Station Medical Group

Quality Report

Station Medical Group
Gatacre Street
Blyth
Northumberland
NE24 1HD
Tel: 01670 542630
Website: www.stationmedicalgroup-blyth.nhs.uk/

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Station Medical Group on 14 October 2014.

We rated the practice overall as: Good

Our key findings were as follows:

- Feedback from patients was positive, they told us staff treated them with respect and kindness.
- The patient participation group were complimentary about the practice and explained their relationship with it as constructive and collaborative.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practice was clean.

We saw areas of outstanding practice:

The practice had participated in a multidisciplinary initiative to successfully address the prescribing of unnecessary medicines to people in care homes.

The practice worked collaboratively with other health care agencies. For example, for patients that were at a high risk of emergency hospital admission the practice had produced emergency health care plans which were readily available to other relevant agencies.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated widely to support improvement to practice. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs had been identified and planned. All staff in the practice received appraisals and from this had developed personal development plans. Multidisciplinary working was evidenced between community services such as health visitors.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Some patients reported difficulty in accessing appointments, but we saw the practice had implemented improvements to address these concerns and was continually evaluating this. Patients reported that they had access to a named GP and continuity of care, in particular patients at nursing and residential care homes. Urgent appointments to see a GP were available the same day. Patients who required emergency treatment were seen quickly.

Summary of findings

There was a complaints system. Review of complaints demonstrated that the practice responded quickly to issues raised. There was evidence of learning from complaints and incidents with staff and other health care professionals. The practice had implemented suggestions for improvement and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG).

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

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 the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and undertook weekly visits to residential care and nursing homes.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals to secondary care made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All patients with a long term condition had a named GP and received regular GP and district nurse reviews to check their health and medication needs were being met. For those people 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

Not sufficient evidence to rate

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, there were weekly multidisciplinary child protection meetings. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. Health visitors were based at the practice where they held child health clinics and breastfeeding groups met. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students).The needs of this group of patients 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, pre-bookable Saturday morning appointments and online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients who may be more vulnerable, such as people with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities and other patients who required them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the population group of people experiencing poor mental health (including people with dementia). 95.3% of people with physical or mental health conditions had received an offer of support and treatment within the last 15 months. 86.4% of patients with dementia had their care reviewed within the preceding 15 months. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had signposted patients experiencing poor mental health to support groups, including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. 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 two members of the practice Patient Participation Group (PPG) during the inspection. We also spoke with 18 patients. The majority of patients were complimentary about the services they received at the practice. The patients we spoke with reported they felt safe and had no concerns when using the service. They told us that all staff treated them with dignity and respect. Some patients raised concerns with us about the process of booking routine appointments. However they told us that they could always get an emergency appointment on the same day.

We reviewed 13 CQC comment cards completed by patients prior to the inspection. Most were complimentary about the practice, staff who worked there and the quality of service and care provided. Words used to describe the practice were excellent service, excellent practice, staff good, always listened to, extremely approachable friendly.

The latest GP Patient Survey completed in 2013/14 showed the large majority of 127 patients who responded were satisfied with the services the practice offered. The results were:

- Contact practice by phone – 49%
- The last GP they saw or spoke to was good at giving them enough time - 93%
- The last GP they saw or spoke to was good at listening to them - 93%
- Surgery opening hours – 67%
- Overall satisfaction – 79%
- Patients who would recommend the practice: 63%

The practice carried out its own survey in 2013 - Improving Practice Questionnaire. 243 patients had provided feedback. The practice achieved a score of 56% for patients who were satisfied with the day and time arranged for their appointments. This is lower than the National score of 66%. They also achieved a score of 87% of patient who would recommend the doctors/nurses they had seen to their friends. This is higher than the National score of 81%.

Outstanding practice

The practice had participated in a multidisciplinary initiative to successfully address the prescribing of unnecessary medicines to people in care homes.

