Also, where appropriate, to the Freedom from Torture charitable organisation.
- The practice had identified two staff as carers champions to ensure the needs of carers were identified and met.
- The practice had hosted a visit with a local school for autistic young adults, to help familiarise and explain what happens at the surgery.
- There were easy read complaints leaflet displayed in the practice reception area to support patients with learning disabilities and others with difficulties reading to make a complaint.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had identified an unmet need for patients who had mental health conditions, although not acute at the time they presented at the practice, where there was potential for significant deterioration before they were able to see a mental health professional in secondary care. This was because of long waiting lists. From 1 October 2018, the practice employed a mental health practitioner to bridge the gap between primary and secondary care for patients experiencing poor mental health. It was too early to see the impact of this role on meeting the needs of patients.
- The practice had taken steps, working with the Alzheimer's Society to be dementia friendly.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Although the practice performance on the National GP Patient Survey relating to timely access to the service were comparable with other local and national practice, they were generally lower than average.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. They acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing a well-led service.

The practice was rated as outstanding for providing a well-led service because:

- Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. They were proactive in responding to the needs of the patients to help reduce health inequalities. They understood the challenges faced by patients in a very deprived area and put in place strategies to support improved outcomes for patients. We found there were strong governance arrangements which supported safe innovation and continual improvement. Change was well managed and innovation was considered and implemented in a safe way.
- They had planned for a sustainable future, and innovated to support sustainability and provision of good quality care.
- All staff were clearly working towards the same shared goals and aspirations of the practice.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had an inspiring shared purpose, strove to deliver and motivated staff to succeed.
- Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. They were proactive in their approach, for example, by identifying at an early stage the needs of patients who had undergone gender reassignment, gender dysphoria or identifying as non-binary. We found there were strong governance arrangements which supported safe innovation and continual improvement. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Safe innovation was celebrated.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable. Within the last two years the practice had taken over another local practice. We found the practice had managed this change well and had developed and implemented plans to ensure where any areas of concern were identified, they were addressed and monitored. Staff told us the change had been well managed and they worked as one team, with shared protocols, policies, procedures and culture.
- All staff were clearly working towards the same shared goals and aspirations of the practice. Change was well managed and innovation was considered and implemented in a safe way.
- There was a systematic approach to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the locality. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- The practice had a very positive patient centred culture, and the staff we spoke with all demonstrated a high level of commitment to providing good quality care.
- There was a systematic approach to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. There was a clear culture of innovation to support sustainability and good quality of care. The practice had considered and implemented innovations, such as e-consultations and group consultations to increase the scope and accessibility of the service.
- The practice had considered sustainability of the service, including recruiting a diverse skills mix led by the needs of patients.

Outstanding ☆

Are services well-led?

- There was a good awareness of the local community and this informed business planning. Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally. The practice was an inclusive employer.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

Outstanding ☆

Are services well-led?

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

- The leaders in the practice drove continuous improvement and supported staff to deliver safe and effective innovation. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment. For example, the practice had implemented group consultations for some long-term conditions to ensure patients received review of their care whilst also effectively managing the use of staff resources. They were also implementing e-consultations to improve access for those patients who found it difficult to access services during normal working hours. There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.