Newcastle Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at Newcastle Medical Centre on 8 December 2016. Overall, the practice is rated as inadequate.

This inspection follows an earlier announced comprehensive inspection at Newcastle Medical Centre on 13 October 2015 at which time the overall rating for the practice was requires improvement. The practice was rated as requires improvement for providing safe and effective care and good for providing caring, responsive and well-led care. The full comprehensive report on the October 2015 inspection can be found by selecting the 'all reports' link for Newcastle Medical Centre on our website at www.cqc.org.uk. Two requirement notes were issued as breaches of regulation were identified during this inspection.

Our key findings were at this inspection were as follows:

- The practice had complied with the requirement notices we set following the last inspection. Care plans were in place and recruitment checks were carried out in line with Schedule 3 of the Health Care Act 2008.
- We saw that the practice had acted to address some of the actions we told them they should take. Staff were fully aware of fire procedures at the practice and the practice held records to demonstrate the maintenance, servicing and calibration of equipment. The practice were not able to demonstrate they had maintained an audit trail for all prescription forms.
- Staff did not always recognise concerns, incidents and near misses and take steps to learn from them. Most understood their responsibilities to raise concerns and report incidents and near misses.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Outcomes for patients were below average for the locality, this included Quality and Outcomes Framework (QOF), childhood immunisation and cervical screening. Action has been initiated by the practice to improve patient outcomes.
- Limited quality improvement work was taking place and there was little evidence that clinical audit was driving improvements in performance to improve patient outcomes. However, quality improvement work has been planned and taken place since the inspection.

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- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- Data from the National GP Patient Survey, published in July 2016, showed that patients rated the practice below average for access to care and treatment. For example, of those that responded 58% found it easy to get through to the practice by telephone (CCG average 79%, national average 73%).
- The practice had a walk-in surgery Monday to Friday. Every patient who presented at the practice between 8am and 9am was guaranteed to see a GP the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a documented leadership structure and staff felt supported by management.
- The practice had gathered the views of patients by completing surveys on patient's overall opinion of the practice and the practice's appointment system. They did not have a patient participation group (PPG). Action has been taken by the practice to recruit members to a patient participation group, however, no meetings have been held yet.
- The provider was aware of and complied with the requirements of the duty of candour regulation.

There were areas where the provider needs to make improvements.

The provider must:

- Improve the governance arrangements at the practice. Specifically, the systems and processes in place to assess monitor and improve the quality and safety of the service provided.
- Ensure all significant events are reported, recorded and managed by the practice to enable lessons to be learned from these incidents to prevent their reoccurrence and to improve the outcomes for patients.
- Improve the arrangements for clinical audit in order to be able to demonstrate a clear link between audits and quality improvement.
- Ensure medicines are managed safely and appropriately. Specifically, make sure there are systems in place for ensuring that the process to monitor the distribution of blank computer prescriptions is in line with national guidance.
- Ensure that Patient Group Directions (PGD's) and Patient Specific Directions (PSD's) are implemented in accordance with national guidance.
- Ensure that complaints including verbal complaints are recorded and managed in line with the practice's own complaints policy
- Improve their arrangements for the clinical supervision of nursing staff at the practice.

The provider should:

- Record minutes of the GP meetings.
- Review the information displayed for patients in the practice waiting area. Specifically information for non-English speaking patients on the services provided by the practice.
- Improve arrangements for the provision of a patient participation groups (PPG) to ensure the views of patients are acted upon by the practice.
- Take steps to improve their identification of carers registered at the practice.
- Take steps to ensure that all staff are aware of who the safeguarding lead at the practice is.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's

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registration to remove this location or cancel the provider's registration. Special measures will give people who use the practice the reassurance that the care they get should improve.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- Staff did not always recognise significant events that might arise from concerns, incidents and near misses. Although most understood their responsibilities to raise concerns and report incidents and near misses at the practice, for two incidents the practice had not reviewed the incidents to show how they had learned from the events that occurred. Following the inspection, the process for managing significant events was reviewed. The practice updated the significant event policy in March 2017 and provided training to their administrative staff on the process.
- The provider was aware of and complied with the requirements of the duty of candour regulation.
- The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse. For example, there was an effective safety alert system and safeguarding leads were in place, however, not all staff, including one of the GP's were aware of who the practice's safeguarding lead was. Since the inspection, we have seen evidence that the clinical staff have been made aware of who safeguarding lead is.
- The system to monitor the use of blank computer prescriptions was reviewed following the inspection to ensure it was in line with national guidance. There was an effective system in place to monitor the use of prescription pads.
- Good infection control arrangements were in place and the practice was clean and hygienic.
- Disclosure and Barring Service (DBS) checks had been completed for all staff that required them.
- The arrangements for the management of Patient Group Directions (PGD's) and Patient Specific Directions (PSD's) were reviewed following the inspection to ensure they were in line with national guidance.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- We found that individual clinicians kept up to date with both National Institute for Health and Care Excellence (NICE)

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guidelines and other locally agreed guidelines. Following the inspection, arrangements were put in place at the practice for the whole clinical team to formally meet and discuss clinical guidelines.

- There was limited and ineffective monitoring of patient outcomes of care and treatment. There was limited clinical audit. Patients' outcomes were variable or significantly worse than expected when compared with other services. Following the inspection the practice told us that action was taken to improve patient outcomes.
- There was a limited focus on prevention and early identification of health needs. However, following the inspection, the practice planned work in this area. This work was at an early stage.
- Data showed patient outcomes were below average for the locality. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 76.3% of the points available in 2015/2016. This was 20.5% below the local average and 19% below the national average. The practice told us that this was because of the unique nature of the population that largely consisted of university students with a high proportion of students whose first language was not English. Following the inspection, the practice initiated work to improve patient outcomes. The practice told us that they had made progress in this area, however, it was not possible to verify the supporting data.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Requires improvement

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

- Data showed that how patients rated the practice varied for several aspects of care. For example, results from the National GP Patient Survey, published in July 2016, showed that 91% of respondents said the last GP they saw or spoke to was good at treating them with care and concern (CCG average 96%, national average 95%). It also showed that 100% of respondents had confidence and trust in the last nurse they saw or spoke to (CCG average 98%, national average 97%). The practice had not reviewed the results of this survey.
- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However, results from the National GP

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Patient Survey, published in July 2016, showed patients responses were below average to questions about their involvement in planning and making decisions about their care and treatment. For example, 76% said the last GP they saw was good at explaining tests and treatments (CCG average of 88%, national average of 86%).

- Information for patients about the services offered by the practice was available; they provided this information on the practice's website, waiting area and in their patient leaflet.
- The practice had links to local and national support organisations and referred patients when appropriate. The practice had identified six of their patients as being a carer (0.04% of the practice patient population). None of the carers on this register had had a carers health check/review in the last year. The practice told us that due to the high number of young patients that they had registered lower numbers of carers would be expected at the practice than at other practices. The practice have told us they initiated work to improve the support they provide for carers.