The practice worked collaboratively with other health care agencies. For example, for patients that were at a high risk of emergency hospital admission the practice had produced emergency health care plans which were readily available to other relevant agencies.

Station 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, CQC inspectors and a

- A specialist advisor with experience of GP practice management

Background to Station Medical Group

The provider is a partnership of five GPs. There are also two salaried doctors, two practice nurses and one health care assistant. The practice also has a medicines manager, two practice nurses, one healthcare assistant, a practice manager, a deputy practice manager and nine reception and administrative staff. They are supported within the practice by the health visiting team, district nurses, midwives and dieticians who were employed by the local NHS trust.

The practice has a patient population of about 9,000 patients. The practice area covers Blyth, Newsham, Seaton Sluice and parts of Bebside. There are five GP partners and two salaried GPs. There were five female GPs in the practice.

The practice, in collaboration with Newcastle University, provides support and training placements to third and fifth year medical students.

The practice has opted out of providing out-of-hours services to their own patients. Out of hours services are provided by the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new 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 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.

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and the NHS Local Area Team (LAT).

We carried out an announced visit on 14 October 2014. During our visit we spoke with a range of staff. This included GPs, Practice Nurses, Healthcare Assistants, Reception and Administrative staff. We also spoke with 18 patients who used the service. We reviewed 13 CQC comment cards where patients and members of the public shared their views and experiences of the service. We also made observation of the environment and the interactions between patients and non-clinical staff in the public areas.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, the practice identified and investigated significant events occurring in the practice. We saw evidence of three significant events which had been identified, reviewed, analysed, identified learning and improvement as a result. The learning from the review of incidents was shared with appropriate colleagues within the practice. Where improvements had been implemented we saw the practice had set a date to evaluate the changes to see if they had been sustained.

We saw significant events which had been discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events. We saw three significant or critical events had been recorded in 2014. We saw details of the event, key risk issues, specific action required and learning outcomes and action points were noted. There was evidence that significant events audits were discussed at clinical meetings, which ensured learning was disseminated and implemented.

We saw the practice had processes in place to ensure patient safety alerts were identified and acted upon. For example the practice held fortnightly meetings where they discussed medicine management and significant events among other topics. We were told that the medicines manager regularly reviewed and monitored prescribing at the practice. They also regularly met up with clinical colleagues to update them and review their prescribing practice.

Reliable safety systems and processes including safeguarding

We saw evidence that staff had either received safeguarding training appropriate to their role or were scheduled to undertake it. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Staff told us that the contact details for other agencies was easily accessible.

There were separate GP leads for safeguarding of children and vulnerable adults. There were weekly multi agency child protection safeguarding meetings where any concerns were raised, attendances to the practice or families in need were discussed. The practice also held weekly child health clinics which gave the practice an opportunity to monitor children's wellbeing. This allowed the practice to monitor and plan for the needs of the most vulnerable families and patients within the practice population.

The practice had a process for fast tracking patients to speak to the emergency on call GP. For example, staff were trained to recognise when patients were experiencing mental health problems and in distress or behaving as if they had mental health problems and would track them to the on call GP.

The practice told us that it had a very good working relationship with a sector psychiatrist who attended the quarterly meetings to discuss patients and provided teaching. This increased awareness and information sharing, which helped support the practice in caring for vulnerable patients.

A chaperone policy was in place. Nursing and health care assistants would act as a chaperone. If none were available a GP would chaperone. We saw that there was a poster in the reception area displaying information about the chaperone service.

Medicines Management

The practice had a medicines manager whose role includes auditing and monitoring the prescribing activity of the practice. They had a policy to reviewing patients on repeat prescriptions. The practice also had a policy for controlled medicines that covered the purchasing, ordering and recording of those medicines. They also undertook medication audits that were used to identify if patients prescriptions needed changing.

The practice held stocks of controlled medicines (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, we saw that all medicines were stored in accordance with the relevant legislation and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of medicines.. There was clear process of what to do in the event of missing, lost or stolen prescriptions.

