Marine Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Marine Medical Group on 16 July 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- 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.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice offered pre-bookable early morning appointments two days per week with the GP or practice nurse, which improved access for patients who worked full time.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team.

However there were areas of practice where the provider needs to make improvements.

The area where the provider must make improvements is:

Summary of findings

- The practice must take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

In addition the provider should:

- Review the level of safeguarding children training to be completed by the healthcare assistant in line with the latest guidance.
- Make arrangements for a fire drill to be completed as soon as is practicably possible.

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 understood their responsibilities to raise concerns, and to report incidents and near misses. We found significant events were recorded, investigated and learned from. Risks to patients were assessed and well managed. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them. Good infection control arrangements were in place and the practice was clean and hygienic. There was enough staff to keep patients safe. The practice must take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training and any further training needs had been identified. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear set of aims and objectives. Staff were clear about their responsibilities in relation to these. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had a virtual patient participation group (PPG) that was active, although the two members of the group we spoke with expressed a wish to meet in person too. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. They offered proactive, personalised care to meet the needs of the older people in its population. For example, patients at high risk of hospital admission and those in vulnerable circumstances had care plans. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The practice offered annual health checks to all of their patients over the age of 75.

The practice maintained a palliative care register and end of life care plans were in place for those patients it was appropriate for. They offered immunisations for pneumonia and shingles to older people and provided flu vaccinations to older people as a priority.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients were offered a structured review at least annually to check that their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. A traffic light system was used to highlight those patients that required more intense input from the clinical team. In addition to the red, amber and green categories, the practice used a 'blue' category. This was to identify patients who were not currently in receipt of palliative care, but had been identified as being at risk of requiring it in the future. The list was reviewed on a regular basis and discussed at multidisciplinary meetings.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were

Summary of findings

recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. NHS health checks were offered to patients between the ages of 40 and 74.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 88% of these patients had received a follow-up in 2014/15. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 94% of people experiencing poor mental health had agreed care plans in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. 98.6% of patients identified as living with dementia had received an annual review in 2014/15 and had agreed care plans in place.

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The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 11 patients in total; 10 patients on the day of the inspection (including one member of the practice's Patient Participation Group (PPG)) and one from the PPG the day after the inspection. They were mostly complimentary about the services they received from the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system.

The National GP Patient Survey results published in July 2015 showed the practice was performing in line with, and in some cases above local and national averages. There were 286 surveys sent out and 101 responses received, which represents a return rate of 35%.

- 85% find it easy to get through to this surgery by phone compared with a CCG average of 74% and a national average of 71%.
- 88% find the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 84% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 97% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 83% describe their experience of making an appointment as good compared with a CCG average of 76% and a national average of 73%.
- 91% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 74% and a national average of 65%.
- 76% feel they don't normally have to wait too long to be seen compared with a CCG average of 68% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards; 22 of which were entirely positive about the standard of care received. Of the 25 CQC comment cards completed, 14 patients made direct reference to the caring and respectful manner of the practice staff. Words used to describe the staff and their approach to patients included helpful, friendly, treat with dignity and respect, polite, ready to listen and caring. Three of the comment cards we received raised some areas where these patients felt the practice could improve. This included the availability of appointments, the opening hours and telephone access.

Areas for improvement

Action the service MUST take to improve

- Take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

Action the service SHOULD take to improve

- Review the level of safeguarding children training to be completed by the healthcare assistant in line with the latest guidance.
- Make arrangements for a fire drill to be completed as soon as is practicably possible.

Marine Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Marine Medical Group

The practice is based within Blyth Health Centre in Blyth, Northumberland. The practice serves people living in the Blyth area and extends as far South as Seaton Sluice. The practice provides services to patients from one location: Blyth Health Centre, Thoroton Street, Blyth, Northumberland, NE24 1DX. We visited this address as part of the inspection.

The practice is located in a purpose built building and provides services to patients at ground floor level. They offer on-site parking including disabled parking, accessible WC's and step-free access. They provide services to around 10,500 patients of all ages based on a Primary Medical Services (PMS) contract agreement for general practice.

The practice has four GP partners and seven GPs in total (three male, four female). There are also two practice nurses, one healthcare assistant, a practice manager, an IT / medicines manager, office manager, administrator, two medical secretaries and nine reception and administrative support staff.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments were available from 8.30am to 10.00am every morning and from 3.00pm to 5.00pm every afternoon. Extended hours surgeries were offered on Monday and Wednesday mornings between 7.30am and 8.30am.