Are services responsive to people's needs?

Requires improvement

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

- The practice worked with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.
- On the day of the inspection, most patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day, however, data from the National GP Survey, published in July 2016 showed that 46% described their experience of making an appointment as good (CCG average 76%, national average 73%).
- Data from the National GP Patient Survey, published in July 2016, showed that patients rated the practice below average for access to care and treatment. For example, of those that responded 58% found it easy to get through to the practice by telephone (CCG average 79%, national average 73%). The practice completed their own patient survey on satisfaction with the appointment system in March 2017. Results showed that most patients were satisfied with the appointment system.
- The practice recognised that their student population contained a high proportion of patients who did not have English as their first language. At the time of the inspection information available in the waiting area, and the patient

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leaflet, were only available in English. The practice has reviewed the information they provide, some information is now available in Spanish and Cantonese and the practice planned to provide more information.

- The practice had a walk-in surgery Monday to Friday. Every patient who presented at the practice between 8am and 9am was guaranteed to see a GP the same day. However, patient feedback on the walk-in service consistently focused on the long wait to see a doctor. The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available on the practice's website and in the waiting areas.

Are services well-led?

Inadequate 

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

- When we inspected the practice in December 2016, we found that the practice's governance framework did not effectively support the delivery of their strategy and good quality care. Additional information provided by the practice demonstrated some improvements in the practice's governance framework since we inspected the practice.
- When we inspected the practice in December 2016 there were no clear or realistic plans to achieve the vison, values and strategy of the practice. An action plan was developed by the practice in March 2017 in response to areas of concern highlighted at the inspection. It is not yet possible to determine if this action plan has been effective. However, it included work to address many of the areas of concern identified at the inspection.
- There were systems in place to identify risk but they were not always effective.
- There was a documented leadership structure and staff felt supported by management.
- The practice's governance framework did not effectively support the management of the practice, for example with regard to the management of significant events. However, following the inspection the practice have taken some steps to improve the governance framework.
- The practice had a number of policies and procedures to govern activity and held practice meetings. At the inspection,

we saw that scheduled meetings were frequently cancelled and that the practice did not produce minutes for some of the meetings they held so that a record of decisions made was not available. The practices meeting policy was reviewed in March 2017. Minutes of meetings held since this review showed that the practice now held regular meetings, and that records of these meetings were clearly documented.

- The provider was aware of and complied with the requirements of the duty of candour regulation.
- The practice had completed two patient surveys to seek feedback from staff and patients, which it acted on. An additional patient survey on satisfaction with the appointment system was completed in March 2017; the results showed that most patients were satisfied with the appointment system.
- At the inspection, we saw that the process for managing complaints could be improved as the practice did not always record verbal complaints. Following the inspection, the practice updated their complaints policy in March 2017, staff have been made aware of the need to record verbal complaints and additional information has been made available for patients.
- The practice did not have a patient participation group (PPG) but was working to recruit virtual members. Following the inspection the practice had undertaken work to recruit members to the PPG. Six patients have agreed to join a PPG and attend meetings, three patients agreed to join a virtual PPG. Meetings have yet to be held.

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The six population groups and what we found

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

Older people

Inadequate

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

This is because the provider was rated as requires improvement for providing safe, caring and responsive care and inadequate for providing effective and well-led care.

- The practice had a lower than average number of older patients registered at the practice.
- When we inspected the practice, we saw little evidence that the practice worked to improve the care of older patients, For example, there was no quality improvement work targeted at older people, the practice did not maintain a palliative care register and there was no lead GP for older people. In April 2017, a lead GP was allocated. They developed an action plan for 2017/2018 to improve the care provided for older patients.
- All patients over the age of 75 had a named GP and patients over the age of 75 were offered an annual health check.
- The practice was offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients with conditions commonly found in older people were in line or above the local and national average. For example, the practice had achieved 100% of the Quality and Outcomes Framework (QOF) points available for providing the recommended care and treatment for patients with heart failure. This was 1% above the local clinical commissioning group (CCG) average and 1.9% above the national average.
- The practice offered immunisations for shingles and pneumonia to older people.

People with long term conditions

Inadequate

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

This is because the provider was rated as requires improvement for providing safe, caring and responsive care and inadequate for providing effective and well-led care.

- When we inspected the practice, we saw little evidence that the practice worked to improve the care of people with long-term conditions, For example, there was no quality improvement work targeted at people with long-term conditions. The practice allocated a lead GP for patients with long-term

conditions in April 2017. They developed an action plan to improve the care of patients who have chronic diseases such as chronic obstructive pulmonary disease (COPD). This work is in its initial stages.

- The practice held regular clinics for long terms conditions, for example for patients with diabetes.
- Nationally reported data showed that outcomes for patients with conditions commonly found in this population group were generally in line with local and national averages. For example, the practice had achieved 94.6% of the QOF points available for providing the recommended care and treatment for patients with diabetes. This was 1.1% above the local CCG average and 4.7% above the national average. However, the practice's clinical exception rate for diabetes was 39%, which was above the national average of 10.8%.(Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- The practice nurses had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority and supported by the practice, care plans were in place and regularly reviewed.
- All patients with a long-term condition had a named GP and were offered a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

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

This is because the provider was rated as requires improvement for providing safe, caring and responsive care and inadequate for providing effective and well-led care.

- When we inspected the practice, we saw little evidence that the practice worked to improve the care of families, children and young people, For example, there was no quality improvement work targeted at families, children and young people.
- There were arrangements for new babies to receive the immunisations they needed. Childhood immunisation rates for the vaccinations given to under two year olds ranged from 68.8% to 92.9% (CCG average 64.7% to 97.1%) and for five year olds ranged from 63.6% to 90.9% (CCG average 90.4% to 97.4%). However, when we inspected the practice the arrangements

that had been adopted by the practice to allow nurses and healthcare assistants to administer medicines were not in line with national guidance. Since the inspection, work has been initiated by the practice to improve the uptake of childhood immunisations and action has been taken to ensure medicines were administered in line with national guidance.