We saw that the practice undertook audits of their medicine prescribing. For example we saw that they had undertaken audits of antibiotic prescribing every six months. A recent audit found that some GPs were prescribing more antibiotic than others. This issue was scheduled for discussion by the GPs the day after our inspection.

Staff told us that in collaboration with the local NHS Foundation Trust the practice had implemented an initiative to work with a multidisciplinary team to review medication in their care homes. With a view, in consultation with patient and their representatives to reducing medicines that may have been prescribed unnecessarily. Following this initiative we were told that the level of prescribing had been reduced and patients' wellbeing had improved.

The practice had a safe system for reviewing patients discharged from hospital. Where patients had been discharged from hospital the medicines manager would routinely review their medication and make any necessary changes and pass the prescriptions to the GPs to check and authorise as appropriate. This demonstrated that staff understood their roles and limitations in this area. This also ensured that patients were prescribed appropriate medication.

We checked the medicine refrigerators and found they were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice used a cleaning contractor to clean the premises. The practice manager explained that they regularly checked the cleanliness of the practice and if they had any concerns they would contact the contractor by telephone and address them.

The practice explained that following the announcement of our inspection they realised that they did not have an infection control policy. We were told that with the assistance of GPs, the practice manager and a practice nurse had written an infection control policy that they intend to implement immediately but recognised that it required more work. However, we saw records that showed all staff received induction training which included infection control guidance specific to their role. Some of the training was provided by a computer course which included guidance on disposing of clinical waste, handling sharps and dealing with needle stick injuries.

Hand hygiene techniques signage was displayed in treatment rooms. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Administrative staff did not handle samples. The practice had a room specifically set up where patients could leave their samples in a hatch from which clinical staff could access them for safe storage, testing and disposal.

The practice had recently undertaken a health and safety risk assessment. We were told that nothing was identified that required attention. We were also told that there was no requirement for the practice to test for legionella (a germ found in the environment which can contaminate water systems in buildings) because the building was purpose built and did not have air conditioning or water storage tanks. We saw records that confirmed the practice was carrying out regular checks in line with its health and safety policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. The practice manager was responsible for ensuring that broken equipment was either repaired or replaced. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and

displayed stickers indicating the last testing date which was January 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure monitors May 2014, spirometry machines January 2014 and weighing scales March 2014.

We looked at the equipment used for medical emergencies and saw that it was checked regularly. Items within the emergency box remained wrapped in its original packaging and were within their use by dates.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS).

The practice manager explained that the practice considered the skill mix before any vacancies were advertised to ensure that the practice maintained the correct levels of skill for their patients' needs. The practice had arrangements in place for shortages of staff. For example, some of the administration staff worked part-time and they cover for each other. GPs also covered for each other and the practice also used GP locums when necessary.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included dealing with emergencies such as a fire and a patient becoming seriously ill at the practice. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and we saw that the practice had undertaken a health and safety risk assessment which did not highlight any concerns.

We saw that the practice used a system where they recorded details of vulnerable patients. These patients have a named GP which enabled those patients to get immediate access to a doctor who understood their circumstances. Staff were made aware of these patients by use of a 'White board' list. In addition the patent's records were flagged up to highlight the vulnerability of those patients to all staff. We were told that the patients on the list were formally discussed by clinical staff and patient records and the white board were updated fortnightly. In addition informal discussions and support provided by the team whilst patients names remained on the white board. This provided patients with a higher level of support and safety.

We saw that the practice were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

The practice held a register of patients at high risk of emergency hospital admissions. Those patients had emergency health care plans that were held in their homes and on the practice computer database. The plans detailed a summary of their medical problems and medication, wishes about future treatment and next of kin.

A community psychiatric nurse was based full time at the practice. Staff explained that they made written referrals to the nurse and they could also have case discussions with them. One member of staff said they had rapid access to counselling for their patients.

Staff told us that they were trained to recognise patients experiencing a mental health crisis, and would support them to access emergency care and treatment.