Information taken from Public Health England placed the area in which the practice was located in the third more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile is weighted towards a slightly older population than national averages. There are more patients registered with the practice over the age of 65 years than the national averages.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 Care Quality Commission at that time.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

• Older people

• People with long-term conditions

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

Before visiting, we reviewed a range of information that we hold about the practice. This highlighted one area to follow-up and this can be found within the effective key question. We also asked other organisations to share what they knew. This included the local clinical commissioning group (CCG).

We carried out an announced inspection on 16 July 2015. We visited the practice's surgery in Blyth. We spoke with 11 patients in total and a range of staff from the practice. We spoke with the practice manager, four GPs, a GP registrar, a practice nurse, a healthcare assistant, the IT/medicines manager and three of the reception and administrative support staff on duty. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 25 CQC comment cards where patients from the practice had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out an analysis of the significant events and this also formed part of the GPs' individual revalidation process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a patient had been incorrectly registered with the practice. As a result, reception staff insisted patients provided identification that included their date of birth and address in order to reduce the risk of this happening again.

Safety was monitored using information from a range of sources, including NPSA and NICE guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice could demonstrate its safe track record through having risk management systems in place for safeguarding, health and safety including infection control, and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that they could request a chaperone, if required. The practice nurses or healthcare assistant carried out this role. All staff who acted as chaperones were trained for the role and had received a disclosure and barring service check (DBS). These 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.
- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy available with a poster on display. The practice had fire risk assessments that were held by NHS Property Services (who owned the premises); however the most recent fire drill had been carried out in October 2012. The practice had raised this with NHS Property Services and this needed to be addressed. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice had raised some concerns with NHS Property Services about the quality of domestic cleaning provided at times and the practice was monitoring this. One of the GP partners was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice had Legionella risk assessments carried out by NHS Property Services and completed regular monitoring.
- Recruitment checks were carried out and the files we sampled showed that 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 checks through the Disclosure and Barring Service.
- 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.

Requires improvement

Are services safe?

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a process in place for ensuring that medicines were kept at the required temperatures; however we found this had not always been followed. Refrigerator temperature checks were carried out by one of the practice nurses. We checked the records of the refrigerator temperatures made and found the maximum temperature recorded during the week prior to the inspection had been 14 degrees Celsius. This is outside the recommended range for the safe storage of vaccines contained within the refrigerator of between two and eight degrees Celsius. The refrigerator did not have data logging equipment attached to it, so we were unable to identify precisely the length of time the refrigerator had operated at this temperature. No action had been taken with regards to this temperature reading, which presented a risk to the safety of these medicines. The practice nurse we spoke with was not aware of what should happen when the temperature recorded was outside of the recommended range. We informed the practice manager of our findings immediately and saw they took the appropriate remedial action. The practice also provided us with an update and detailed timeline of events after the inspection. This included advice taken from the local screening and immunisation team and confirmation that the affected vaccines had been quarantined, and then disposed of.

The nurse practitioner used Patient Group Directions (PGDs) to administer vaccines and other medicines. The health care assistant had been trained to immunise patients; however they had administered flu vaccines to patients without using Patient Specific Directions (PSDs) that had been produced by the prescriber. A PSD is an instruction to administer a medicine to a list of named patients where each patient on the list has been individually assessed by that prescriber. The prescriber must have knowledge of the patient's health, and be satisfied that the medicine to be administered serves the individual needs of each patient on that list. In this case the healthcare assistant had previously run influenza immunisation clinics without the prescriber having reviewed the patients planned to attend the clinic or producing a list of those that they authorised to be immunised.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not always handled in accordance with national guidance. They were stored securely in a locked cupboard and comprehensive records were kept of loose-leaf prescriptions as they were used. However records were not kept of the first and last serial numbers of boxes of loose-leaf blank prescriptions on receipt into the practice. This presented a risk, as the practice would not be able to identify or report the serial numbers of any prescription forms that were misdirected or lost. The member of staff with responsibility for prescriptions said they would introduce a system for this straight away.

Processes were in place to check medicines were within their expiry date and suitable for use. The medicines we checked were within their expiry dates.

There was a protocol for repeat prescribing which was followed in practice to ensure that patients' repeat prescriptions were still appropriate and necessary.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Arrangements to deal with emergencies and major incidents

There was a messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

Requires improvement

Are services safe?

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The practice carried out assessments and treatment in line with NICE best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, the practice had adopted the 'Diabetes Year Of Care' model to help and encourage their patients living with diabetes to manage their condition. The practice monitored that any guidelines used were followed through audits and random sample checks of patient records.

Patients' consent to care and treatment was always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Protecting and improving patient health

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. A total of 63 referrals had been made to 'Health Start' for exercise and physical activity and smoking cessation advice was available. In Q4 2014/15, a total of 20 patients had been seen for smoking cessation and 65% of these had stopped smoking after four weeks.