- Nationally reported data showed that outcomes for patients with asthma were below average. The practice had achieved 63.5% of the QOF points available for providing the recommended care and treatment for patients with asthma. This was 34.5% below the local CCG average and 33.9% below the national average. The practice told us they thought this rate was low as some of their student patient's preferred to access care and treatment for this condition during university holidays at their home address, but there was no data to confirm this. Following the inspection the practice told us about work they were doing to improve outcomes for patients with asthma, this work was ongoing.
- 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 childcare professionals such as health visitors. The practice had a lower than average number of children registered at the practice.
- Four staff, including one of the GP's, were not aware of who the safeguarding lead at the practice was. One of the GPs attended regular safeguarding meetings; they met with the health visitor each month to discuss safeguarding issues at the practice. Meeting minutes we saw did not document how these issues were fed back to the practice. Following the inspection the provider told us these issues had been addressed.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Urgent appointments for children were available on the same day.
- Pregnant women were able to access an ante-natal clinic provided by healthcare staff attached to the practice.
- The practice provided contraceptive and sexual health advice.

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Working age people (including those recently retired and students)

Inadequate

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

This is because the provider was rated as requires improvement for providing safe, caring and responsive care and inadequate for providing effective and well-led care.

- Although the practice had a higher than average number of working age people and students registered, when we inspected the practice, we saw little evidence that the practice worked to improve the care of working age people. For example, there was limited quality improvement work targeted at working age people and cervical screening uptake was lower than average.
- A full range of health promotion and screening which reflected the needs for this age group was offered.
- The practice were aware that they had a higher than average number of working age people and students registered. However, the services the practice offered did not ensure these services were accessible, flexible and offered continuity of care. For example, when we inspected the practice they had no effective plans to address concerns about access to services raised by the National GP Survey or by patients who were dissatisfied with the waiting time on the day to see the GP at the walk-in surgery.
- The practice had a walk-in surgery Monday to Friday. Every patient who presented at the practice between 8am and 9am was guaranteed to see a GP the same day. However, we found that the feedback from patients about this service was frequently negative. The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017.Since then additional appointments have been provided.
- The practice's uptake for cervical screening was 26.4%, compared to the CCG average of 81% and the national average of 81.4%. The practice told us that they encouraged patients who were eligible for screening to attend for testing. However, when we inspected the practice did not have a documented plan for improvement. Work was initiated at the practice in 2017 to improve the uptake of cervical screening; this included a more detailed action plan and the provision of cervical screening information in some other languages.
- Telephone appointments were available.
- Patients could order repeat prescriptions and routine healthcare appointments online.

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- Patients were able to receive travel vaccinations that were available on the NHS. The practice was also a designated yellow fever vaccination centre.
- The practice website provided a good range of health promotion advice and information.

People whose circumstances may make them vulnerable

Requires improvement

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

- When we inspected the practice, we saw little evidence that the practice worked to improve the care of people whose circumstances make them vulnerable. 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 normal working hours and out of hours. However, not all staff, including one of the GP's, were aware of who their safeguarding lead was. Following the inspection the practice ensured that the clinical staff were aware that the lead GP was the safeguarding lead for the practice
- The practice had identified six of their patients as being a carer (0.04% of the practice patient population). None of the carers on this register had had a carers health check/review in the last year. The practice told us that due to the high number of young patients that they had registered lower numbers of carers would be expected at the practice than at other practices, however, this does not recognise that many young people have caring responsibilities.
- The practice held a register of patients living in vulnerable circumstances including patients with a learning disability; patients with learning disabilities had been invited to the practice for an annual health check. All of the patients on this register had received an annual review in the last 12 months. The practice had worked to improve the support they provided for patients with learning disabilities.
- There were longer appointments available for patients with a learning disability and those requiring the use of an interpreter.
- The practice regularly worked with multi-disciplinary teams (MDT) in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

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People experiencing poor mental health (including people with dementia)

Inadequate 

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

This is because the provider was rated as requires improvement for providing safe, caring and responsive care and inadequate for providing effective and well-led care.

- When we inspected the practice, we saw little evidence that the practice worked to improve the care of people experiencing poor mental health. Since the inspection, the practice had completed some quality improvement work in this area.
- The practice had identified 0.3% of their population with enduring mental health conditions on a patient register to enable them to plan and deliver relevant services. Thirty-nine patients were on this register, 72% of those had an annual review in the last year, and two patients declined this review. Ten percent of these patients had had a flu jab and five patients had declined this vaccination. The practice had undertaken some work to improve the service they offered for patients with mental health conditions.
- Nationally reported data showed that outcomes for patients with mental health conditions were below average. The practice had achieved 76.4% of the QOF points available for providing the recommended care and treatment for patients with mental health conditions. This was 18.6% below the local CCG average and 16.4% below the national average.
- The practice advised they had a lot of student patients with mental health related issues although this was not reflected in patient records with only four patients recorded with depression and a further 40 with Mental Health issues at the time of the visit. When we inspected the practice, we saw limited evidence that the practice were working to identify or support students with mental health despite students being at higher risk of mental health issues.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia. The practice had a very low number of patients with dementia registered.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. A counselling service was available at the practice.

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What people who use the service say

The National GP Patient Survey results published in July 2016 showed the practice was performing below the local and national averages in most areas. There were 377 forms sent out and 29 were returned. This is a response rate of 8% and represented 0.2% of the practice's patient list. Of those who responded:

- 58% found it easy to get through to this surgery by telephone (CCG average 79%, national average of 73%).
- 62% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85%, national average 85%).
- 65% described the overall experience of their GP surgery as good (CCG average 88%, national average 85%).
- 51% said they would recommend their GP surgery to someone who has just moved to the local area (CCG average 80%, national average 78%).
- 61% found the receptionists at this surgery helpful (CCG average 89%, national average of 87%).
- 68% said the last appointment they got was very convenient (CCG average 92%, national average 92%).
- 46% described their experience of making an appointment as good (CCG average 76%, national average of 73%).
- 53% usually waited 15 minutes or less after their appointment time to be seen (CCG average 68%, national average 65%).

The practice told us that due to the low response rate they had not reviewed the results of this survey; as they felt that it would not be a representative sample of patient views. They also told us that they thought that the poor survey results could have been because of the long waits that patients experienced when they attended the walk-in surgery. The practice continued to provide the walk-in surgery as they thought that it was a useful service for the population they served.

However, the practice had gathered the views of patients by completing two surveys in the last year. The first survey, on patients overall satisfaction of the service provided, had been completed with the support of a local organisation that carried out patient surveys. Sixteen patients responded, and the practice was rated three out of five overall. Positive comments were noted, for example, on the polite staff. Negative comments largely focused on the long wait and poor appointment booking system. Sixty patients had completed the second survey, on awareness of the practice's appointment system. Following this survey, the practice had extended the walk in surgery so that it was available all year round; however, this information was not on the practice's website that told patient the walk-in surgery was not available from July to September 2016.

The practice retrospectively reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments.

We reviewed two CQC comment cards that patients had completed. Both of these were positive about the standard of care received and the staff at the practice.