The practice had a dedicated on call emergency GP for each day. They took all the emergency appointments for all patients. They did not see non-urgent patients.

The practice has a repeat prescriptions policy. Repeat prescriptions were monitored regularly. Staff told us that the system works well.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all staff had received training in basic life support with administrative staff receiving an update every three years and clinical staff every eighteen months. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Staff explained that a patient collapsed recently in the reception area. The staff followed their emergency procedures including using the defibrillator and an ambulance was called. The patient recovered in hospital.

Good

Are services safe?

A fire risk assessment had been undertaken that included actions required to maintain fire safety. The practice had an identified fire marshal. Staff told us that the fire alarms were tested once a month. We saw records that showed staff had fire safety training. We saw that the practice had passed a fire safety audit in May 2014.

We were told that a copy of the emergency planning policy was kept off site as well as in the reception and on computers at the practice for ease of access when required. The plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. It contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we spoke with were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence (NICE) and from the local health commissioners. They told us these were discussed in clinical meetings.

We spoke with staff about how the practice helped patients with long term conditions manage their health. They told us that there were regular clinics held by practice nurses where patients were booked in for recall appointments. These ensured patients had routine assessments for high blood pressure for example and tests, such as blood or spirometry (lung function) tests to monitor their condition.

The practice had GP leads in specialist clinical areas such as diabetes, primary and secondary heart disease prevention and women's health, which allowed the practice to focus on specific conditions. Clinical staff we spoke with told us that they would ask for advice and support from colleagues and commented that everyone was approachable.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2012 / 2013. The QOF is part of the NHS contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored high on clinical indicators within the QOF. They achieved 99.8%, which was above the England average of 96.1%.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We saw that an audit had been undertaken of urgent referrals under the two week rule for suspected cases of cancer for the period April to June 2014. The audit showed that there were no inappropriate referrals and in one instance it showed that cancer was picked up early. A formal presentation of the audit to colleagues was scheduled for October 2014 and the second cycle of the audit scheduled for Spring 2015.We saw also saw an example of a clinical audit for Chlamydia which took place in June 2014 and was due to be evaluated in December 2014. The clinical audits showed evidence of quality improvement processes aimed at improving patient care and outcomes through the review of care and implementation of change.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. This demonstrated that the practice was performing the same as or better than average when compared to other practices in England.

The medicines manager told us they undertook medication audits. For example antibiotic prescriptions were audited every six months. The most recent audit showed that locum GPs prescribed more antibiotics than the other GPs. We were told that this issue was going to be discussed at a practice meeting the day after our inspection.

In addition GPs told us that the Clinical Commissioning Group (CCG) sent them practice data on prescribing which uses a traffic light system to highlight their activity. The practice used this data to revise their prescribing patterns were necessary. For example the data confirmed that the practice had high levels of antibiotic prescribing. In addition we saw that the practice had audited prescribing to elderly patients in care homes and acted on their findings in collaboration with other care providers. As a consequence there had been a large reduction in prescribing of certain medicines without detriment to patients' wellbeing.

The practice had care plans for those identified at most risk of poor or deteriorating health. This included care plans for patients with long term conditions who were most at risk of deteriorating health and whose conditions were less well controlled. These patients all had a named GP for their care. All patients over the age of 75 had been allocated a named GP.

Staff told us that they used a 'white board' system to help manage vulnerable patients. The names of vulnerable patients were added to the white board and their patient records are flagged up to highlight this. Staff were instructed to let the patient's named GP know if the patient contacted the practice so that the GP is quickly alerted and decides what action to take. GPs told us that the names on the white board were regularly reviewed and up dated. We saw that the white board was located in the administrative area of reception out of sight of the public.

Good

Are services effective?