The patients we spoke with were consistent in telling us the GPs and nurses regularly spoke with them about their lifestyles. This included giving them advice and support with regards to exercise, diet, consumption of alcohol and smoking cessation where this was relevant.

The practice's uptake for the cervical screening programme was 84.96%, which was higher than the national average of 81.88%. The practice also encouraged its patients to attend national screening programmes such as breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to the local clinical commissioning group (CCG) averages. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 94.4% to 98.4% and five year olds from 93.5% to 99.1%. Flu vaccination rates for the over 65s were 63.9%, and at risk groups 78.4%. These were also above the national averages of 52.3% and 73.2% respectively.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. A total of 1,469 NHS Health Checks had been completed since August 2010. Appropriate follow-up on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. For example, 52 patients had been prescribed a 'statin' medicine (a cholesterol lowering medicine) following their NHS Health Check.

Co-ordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for

Good

Are services effective?

(for example, treatment is effective)

the QOF and performance against national screening programmes to monitor outcomes for patients. Current results for 2014/15 were 97.6% of the total number of points available. This practice had been an outlier in 2013/14 on agreeing care plans with patients living with mental health conditions. Only 19.6% of their patients had agreed care plans in place in 2013/14 compared to the national average of 86%; however this had improved to 94% in 2014/15. The latest publicly available QOF data from 2013/14 showed:

- Performance for diabetes related indicators was similar to the national average (89.9% compared to 90.1% nationally).
- Performance for asthma related indicators was better than the national average (100% compared to 97.2% nationally).
- Performance for mental health related indicators was below the national average (85% compared to 89.4% nationally).
- The percentage of patients diagnosed as living with dementia whose care had been reviewed in the preceding 12 months was lower than the national average (72.9% compared to 83.8% nationally). The practice had improved this to 98.6% for 2014/15.

Clinical audits were carried out and all relevant staff were involved to improve care and treatment and people's outcomes. There had been 17 clinical audits completed in the last four years; 11 of these were completed audits where the improvements made were checked and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken as a result included improvements in the discussion with patients and recording of risks associated with the use of combined oral contraceptive pills (COCP).

Information about patient's outcomes was used to make improvements. For example, secondary care referral patterns were reviewed within the practice, with reduced numbers of referrals achieved in some areas.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision, and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Most staff had completed safeguarding children training to the recommended levels; however the healthcare assistant had only completed training to level one. The intercollegiate document published by the Royal College of Paediatrics and Child Health 2014 recommends that healthcare assistants should be trained to level two. The practice manager said they were aware some staff were approaching the point where they needed to update their mandatory training and they were attempting to source this.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients; both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

22 of the 25 patient CQC comment cards we received were wholly positive about the service experienced. The patients who completed the other three comment cards were mostly positive, with each making one suggestion where the practice could improve the service for them. We shared these suggestions with the practice management. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We also spoke with two members of the practice's patient participation group (PPG) on the day of our inspection and the following day. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Notices in the patient waiting room told patients how to access a number of support groups and organisations. The results from the latest National GP Patient Survey showed 88% of patients who responded said they found the receptionists at the practice helpful; compared to the CCG average of 89% and national average of 87%.

The practice's computer system alerted GPs if a patient was also a carer. Patients identified as carers were being supported, for example, by offering health checks. Written information was available for carers to ensure they understood the various avenues of support available to them.

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

Results from the National GP Patient Survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with doctors and well above local and national averages for nurses. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 89% and national average of 87%.
- 88% said the GP gave them enough time compared to the CCG average of 88% and national average of 85%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 92%
- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 83%.
- 86% said the nurse was good at listening to them compared to the CCG average of 82% and national average of 78%.
- 87% said the nurse gave them enough time compared to the CCG average of 84% and national average of 79%.
- 93% said they had confidence and trust in the last nurse they saw compared to the CCG average of 89% and national average of 85%
- 85% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 82% and national average of 77%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey we reviewed showed patients responded positively to questions about

Good

Are services caring?

their involvement in planning and making decisions about their care and treatment. Results for GPs were in line with local and national averages and for nurses were above the local and national averages. For example:

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 81%.
- 72% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 74%
- 85% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 76%.
- 75% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 69% and national average of 65%

Staff told us that translation services were available for patients who did not have English as a first language.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example one of the GP partners told us the CCG had been open to their work on how to support patients with learning disabilities. This included the facilitation of joint annual health checks in partnership with a community based learning disability nurse.