On the day of the inspection we spoke with eight patients, we also asked patients to complete a short questionnaire, 11 responded. Most patients said they said they were happy with the care they received. They said they thought the staff involved them in their care and explained tests and treatment to them. They thought the practice was clean and they said that urgent appointments were always available. However, some patients said they could not make a routine appointment in a timely manner and most patients said they were not aware of the chaperone system.

We have since been able to review additional comments made to the practice by patients that were positive about the care they received by the practice.

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Areas for improvement

Action the service MUST take to improve

- Improve the governance arrangements at the practice. Specifically, the systems and processes in place to assess monitor and improve the quality and safety of the service provided.
- Ensure all significant events are reported, recorded and managed by the practice to enable lessons to be learned from these incidents to prevent their reoccurrence and to improve the outcomes for patients.
- Improve the arrangements for clinical audit in order to be able to demonstrate a clear link between audits and quality improvement.
- Ensure medicines are managed safely and appropriately. Specifically, make sure there are systems in place for ensuring that the process to monitor the distribution of blank computer prescriptions is in line with national guidance.
- Ensure that Patient Group Directions (PGD's) and Patient Specific Directions (PSD's) are implemented in accordance with national guidance.
- Ensure that complaints including verbal complaints are recorded and managed in line with the practice's own complaints policy
- Improve their arrangements for the clinical supervision of nursing staff at the practice.

Action the service SHOULD take to improve

- Record minutes of the GP meetings.
- Review the information displayed for patients in the practice waiting area. Specifically information for non-English speaking patients on the services provided by the practice.
- Improve arrangements for the provision of a patient participation groups (PPG) to ensure the views of patients are acted upon by the practice.
- Take steps to improve their identification of carers registered at the practice.
- Take steps to ensure that all staff are aware of who the safeguarding lead at the practice is.

Newcastle Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a GP specialist advisor and a specialist advisor with experience of practice management.

Background to Newcastle Medical Centre

Newcastle Medical Centre is registered with the Care Quality Commission to provide primary care services. The practice provides services to around 13,500 patients from one location. The practice has a high proportion of patients who are students. We visited this address as part of the inspection:

- Boots The Chemist, Hotspur Way, Intu Eldon Square, Newcastle upon Tyne, Tyne and Wear, NE1 7XR.

Newcastle Medical Centre is located in the centre of Newcastle upon Tyne within Boots The Chemist in the Eldon Square shopping centre. The practice serves the centre of Newcastle upon Tyne and some of the surrounding areas. All patient services are provided at lower ground floor level. The practice can be accessed by the stairs, an in store escalator or by a passenger lift. On-site parking is not available due to the practice's city centre location.

The practice population is made up of a higher than average proportion of patients who are students or of working age. 85% of patients are between the ages of 20 and 49 (CCG average 45.3%, national average 41.2%). It is located in central Newcastle, close to two universities and student accommodation. The practice told us students account for most of the patients registered at the surgery.

The practice has a lead GP (male) and three contracted GP's (one male, two female) who are contracted to provide GP services for the practice. The practice employs two practice managers, a practice nurse, a nurse practitioner, a healthcare assistant and ten staff who undertake reception and administrative duties. The practice provides services based on a General Medical Services (GMS) contract agreement for general practice.

Newcastle Medical Centre is open at the following times:

- Monday to Friday 8am to 6:30pm
- Saturday 8:30am to 5pm

The telephones are answered by the practice during their opening hours apart from on Saturdays when there is no telephone availability. This information is also available on the practice's website and in the practice leaflet. The service for patients requiring urgent medical care out of hours is provided by the NHS 111 service and Vocare, which is locally known as Northern Doctors Urgent Care Limited.

The practice runs a walk-in clinic Monday to Friday. Every patient who presents at the surgery between 8am and 9am are guaranteed to see a GP that day. In addition to this pre-bookable appointments are available at the following times:

- Monday to Friday 8:30am to 5:30pm
- Extended hours appointments with a nurse or healthcare assistant are available from 8:30am to 4:30pm on Saturday's.

The practice is part of NHS Newcastle Gateshead Clinical Commission Group (CCG). Information from Public Health England placed the area in which the practice is located in

the fifth most deprived decile. In general, people living in more deprived areas tend to have greater need for health The practice has a proportion of patients who are from ethnic minorities (2.4% mixed, 21% Asian, 3% black and 3.4% other non-white ethnic groups).

The proportion of patients with a long-standing health condition is below average (29% compared to the national average of 53%). The proportion of patients who are in paid work or full-time employment or education is above average (85% compared to the national average of 62%). The proportion of patients who are unemployed is above average (12% compared to the national average of 4%).

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 December 2016.

During our visit we:

- Reviewed information available to us from other organisations, such as NHS England. Reviewed information from the CQC intelligent monitoring systems.
- Spoke to staff and patients. This included the lead GP, a contracted GP, a locum GP, a practice manager, a nurse practitioner, a practice nurse, the healthcare assistant and two members of the reception team. We spoke with eight patients who used the service, and 11 patients completed questionnaires on the day of the inspection. We spoke with three members of the extended community healthcare team who were not employed by, but worked with the practice.
- Looked at documents and information about how the practice was managed and operated.
- Reviewed patient survey information, including the National GP Patient Survey of the practice.
- Reviewed a sample of the practice's policies and procedures.

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 were provided for specific groups of people and what good care looked 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)

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

- Most staff understood their responsibilities to raise concerns and report incidents and near misses, however, when we inspected the practice we were told of a significant event that had not been reported in line with the practice's policy. This related to a needle stick injury to a member of staff, (which the practice later told us they had reported as an accident and acted in line with their needle stick injury policy). The governance system in place did not pick up that this significant event had occurred.
- There was a recording form available for staff to use to document significant events.
- In advance of the inspection, we asked the practice to provide us with a summary of any significant events in the last 12 months, the actions they had taken in response and how learning was implemented. Details of 12 significant events were provided. For the significant events that were recorded, we saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had carried out a thorough analysis of the significant events they recorded on their significant events log. However, in addition to the additional significant event that had not been recorded we also became aware of two significant events that the practice had reported externally but not recorded internally on their significant events log. Both of these incidents involved patients who may have required additional support. The practice had not reviewed the actions taken by the practice or identified any learning that could prevent the event from reoccurring. As no review has been carried out we were unable to determine the impact of the care provided by the practice.
- Some incidents were also reported on the local cross primary and secondary care Safeguard Incident and Risk Management System (SIRMS).
- The practice had an effective system for reviewing and acting on safely alerts received.
- The practice updated the significant event policy in March 2017 and provided training to their administrative staff on the process.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, however, some of these required improvement. We found that:

- 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 whom to contact for further guidance if staff had concerns about a patient's welfare. However, the practice's child protection policy, which we were provided with on the day of the inspection did not have the date recorded when the policy needed to be reviewed by. There was a lead member of staff for adult and child safeguarding. However, four staff, including one of the GP's, were not aware of who the safeguarding lead at the practice was. Following the inspection the provider provided evidence to show that the clinical staff have now been made aware of whom the practice's safeguarding lead is. One of the GPs attended regular safeguarding meetings; they met with the health visitor each month to discuss safeguarding issues at the practice. Meeting minutes we saw did not document how these issues were fed back to the practice. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to level three in children's safeguarding.
- All staff who acted as chaperones were trained for the 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). Most patients told us that they were unaware of the chaperone system.
- The practice maintained appropriate standards of cleanliness and hygiene. We saw that the premises were clean and tidy. The nurse practitioner was the infection control lead; they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place. We saw that infection control audits were undertaken. Staff told us that they took action to address any issues raised.