(for example, treatment is effective)

The most recent QOF data demonstrated that 86.4% of patients with dementia had their care reviewed within the preceding 15 months which was higher than the CCG and England averages of 85.25% and 83.2% respectively. For those patients with coronary heart disease 95.9% had their blood pressure reading within the preceding 15 months which was higher than the CCG and England averages of 91.8% and 90.6% respectively.

Child health clinics were held each week at the practice by health visitors. A clinic was being held on the day of our inspection. Staff explained that there were close links with staff running the clinics and the practice. Staff gave us an example, a member of staff raised a concerned about a child at the clinic and how they were seen immediately by a GP. The clinics gave staff the opportunity to assess the growth and development of young children, identify risk factors and opportunities for improving health. It also gave parents the opportunity to routinely discuss any concerns they had about their children.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. The practice held weekly multidisciplinary meetings which included health visitors, district nurses, community psychiatric nurse, GPs and social workers to discuss concerns raised about children and young people and families in need.

For patients prescribed medication for a long time, such as Disease-modifying Antirheumic Drugs(DMARDs), we were show that they were recalled for regular blood tests to check to see if the medication was having any side effects. Patients discussed the results of their blood tests with their named GP.

The practice reported that a community psychiatric nurse was based at the practice which meant that they were able to rapidly access counselling for their patients who were experiencing mental health problems. The practice also reported that they have 24 hour access to the Crisis Assessment and Intervention team. In addition the practice provided patients with information that enabled them to self-refer to other support services such as MIND and SANE.

Effective staffing

We reviewed staff training records and saw that all relevant staff were up to date with attending mandatory courses such as annual basic life support for clinical staff, and the safeguarding of vulnerable adults and children. Most clinical staff had completed their Mental Capacity Act 2005 training. We saw that the one person who had not undertaken their mental capacity training recently was waiting for a course to become available. A good skill mix was noted amongst the doctors with special interests in palliative care, dementia, paediatrics, psychiatry, dermatology, paediatric phlebotomy, (difficult) adults and mental health. All GPs have either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The practice maintained a training matrix that displayed the member of staff's name, the type of training undertaken and the date the training had taken place which helped them ensure that mandatory training was up-to-date. We saw that staff developed plans which identified training needs and these were followed up by the practice. Staff were given protected time for all training. The practice accommodated training courses that did not fit with their business needs. For example, they allowed a member of staff a day off to attend a beauty therapy course. All staff undertook annual appraisals which also identified learning needs that were sponsored by the practice. This was confirmed when a member of staff told us that they were undergoing a NVQ course in Business and Administration Level 2.

In collaboration with a local University the practice provided third and fifth year medical students placements. One of the GPs at the practice was a tutor for fifth year medical students. On the day of our inspection we saw that a medical student was shadowing a GP and preparations were being made to video the student's consultation with a patient for training purposes. Staff told us that being involved in the placement process was stimulating for the practice and another way being aware of current thinking and ideas.

We were told that the practice held fortnightly education meeting which included updated guidelines, case discussions and feedback from courses. Staff confirmed that those meeting took place. We were also told that the practice operated an 'open door' policy on second opinions or help from other GPs. For example if the on call GP is busy they were always helped out by other GPs. In

Good

Are services effective?

(for example, treatment is effective)

addition all staff we spoke with said that colleagues were approachable and commented that the practice was very supportive, everybody helped each other, and there was good team working.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and smoking cessation clinics. Those with extended roles were also able to demonstrate they had appropriate training to fulfil these roles. For example seeing patients with long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD). COPD is a collective name for lung diseases, and diabetes.

Working with colleagues and other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were monthly meetings with the multi-disciplinary team within the locality. This usually included district nurses, social workers and health visitors. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk. There were a range of secondary health services located at the practice provided by other organisations. This included health visitors, a dietician a midwife and the community psychiatric nurse. The practice also communicated with the out of hours service and made referrals to hospital. District nurses also attended the surgery regularly. The practice also had access to Macmillan Nurses and a palliative care consultant. Staff told us this helped the communication between different organisations and providing effective care to patients. For example GPs told us that where appropriate they had case discussions with the community psychiatric nurse in preference to a written referral.