The practice had a virtual patient participation group (PPG) of around 30 patients who they communicated with by email. We spoke with two members of the group and they both expressed a preference for meeting as a group in person in addition to the virtual arrangements. We gave this feedback to the IT manager who had responsibility for the group. Members of the group were contacted on a regular basis and asked for their opinion on what should be included within the practice's own patient surveys. The group were asked to suggest areas where the practice could improve the services they offered. Examples of improvements delivered as a result included a new telephone system to reduce the length of time patients waited on the telephone and the introduction of lunchtime surgeries during times of high patient demand.

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

- The practice offered appointments on a Monday and Wednesday morning from 7.30am for patients who could not attend during normal opening hours.
- Appointments with GPs could be booked online.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice had a supply of commonly used easy read leaflets. This included on cervical screening, bowel and breast screening.
- Block appointments could be made for family members to see GPs or nurses.

Other reasonable adjustments were made and action was taken to remove barriers when people found it hard to use or access services. For example the practice had placed posters about help that was available for patients subject to domestic violence in the male and female patient toilets. This was deliberately done to allow those patients to be able to make a note of the telephone numbers without being seen by others.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were available from 8.30am to 10.00am every morning and from 3.00pm to 5.00pm every afternoon. Extended hours surgeries were offered on Monday and Wednesday mornings between 7.30am and 8.30am. In addition to pre-bookable appointments that could be booked up to three weeks in advance, urgent appointments were also available. The practice had also run lunchtime surgeries in the event of increased demand from their patients on occasion.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. Routine appointments to see a GP were available to be booked the next day, as were appointments to see the healthcare assistant. Appointments to see a practice nurse were available to be booked in two working days' time. Urgent same-day appointments were made available for patients each day. The practice offered same day telephone consultations with a GP and practice nurse too. This helped to improve same day access to the service for the practice's patients.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages. For example:

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 85% patients said they could get through easily to the surgery by phone compared to the CCG average of 74% and national average of 71%.
- 83% patients described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%.
- 91% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 74% and national average of 65%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. This included leaflets in the patient waiting area, information within the practice leaflet and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

We saw the practice had received 12 formal complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. Formal reviews of complaints received by the practice were completed on a quarterly basis.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a number of aims and values that were central to the services they provided. These included:

- To provide high quality health care
- To provide a patient centred, caring, friendly service
- To treat patients with respect and dignity
- To provide patients with evidence based, personalised care

Staff we spoke with showed they shared these values, and they consistently spoke about the care of patients being their main priority.

The practice had identified a number of key clinical and non-clinical business objectives for the current year. Non-clinical objectives included plans for succession planning and recruitment and the continuing expansion of the population of Blyth. Clinical objectives included continuing with their focus on patient groups such as patients living with dementia, patients with caring responsibilities and patients living with diabetes.

Governance arrangements

The practice had an overarching governance policy. This outlined the structures and procedures in place.

Governance systems in the practice were underpinned by:

- A clear staffing structure and a staff awareness of their own roles and responsibilities.
- Named members of staff took on lead roles. For example, one GP partner led on infection control, learning disabilities and dementia and one of the salaried GPs led on safeguarding and family planning.
- Practice specific policies that were implemented and that all staff could access.
- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place.
- A system of continuous audit cycles and an audit programme which demonstrated an improvement on patients' welfare.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- Proactively gaining patients' feedback and engaging patients in the delivery of the service. Acting on any concerns raised by both patients and staff.
- The GPs were all supported to address their professional development needs for revalidation and all staff in appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints.

Innovation

The practice team was forward thinking and part of local schemes to improve outcomes for patients in the area. For example, the practice had participated in local and national audits on topics such as dementia and cognitive enhancers (local) and on diabetes (national).

The practice was performing above the national average for cervical screening; however they recognised there was still room for improvement. A local 'pink letter' programme to promote the uptake of cervical screening was due to be rolled out and the practice intended to participate in this.

The practice used a traffic light system to identify it's at risk patients. These were discussed on a monthly basis at multidisciplinary team (MDT) meetings. In addition to the red, amber and green categories (used to identify the risk of serious illness); the practice used a 'blue' category. This was used to identify patients who were not currently in receipt of palliative care, but had been identified as being at risk of requiring it in the future.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **Care and treatment was not provided in a safe way for service users because some aspects of the management of medicines were unsafe. Specifically:** • Monitoring records showed some temperature sensitive medicines were being kept in a refrigerator whose temperature had exceeded the recommended safe maximum temperature. No action had been taken in response to this and staff involved with the recording of refrigerator temperatures were not aware of the process to follow. • The health care assistant had administered flu vaccines to patients without using Patient Specific Directions (PSDs) that had been produced by the prescriber. • Blank prescription forms were not always handled in accordance with national guidance, as records were not kept of the first and last serial numbers of boxes of loose-leaf blank prescriptions on receipt into the practice. (Regulation 12(1)(2)(g))