The infection control lead told us that medical equipment, such as the spirometer used to help diagnose and monitor certain lung conditions, was cleaned regularly.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice were not always appropriate (including obtaining, prescribing, recording, handling, storing, security and disposal). We saw that blank prescription forms and pads were securely stored. However, we saw that the practice did not have an effective system in place to monitor the use of blank computer prescriptions. There was a system in place to monitor the use of prescription pads. The provider has told us they updated their prescription storage policy in March 2017; this included a more effective system for recording and monitoring blank computer prescriptions. Administrative staff completed training on this policy in April and May 2017. In March 2017, the practice completed an audit of prescriptions that had not been collected by patients and ensured these prescriptions were destroyed.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) We saw that several of these had not been authorised by the GP or practice manager in line with national guidance. Following the inspection the practice updated their policy for the management of PGD's to ensure they were managed correctly.
- On the day of the inspection, we asked to see the Patient Specific Directions (PSD) that had been adopted by the practice to allow the healthcare assistant (HCA) to administer medicines in line with legislation. (A PSD is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis). They were not made available. Following the inspection, the practice sent copies of the PSD's. We saw that these had been authorised by the GP, and signed by the HCA, on the 15 December 2016. Following the inspection the practice updated their policy for the management of PSD's to ensure they were managed correctly.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.
- The practice had a system in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster, which identified local health and safety representatives. The practice had an up to date fire risk assessment, this was last completed in October 2016 and no follow up actions were required. The practice took part in regular fire drills carried out by Boots the Chemist that involved the whole building. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. A variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella were in place. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available.

Requires improvement

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks were available in a treatment room. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All of the medicines we checked were in date and fit for use.
- The practice had a disaster handling and recovery plan. It Included details of actions to be taken in the event of possible disruptions to service, for example, loss of power. The plan stated that it should be reviewed every six months, however, the copy we were given was not dated, we were therefore unable to tell when this plan had last been reviewed. We also found that the plan contained an inaccurate staff list.
- The practice also had an operating manual that included the emergency procedures of Boots the Chemist that ensured they were aware of the actions required if an emergency affected the building they were situated within.

Inadequate

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.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. However, the process to ensure all staff were aware of national and local guidelines was not clear. We saw that the practice scheduled GP meetings but these were not always held. These were not routinely minuted so we were not able to see records of what was discussed. The lead GP did not attend these meetings.
- To ensure that all clinical staff were aware of new NICE guidelines the practice updated their NICE guideline policy In March 2017, new NICE guidance will now be scheduled to be discussed at a clinical meeting. This meeting is to include a review of any new guideline by a nominated clinician to ensure that the practice takes appropriate action to implement any required changes. The lead GP now regularly attends meetings at the practice.

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 most recent published results showed the practice had achieved 76.3% of the total number of QOF points available compared to the local clinical commission group (CCG) average of 96.8% and the national average of 95.3%. At 25.7%, their clinical exception-reporting rate was 16% above the local CCG average and 9.2% above the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice told us the vast majority of patients registered at this practice are students, which might explain their rate of exception reporting. The practice reviewed their QOF exception policy in March 2017 to ensure it was in line with guidance. They also agreed at a clinical meeting in April 2017 that the practice would only exception report a patient when they had been contacted three times. The third contact would be by telephone when possible.

Data from 2015/2016 showed;

- Performance for the diabetes related indicators was above the average (94.6% compared to the national average of 89.9%). The practice's clinical exception rate for diabetes was 39%, which was above the national average of 10.8%.
- Performance for the mental health related indicators was below average (76.4% compared to the national average of 92.8%). The practice's clinical exception rate for mental health was 17%, which was above the national average of 11.1%.
- Performance for the heart failure related indicators was above average (100% compared to the national average of 97.9%). The practice's clinical exception rate for heart failure was 17%, which was above the national average of 9.3%.
- Performance for the asthma related indicators was below average (63.5% compared to the national average of 97.4%). The practice's clinical exception rate for asthma was 6%, which was in line with the national average of 6.8%.
- The practice performed well in some other areas. For example, the practice had achieved 100% of the points available for ten of the 19 clinical domains, including for epilepsy and arterial fibrillation.

For the depression clinical domain the practice performance for the indicator was 0%. The practice told us they had low numbers of patients with most long-term conditions but that it was likely that the performance for depression and mental health was low due to these patients being incorrectly coded by the practice.

Following the inspection the practice provided a detailed review of their QOF performance as at March 2017 and 17 May 2017. This confirmed they had low numbers of patients with long-term conditions. The practice told us their action plan was to write to those patients who had not attended for reviews and tests. They also told us of work they were doing to improve outcomes for patients with asthma as part of the CCG practice engagement plan, this work was ongoing.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice had met in February 2017 to develop an action plan to improve the outcomes of patients with dementia.

Following the inspection the practice sent us details of their QOF performance at May 2017, the practice told us that they had made improvements in this area and we could see this. However, this data has not been verified or published; it is also not possible to determine the practice's exception reporting rate overall or for each domain.

When we inspected the practice we saw that limited quality improvement work was taking place and there was little evidence that clinical audit was driving improvements in performance to improve patient outcomes. Additional evidence has since been reviewed which demonstrated some improvements have been made since the practice was inspected.

- When we inspected the practice, we saw evidence of three single-cycle reviews. For example, we saw a single-cycle review that looked at the appropriateness of referrals made by one GP at the practice. In October 2015, a sample of the referrals made to dermatology was reviewed, this was the most common referral made by the GP who completed the clinical audit. Following this audit, the GP planned to update his treatment regime for common conditions. A second cycle of this audit, planned for October 2016, had not commenced.
- The clinical commissioning group (CCG) pharmacist completed CCG led prescribing audits at the practice.
- Following the inspection the practice showed us that they had participated in the CCG practice engagement programme to improve their prescribing performance. The practice had performed well, for example, they were achieving the targets set by the CCG for antibiotic prescribing. We also saw five additional reviews, which had been completed since the inspection.
- Since the inspection the practice provided information to show that audit meetings had been introduced. We saw that these had been held in April and May 2017, these meetings showed evidence of an improved focus on quality improvement.