The practice worked with other service providers to meet people's needs and manage complex cases. For example since 2011 all nursing and residential homes had a named GP. We were told that the majority of these were visited weekly by the same GP to review patients and their clinical need. We were also told that this approach enabled the practice to know the homes, their staff and the patients well to everyone's benefit and continuity of care was provided. A professional from a care home who had experience of this service was complimentary about the service that had been provided.

The practice was commissioned to provide enhanced services. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). These services included dementia screening and end of life care. We were told that the practice had a system for health checks for patients who were aged between 40-74 years old. However, as the recall system was not as good as they would like it to be, it was under review.

Information Sharing

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with clinical staff about the how information was shared with the Out of Hours services in the local area. All information is kept on a shared drive on the practice computer where access was restricted to staff that need it. The practice also backed up that information.

For those patients who were at a high risk of emergency hospital admission for example all nursing home patients, the practice held emergency health care plans on their computer database. Hard copies were also available in their patient's homes for other health care providers' to access when required.

The practice had systems in place to provide staff with the information they needed about each patient. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that relevant staff were aware of the principles of the Mental Capacity Act 2005(MCA) and their duties in fulfilling it. The training records we saw confirmed that most staff had undertaken MCA training. We asked staff how they ensured they obtained patients' consent to treatment. Staff were all able to give examples of how they obtained written, verbal or implied consent.

Staff told us that when patients underwent minor surgery, written consent to the procedure was obtained before the procedure took place and this was recorded in the patients' notes.

Good

Are services effective?

(for example, treatment is effective)

A GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. They gave examples of dealing with requests for contraception and testing for competency.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. We found the doctors were aware of the MCA and used it appropriately. The doctors described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. A doctor gave an example of where they had dealt with a patient who needed to be admitted to hospital but had initially refused to go. On reviewing the patient the doctor decided that the patient had capacity. The doctor had a discussion with the patient which allowed the patient to understand the need for the proposed actions and reconsider their decision.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to teenage patients, offering smoking cessation advice to smokers and dietary advice.

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health. There were details on display about flu clinics and, meningitis awareness.

In addition to the posters and leaflets in the practice there was health promotion and prevention advice on their practice website. The practice in conjunction with the Patient Participation Group (PPG) regularly publishes a newsletter for patients which included advice on health and wellbeing.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The majority of patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on 13 CQC comment cards we received reflected this.. None of the comments raised any concerns in this area.

We observed staff who worked in the reception and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. The reception desk was adjacent to the patient waiting area. We saw staff who worked in these areas made efforts to maintain people's privacy and confidentiality. We saw voices were lowered and personal information was only discussed when absolutely necessary. Staff were spoke with told us that they would offer patients the option of a more confidential area or private room to hold their conversations. This option was always offered to patients in distress or appeared to be in distress.

We reviewed the most recent data available for the practice on patient satisfaction from the national patient survey. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice also commissioned its own survey to gauge feedback from their patients. The survey was called 'Improving Practice Questionnaire Report 2013' (IPQ). There were 243 respondents to the questionnaire. The practice achieved a score of 84% for both showing consideration and care for patients which was higher than the national score of 78% and 79% respectively.

Patient's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. We saw information about the chaperone service offered was clearly displayed in the reception. We were told that staff who acted as chaperones had completed chaperone training.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains and window blinds were provided in the treatment room so that patients' privacy was maintained during examinations 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.

Staff told us that the practice made allowances for their patients. For example, screen messages were sent to clinicians to alert them of issues such as patients being needle phobic so that this can be taken into account when treating those patients. We saw a patient who appeared to have mental health issues being spoke with by a nurse in a caring and compassionate manner.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. Information provided by patients who filled in CQC comment cards reflected this, as did those patients who completed the IPQ.

We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service. Patients whose first language was not English were supported to access the service and communicate their needs.