Effective staffing

- The practice had an induction programme for all newly appointed staff, including locum GPs.
- The practice could demonstrate how they ensured role-specific training and updates for relevant staff. For example, for those reviewing patients with long-term conditions. Staff who took samples for the cervical screening programme had received specific training which included an assessment of competence. Most staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example, by having access to on-line resources. However, one of the nurses we spoke to on the day of the inspection was not aware of some of the recommended sources of immunisation advice, when made aware of this they were very responsive to ensuring they addressed this issue promptly.
- Staff received training which included: safeguarding, basic life support and equality and diversity. Staff had access to and made use of in-house training and external training. Staff told us the practice was supported their training needs.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. We saw that staff training needs were monitored. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included support for revalidating GPs and nurses. However, the lead GP told us that the nursing staff did not have regular clinical supervision. Following the inspection, the provider gave us information to show that in April and May 2017 the nurses and the HCA were provided with clinical supervision by the lead GP. The practice planned for this to be completed on a regular basis. Staff had received an appraisal within the last 12 months.
- The healthcare assistant who worked at the practice had originally been employed as a receptionist but had been supported by the practice to change roles. They were currently completing the Care Certificate qualification for healthcare assistants. They told us that they had received a great deal of support from one of the nurses and felt very supported by the practice in their new role.
- The lead GP and a contracted GP had undertaken a peer review of each other's practice in November 2016, this had led to training and support being identified for the contacted GP. The peer review process was expanded in March 2017 when the peer review policy was updated, we saw evidence that six of the GP's at the practice had now participated in the peer review process. The practice planned to complete GP peer reviews each quarter.

Inadequate

Are services effective?

(for example, treatment is effective)

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 and intranet systems.

- This included 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 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.
- The practice had participated in a local CCG initiative to reduce the number of unplanned admissions to hospital for patients with long-term conditions. As part of this initiative, the practice wrote to six percent (666) of the practice's registered patients to let them know of the services available as part of this work, for example, the provision of personalised care plans. Of the 34 patients that had responded, 28 now had a care plan started and a follow up appointment with the practice agreed. The practice told us that this work was more suited to practices where more patients have long-term conditions.
- Multi-disciplinary team (MDT) meetings took place each month. The district nurses and health visitors that worked with the practice were invited to attend part of the practice's meeting to discuss any areas of concern and vulnerable patients.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed their 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.

- This included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking cessation.
- The practices website provided a good range of health information and details of support services available for patients.
- Information such as NHS patient information leaflets was also available in the practice's waiting area. The practice recognised that their student population contained a high proportion of patients who did not have English as their first language, however, the practice had made little effort to ensure they effectively communicated with and responded to this particular group's needs. For instance, information that was available in the waiting area, and the patient leaflet, were only available in English.
- Following the inspection, the practice reviewed the information they provided for patients whose first language was not English. It now planned to provide the practice leaflet in Cantonese; this work will be supported by a student from the local university. It is hoped to have this support in place by June 2017.

The practice's uptake for the cervical screening programme was 26.4%, which was below the local average of 81% and national average of 81.4%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice also encouraged their patients to attend national screening programmes for bowel and breast cancer screening. The practice told us that they encouraged patients who were eligible for screening to attend for testing. However, when we inspected the practice did not have a documented plan for improvement. Cervical screening uptake at the practice remained low and no improvements in uptake could be seen over the last two years. The practice told us that they had tried over many years to increase the uptake of cervical screening with their university students, which included running clinics at the university itself. The practice was not able to continue with

this due to problems outside their control. They also told us they had offers from other organisations to support them in targeted screening but these had not materialised. The practice provided us with an updated action plan, which included an increased focus on meeting the needs of the practice's population. For example, information has now been made available in Spanish and Cantonese and eligible patients who register during the local universities 'fresher's week' will be sent information on cervical screening. However, it is not yet possible to determine if these actions have had any impact or have become embedded into practice.

Childhood immunisation rates for some of the vaccinations given were lower than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two years old ranged from 64.3% to 92.9% (CCG average 64.7% to 97.1%). For five year olds rates ranged from 68.2% to 90.9% (CCG average 90.1% to 97.4%). The practice told us they worked to encourage uptake of screening and immunisation programmes with the patients at the practice, for example, by offering opportunistic testing. They told us that as many of their patients were students they were not always at the practice for the time required to complete the immunisation programme. However, when we inspected the practice did not have a documented plan to improve the uptake of childhood immunisations. In 2017 we saw evidence that work had been initiated by the practice to improve the uptake of childhood immunisations. For example, we were told information has been displayed in the waiting area advising patients to have their children vaccinated, clinical staff were told to check children's immunisation records when they attended for other appointments and administrative staff have been advised of the correct procedures for ensuring the practice held the correct childhood immunisation records. However, it is not yet possible to determine if these actions have had any impact or have become embedded into practice.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We saw that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- On the day of the inspection, we saw that staff were caring and that they treated the patients with respect.

We reviewed two CQC comment cards that patients had completed. Both of these were positive about the standard of care received and the staff at the practice.

Results from the National GP Patient Survey, published in July 2016, showed patients were mostly satisfied with how they were treated and that this was with compassion, dignity and respect. Of those who responded:

- 91% said they had confidence and trust in the last GP they saw or spoke to (CCG average 96%, national average 95%).
- 91% said the GP they saw or spoke to was good at listening to them (CCG average 91%, national average 89%).
- 100% had confidence or trust in the last nurse they saw or spoke to (CCG average 98%, national average 97%).
- 91% said the last nurse they saw or spoke to was good at listening to them (CCG average 93%, national average 91%).

The practice gathered patients' views on the service through the national Friends and Family test (FFT). (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). Data from the most recent Friends and Family Test carried out by the practice, from July 2016 to September 2016, showed that, from 169 respondents, 69% of patients said they would be extremely likely or likely to recommend the service to family and friends. Seven percent of patients would be unlikely to recommend the service to family and friends. From October 2016 to March 2017, no responses were recorded for this practice.

Care planning and involvement in decisions about care and treatment

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

However, results from the National GP Patient Survey, published in July 2016, showed patients responses were below average to questions about their involvement in planning and making decisions about their care and treatment. Of those who responded:

- 76% said the last GP they saw was good at explaining tests and treatments (CCG average of 88%, national average of 86%).
- 82% said the last GP they saw was good at involving them in decisions about their care (CCG average 85%, national average 82%).
- 78% said the last nurse they saw was good at explaining tests and treatments (CCG average 92%, national average 90%).
- 79% said the last nurse they saw was good at involving them in decisions about their care (CCG average 88%, national average 85%).