Patient/carer support to cope emotionally with care and treatment

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups. For example, there was information on the use of statins (Statins are a medicine that reduces the level of cholesterol. Lowering levels of cholesterol can help reduce people's risk of coronary disease and stroke.) and drop in health centres.

The practice told us that they provided support and information to relatives of patients who had died. For example, a GP always telephoned the family first to offer their support and then arranged a visit if the family requested or agreed to it.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice from Public Health England, published in 2013. The average male life expectancy for the practice population was 75.24 years and female life expectancy was 79.31years. The majority of patients registered with the practice were between the ages of five and 65 years plus, with the percentage of patients within the 65 years plus age group higher than the England average for practices. For the patient group 59.1% had a long standing health condition and 61.4% reported they had health-related problems in daily life. There were 81.0 per 1000 people in the area claiming disability allowance.

There were also 24.4% of patients reported having caring responsibilities. There were slightly less patients in the area that lived in nursing homes when compared to the England average.

The needs of the practice population were understood and systems were in place to address these identified needs. For example the practice told us that all nursing and residential homes have named GPs and the majority were visited weekly. A professional with knowledge about this service made favourable comments to us about the provided service from the practice. In addition for patients with long term conditions clinics were held by the practice nurses. Patients were routinely invited by post or telephone to attend for annual or six monthly reviews.

Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP. Home visits were made to patient who experienced difficulty in attending the practice. We were told on average there were four visits a day for each GP. The practice also used an on call system where the nominated GP would not see any routine appointments. They dealt with all emergency calls and appointments and if they got too busy other GP colleagues would provide support.

As part of the inspection we spoke with representatives of the Patient Participation Group (PPG). They explained that it was formed in 2011 and they had seen consistent improvements with the service. They told us that access to appointments was a regular topic for discussion. The practice had tried various methods to address this issue. For example, they introduced a different system for appointments which was monitored. Patients and GPs raised concerns about the system as a consequence the practice stopped this process. We were told that the practice was continuously looking to improve patients' access to appointments.

The practice worked collaboratively with other health care agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. For example, for patients that were at a high risk of emergency hospital admission the practice has produced emergency health care plans that summarise their medical condition(s) and medication and wishes about the future. Those plans were readily available to other relevant agencies electronically or in hard copy. The practice explained that for patients in vulnerable circumstances, for example patients feeling unwell or ill or struggling to understand or access care, their telephone calls would be transferred to the on-call GP who would assess the position and take appropriate action.

Tackle inequity and promote equality.

The practice had recognised the needs of the different groups in the planning of its services. The practice had made arrangements so that people with physical disabilities were able to access the service. Consultation and treatment rooms were on the ground floor. There was parking near to the surgery.

For those patients who did not speak English as their first language. There were arrangements in place to access interpretation services.

Access to the service.

Appointments were available from 8:30 am to 18:30 pm on weekdays. There were pre-bookable appointments available on Saturday morning between 8:30am and 12:30pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments. There were also

Good

Are services responsive to people's needs?

(for example, to feedback?)

arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Data available for the practice from Public Health England, published in 2013, 58.2% of patients reported a good overall experience of making an appointment. This is lower than the England average of 76.3%. Some of those patients who complete our comment cards expressed concerns about the difficulty of making appointments but were complementary about the services they received. The practice told us that they were aware of this and were continually thinking of ways to improve access to their services for all their patients. They also explained that if a patient needed to be seen on the day they would be seen.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The deputy practice manager was designated the responsible person who handled all complaints in the practice. They were supported by the practice manager and senior management when dealing with more complex or demanding complaints.

We saw that information was available in a leaflet to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

The practice told us that all complaints verbal and written were recorded electronically in the patient's record. They were also recorded on a spread sheet so that the practice could identify any trends. The practice explained that they had not received any complaints in the last twelve months.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values included the following aims: to seek continuous improvement on the health status of the practice population, developing and maintaining a cohesive team which was responsive to people's needs and expectations and which reflected ,whenever possible, the latest advances in primary health care.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to staff via the desktop on any computer within the practice and hard copies were available to staff in a file at reception. In addition certain policies, for example, the information governance policy, forms part of the employees contract of employment and was retained with their contract.

The policies were updated immediately when changes occurred or annually as required. Staff were notified of any changes. Where significant changes had taken place staff were asked to sign to indicate that they had read and understood the policy.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data that showed the practice had consistently scored highly over the last three years. The most recent record showed a score 99.8% for total QOF points which was higher than the averages for England and the Clinical Commissioning Group (CCG) which were 96.1% and 97.7% respectively.

The staff we spoke with were clear on their roles and responsibilities. All of them demonstrated an understanding of their area of responsibility. We found that managers in the practice understood their role in leading the organisation and enabling staff to provide good quality care.

Leadership, openness and transparency

The practice told us that it had an 'open door' policy where all staff were encouraged to raise any concerns or issues with their colleagues, managers and GPs at any time. Staff we spoke with told us that if they needed help, support or guidance they would ask any of their colleagues, management or GPs and it would be openly and freely given. We were also told that the practice did not hold formal full team meetings but instead held smaller group meetings on an ad hoc basis. In addition information and minutes of formal meetings, for example the weekly practice manager and GPs meetings, were emailed to relevant staff and accessible to staff on a shared drive in the practice computer.

The practice held daily informal thirty minute meetings for all GPs to discuss surgeries, visits and any issues.

We were shown a clear leadership structure which had named members of staff in lead roles. For example there were GP leads for adult safeguarding and another for child protection. Staff we spoke with were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

Practice seeks and acts on feedback from users, public and staff

The practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with two representatives of the PPG who explained their role and how they worked with the practice. They told us that the group was currently trying to attract younger members to help make the group more representative of the patient population.

They told us that they gave the practice positive and negative feedback and it was listened to and acted upon. They had a constructive and collaborative relationship with the practice. They told us that since the group started in 2011 they had seen continuous improvement. For example they explained that it was noticeable that the attitude of reception staff had improved and they now give their names when speaking to patients. They said that the practice regularly discussed access to appointments and were involved in changing the telephone system. They commented that it had been a good improvement but not ideal and stated that access was a difficult problem to deal with. They were complimentary about the practice and said its commitment to the PPG was exceptional. The group produced a practice newsletter each quarter. We saw the Autumn 2014 issue. It contained lots of useful information including details about free flu vaccinations, meningitis, migraine, out of hours contacts, and a feature article on statins.

Are services well-led?

Good

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

The PPG met bi-monthly. The first half hour of the meeting is for the PPG members, they are then joined by the Practice Manager or Deputy and one of the GP's. We were told that access issues were reviewed each meeting.

The practice told us all staff were encouraged to raise any issues or concerns with their manager or a GP. Staff we spoke with confirmed this and told us that they felt well supported by the practice and were able to raise any issues or concerns at any time and felt that they would always be listened to and action would be taken if required. In addition to holding meeting with small groups of staff, as and when required, we were told the practice communicated with colleagues via email.

Management lead through learning & improvement

The practice told us that they held monthly supervision sessions for salaried GPs and nurses. Fortnightly education meetings were also held which included such topics as updated guidelines to ensure the teams knowledge is current and case discussions. In addition the practice introduced the Blyth GP teaching sessions for all local GPs which was hosted at the practice. The third teaching session was scheduled for November 2014 with the topic being dermatology.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw staff training records that confirmed their training was up to date. Staff told us that the practice was very supportive of training.

The practice told us that they were considering becoming a GP registrar training practice in the next 12 to 18 months.

The practice had completed reviews of significant events and clinical audits and shared results with staff at practice meetings. For example, the senior partner audited their cancer referrals and as a consequence asked all the GPs to audit their referrals. This was to establish how the practice and individual GPs compare with regional and national expectations so as to highlight areas that may require improvement.