The practice told us that due to the low response rate they had not reviewed the results of this survey; as they felt that it would not be a representative sample of patient views.

The practice had gathered the views of patients by completing two surveys in the last year. The first survey, on patients overall satisfaction of the service provided, had been completed with the support of a local organisation that carried out patient surveys. Sixteen patients responded, and the practice was rated three out of five overall. Positive comments were noted, for example, on the polite staff. Negative comments largely focused on the long wait and poor appointment booking system. The second survey focused specifically on awareness of the practice's appointment system. An additional patient survey on satisfaction with the appointment system was completed in March 2017 and the practice published this information

on their website. It plans to repeat this survey in September 2017. Results showed that most patients were satisfied; however, no questions were asked that related to the walk-in surgery.

The practice provided some facilities to help patients be involved in decisions about their care but these required review to fully meet the needs of patients:

- The practice told us that their practice list contained a large student population that contained a high proportion of patients who did not have English as their first language, information available in the waiting area, and the patient leaflet, was only available in English. Following the inspection the practice reviewed the information they provided and now some information is available in Spanish and Cantonese, the practice planned to provide more information for patients in these languages.
- Following the inspection the practice provided a detailed breakdown of the proportion of patients from ethnic minorities and by age. This confirmed what the practice had told us during the inspection, that there was a wide range of ethnicities represented in the practice population.
- Staff told us that translation services were available for patients who did not have English as a first language. When patients registered with the practice, they were asked what language they used. Staff told us that this service was well utilised by patients at the practice and that when patients who required an interpreter attended the walk-in surgery, or attended for an urgent appointment a telephone interpretation service was used.
- A hearing loop was available for patients who were hard of hearing.

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 website also provided a range of health advice and information.

The practice's computer system alerted GPs if a patient was also a carer. The practice had links to support organisations and referred patients when appropriate. The practice had identified six of their patients as being a carer (0.04% of the practice patient population). Four of the six carers on this register had an influenza immunisation completed in the last year. None of the carers on this register had had a carers health check/review in the last year. The practice told us that due to the high number of young patients that they had registered lower numbers of carers would be expected at the practice than at other practices.

The practice have responded to the issues raised by the inspection. They developed a brief action plan in March 2017 to improve the identification of carers. They updated their carer's identification protocol to ensure carers were provided with appropriate support. For example, we were told a poster asking carers to identify themselves to the practice was displayed in the waiting area. They also plan to offer carers a six-monthly review with the practice nurse to ensure appropriate care and support is provided for carers. Three new carers have been identified by the practice since we inspected the practice in December 2016.

Staff told us that if families had suffered bereavement, the practice would then offer support in line with the patient's wishes.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of their local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

The practice was aware of the needs of their practice population and provided services that reflected their needs. For example:

- When a patient had more than one health condition that required regular reviews, they were able to have all the healthcare checks they needed completed at one appointment if they wanted to.
- The practice held regular clinics to provide childhood immunisations. Childhood immunisation rates for some of the vaccinations given were lower than CCG averages.
- There were longer appointments available for patients with a learning disability, patients with long terms conditions and those requiring the use of an interpreter.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Patients could call the practice each day and receive test results from the healthcare assistant.
- The practice had a walk-in surgery Monday to Friday. Every patient who presented at the practice between 8am and 9am was guaranteed to see a GP the same day.
- Patients told us that urgent appointments were available when required. Most patients told us that routine appointments were available when required but some patients said that these were not available in a timely manner.
- Patients were able to receive a wide range of travel vaccinations. The practice was a designated yellow fever vaccination centre.
- Smoking cessation support and dietary advice was provided by the practice.
- There were disabled facilities, a hearing loop and translation services were available.
- Patients could order repeat prescriptions and book GP appointments on-line.
- There was information for patients available in the waiting room and reception area.
- The practice provided contraceptive and sexual health advice to patients.
- Telephone appointments were available.
- Extended hours pre-bookable appointments with a nurse or a healthcare assistant were available each Saturday. The lead GP was on call and available for any clinical queries, however, they were not at the practice when these appointments were carried out.

We also found that:

- The practice had worked with the local community team for learning disabilities to improve the support they provided for patients with learning disabilities.
- The practice had undertaken work to improve the service they offered for patients with mental health conditions. A psychologist had attended the practice to discuss best practice and the services available to patients in the area. Appointments are available with this psychologist at the practice each week.

Access to the service

The practice ran a walk-in clinic Monday to Friday. Every patient who presented at the surgery between 8am and 9am was guaranteed to see a GP that day. Patients were seen in order of attendance, if they attended after 9am patients asked to book an appointment.

Appointments were available at the practice at the following times:

- Monday to Friday 8:30am to 5:30pm
- Extended hours appointments with a nurse or healthcare assistant were available from 8:30am to 4:30pm on Saturday's.

Results from the National GP Patient Survey, published in July 2016, showed that patients' satisfaction with how they could access care and treatment was below local and national averages. Of those who responded:

- 51% of patients were satisfied with the practice's opening hours (CCG average 81%, national average of 76%).
- 58% patients said they could get through easily to the surgery by phone (CCG average 79%, national average 73%).
- 62% patients said they able to get an appointment or speak to someone last time they tried (CCG and national average 85%).

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 43% feel they normally don't have to wait too long to be seen (CCG average 60%, national average 58%).
- 46% describe their experience of making an appointment as good (CCG average 76%, national average 73%).

The practice told us that due to the low response rate they had not reviewed the results of this survey; as they felt that it would not be a representative sample of patient views.

Sixty patients had completed a practice survey on patient's awareness of the practice's appointment system in June 2016. Following this survey, the practice had extended the walk in surgery so that it was available all year round; however, this information was not on the practice's website that told patient the walk-in surgery was not available from July to September 2016.

An additional patient survey on satisfaction with the appointment system was completed in March 2017 and the practice published this information on their website. It plans to repeat this survey in September 2017. Results showed that most patients were satisfied; however, no questions were asked that related to the walk-in surgery. The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments.

Most patients told us they were able to get urgent appointments when they needed them.

The practice had a system in place to assess:

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

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

On the day of the inspection we spoke with eight patients, we also asked patients to complete a short questionnaire, 11 responded. They told us that urgent appointments were available when required. Most patients told us that routine appointments were available when required but some patients said that these were not available in a timely manner. On the day of the inspection, there was a routine appointment with a nurse available the next day. A routine GP appointment was available in two working days.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice; GPs provided clinical oversight when required.
- We saw that information was available to help patients understand the complaints system. Information was on display in the reception area, in the practice leaflet and on the practice website. The information on the practices' website could be translated into many languages; all written information was available in English only.

We looked at two of the six complaints received in the last 12 months; and found that these were dealt with in a timely way and with openness and transparency. However, staff told us that they did not record all the verbal complaints they received. The lead GP told us that they received a lot of verbal complaints, despite this only six complaints had been recorded in the last 12 months. We reviewed the log of complaints that the practice provided us with prior to the inspection and it was not clear if any of these complaints had been made verbally. The practices complaints policy states that comments and concerns made by patients 'are really complaints and need to be handled as such'. However, this was not happening at the practice.

Following the inspection, the practice updated their complaints policy in March 2017. As part of this, they planned to ask people who complained to complete a short questionnaire on the process. Staff have been made aware of the need to record verbal complaints and additional information has been made available for patients. Information on how to complain is also now available in Spanish and Cantonese. We have not seen any evidence that shows if these changes had had any impact yet.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

- When we inspected the practice in December 2016 there were no clear or realistic plans to achieve the vison, values and strategy of the practice. An action plan was developed by the practice in March 2017 in response to areas of concern highlighted by the inspection. It is not yet possible to determine if this action plan has been effective. However, it included work to address many of the areas of concern identified.
- The practice aims included 'the provision of excellent patient care delivered in a clean, suitably equipped and safe environment' and 'all patients and users of the practice will be treated with dignity and respect'.
- The practice had a mission statement, which included their aims to 'treat our patients with dignity and respect' and 'thoroughly discuss the care and treatment we can provide for our patients'.
- When we inspected the practice we saw that the practice had developed a draft business development plan for 2013-2018; this was last reviewed in August 2016. However, the plan had not been updated to reflect the current management of the practice. It still referred to the practice as having partners when this was no longer the case. The goals and objectives the plan contained all ended by 2014 and more recent goals and objectives had not been recorded. Following the inspection the practice showed us an updated action plan for 2016-2020 that included more recent objectives.
- The practice told us that they were proud of their walk in surgery and that it was responsive to the needs of their population. However, we found that the feedback from patients about this service was frequently negative due to the long wait to see a GP. No effective plans had been put in place to address patient concerns so that patients would have a better experience of patient care when attending the walk in surgery. The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments.

Governance arrangements

When we inspected the practice in December 2017 we found that the practice's governance framework did not effectively support the delivery of their strategy and good quality care. Additional information provided by the practice demonstrated some improvement in the practice's governance framework had recently been made.

- There was a documented leadership structure and staff felt supported by management. However, not all staff were aware of who the practice's safeguarding lead was. The practice has taken steps to ensure staff knew who was responsible in terms of lead roles in the leadership structure.
- Most staff understood their responsibilities to raise concerns and report incidents and near misses at the practice. However, the practice did not always understand their responsibility to review significant events.
- Practice specific policies were implemented and were available to all staff.
- When we inspected the practice limited quality improvement work was taking place and there was little evidence that clinical audit was driving improvements in performance to improve patient outcomes. Additional evidence has since been reviewed which demonstrated some improvements have been made since the practice was inspected.

Leadership and culture

On the day of the inspection the lead GP told us they prioritised safe, high quality and compassionate care. Staff told us the GP's were approachable and always took the time to listen to members of staff.

The provider was aware of and complied with the requirements of the duty of candour regulation.

(The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The practice had systems in place for knowing about notifiable safety incidents.

- The practice told us they held regular meetings. However, when we reviewed the meetings that had been planned since May 2016 we saw that a large number had not taken place. For example, the practice scheduled a weekly meeting that alternated between a staff meeting, a nurses meeting and staff training time. Eighteen of the scheduled 29 meetings had not taken place; the practice told us that this was due to annual leave and the need to register large numbers of new patients at the start of the university year. The practice

Are services well-led?

Inadequate

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

had scheduled five GP meetings in the last year. Two of these meetings had been cancelled and the three that had been held were only attended by two of the contracted GP's, the lead GP did not attend these meetings and they were not routinely minuted, therefore no formal records were made of the discussions. The practice told us that they regularly held informal meetings with clinical staff. The practices meeting policy was reviewed in March 2017, as part of this they introduced protected time for staff to ensure they were available to attend meetings that supported the management of the practice or care of patients. Minutes of meetings held since this review showed that the practice now held regular meetings and that records of these meetings were clearly documented and the lead GP now regularly attended meetings held at the practice.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident in doing so and were supported if they did.
- Practice specific policies were implemented and were available to all staff.
- Staff said they felt respected, valued and supported by the partners.

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

The practice had taken some steps to gather feedback from patients, however, these required improvement.

- The practice told us that they found it hard to establish an active patient participation group, the practice website and information in the waiting area asked patients if they would be willing to join a virtual patient participation group. Following the inspection the practice had undertaken work to recruit members to the PPG. This involved completing an 'improve our services' survey in April 2017. GP's also asked patients directly if they would be interested. Following this, six patients agreed to join a PPG and attend meetings, three patients agreed to join a virtual PPG. Meetings have yet to be held.
- The practice had carried out a patient survey in February 2016, the survey noted that most patients spoke positively of the staff at the practice, however, the majority of the negative comments made related to the walk-in surgery the practice provided, the practice did not have an effective plan in place to address these concerns. The practice had also completed a survey on patient awareness of the appointment system in June 2016. Following this survey, the practice had extended the walk in surgery so that it was available all year round; however, this information was not on the practice's website that told patient the walk-in surgery was not available from July to September 2016. The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments.
- The practice gathered some feedback from patients through the complaints they received. Following the inspection, the practice took action to improve how they recorded and responded to verbal complaints.
- The practice had gathered feedback from staff through staff meetings and discussion. Action had been taken by the practice to improve the governance of meetings. However staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The practice had taken steps to address most of the concerns raised at a previous inspection:

For example:

- The practice had complied with the requirement notices we set following the last inspection. Care plans were in place and recruitment checks were carried out in line with Schedule 3 of the Health Care Act 2008.
- We saw that the practice had acted to address some of the actions we told them they should take. Staff were fully aware of fire procedures at the practice and the practice held records to demonstrate the maintenance, servicing and calibration of equipment at the practice. The practice were not able to demonstrate they had maintained an effective audit trail for all prescription forms.

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was a lack of systems and processes in place to assess monitor and improve the quality and safety of the service provided. The practice's systems and processes with respect to significant events did not ensure that such events were recognised, reported, recorded and effectively managed. The practice audit and governance systems were not effective. The practice did not have an up to date plan to achieve their business goals and objectives. The practice did not have plans in place to show how the practice would improve on its performance. Complaints were not managed in line with national guidance. Nursing staff at practice were not supported by the provision of clinical supervision. The governance system of the provider did not ensure the safe management of medicines. They had not made sure that: Patient Specific Directives and Patient Group Directions were adopted in line with national guidance. Blank computer prescription were not managed in line with national guidance. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.