Lintonville Medical Group

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Lintonville Medical Group on 14 April 2016. Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and a highly effective system for reporting and recording significant events. The staff team took the opportunity to learn from all internal and external incidents.
- Risks to patients and staff were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment.
- The practice worked closely with other organisations, when planning how services were provided, to ensure patients' needs were met.
- Patients' emotional and social needs were seen as being as important as their physical needs, and there was a strong, visible, person-centred culture. Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Services were tailored to meet the needs of individual patients and were delivered in a way that ensured flexibility, choice and continuity of care. All staff were actively engaged in monitoring and improving quality and patient outcomes. Staff were highly committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.
- The leadership, governance and management of the practice assured the delivery of good quality person-centred care, supported learning, and

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promoted an open and fair culture. Staff had a clear vision and strategy for the development of the practice and they had invested in the practice doing well.

However, there were also areas where the provider needs to make improvements. The provider should:

- Continue to review and improve the practice's telephone access and appointment system.
- Provide those nursing staff who are prescribers with regular and appropriate clinical supervision.
- Keep a written record of any fire drills that take place.

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 providing safe services.

There was an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. The practice had clearly defined systems and processes that helped keep patients safe. Individual risks to patients had been assessed and were well managed. Good medicines management systems and processes were in place. The premises were clean and hygienic. Required employment checks had been carried out for staff recently appointed by the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

Outcomes for patients were consistently good. Data from the Quality and Outcomes Framework (QOF) showed that all but one of the outcomes for patients, were either above or in line with, local clinical commissioning group (CCG) and England averages. Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance. Clinical audits were carried out to help improve patient outcomes. Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion. This included providing advice and support to patients to help them manage their health and wellbeing. Staff worked effectively with other health and social care professionals to ensure the range and complexity of patients' needs were met. Staff had the skills, knowledge and experience to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients' emotional and social needs were seen as being as important as their physical needs, and there was a strong, visible, person-centred culture. Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction with the quality of GP and nurse consultations was either above, or broadly in line with, the local CCG and national averages. Patients told us they were treated with compassion, dignity and respect, and they felt well looked after. Information for

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patients about the range of services provided by the practice was available and easy to understand. Staff had made good arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. Historically, the practice had been early adopters of new ways of delivering general practice within the locality including, for example, being one of the first to pilot the nurse practitioner role.

Patients we spoke with, and most of those who completed Care Quality Commission (CQC) comment cards, were satisfied with access to appointments. They said they were able to obtain an appointment in an emergency. Results from the NHS GP Patient Survey of the practice, published in January 2016, showed that patient satisfaction levels with the convenience of appointments, and appointment waiting times, were above the local CCG and national averages. Patient satisfaction with telephone access and appointment availability, were below the local CCG and national averages. Staff had been proactive in taking action to make improvement in these areas. This included the recent implementation of the Doctor First appointment system.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. There was evidence the practice responded quickly to any issues raised.

Are services well-led?

Good

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

The practice had good governance and performance management arrangements. They had clearly defined and embedded systems and processes that kept patients safe. There was a clear leadership structure and staff felt well supported by the GPs and the practice management team. Examples of good governance arrangements included the carrying out of evidence based assessments, the allocation of lead roles to staff to help promote good clinical leadership, and the holding of regular planned meetings to share information to manage patient risk. The practice actively sought feedback from patients via their Friends and Family Test survey and

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patient participation group. They had acted on this feedback by improving patients' access to same-day care and treatment. There was a very strong focus on, and commitment to, continuous learning and improvement at all levels within the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed very well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had obtained 100% of the total points available to them, for providing care and treatment to patients who had heart failure. This was 1.1% above the local clinical commissioning group (CCG) average and 2.1% above the England average. The practice offered proactive, personalised care which met the needs of older patients. For example, all patients over 75 years of age had a named GP who was responsible for their care. Staff had worked in partnership with specialist health care professionals to ensure that older patients received the care and treatment they needed, so that where possible, emergency admissions into hospital could be avoided.

People with long term conditions

Good

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

Nationally reported QOF data, for 2014/15, showed the practice had performed well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had obtained 99.8% of the total points available to them, for providing care and treatment to patients with diabetes. This was 4.8% above the local CCG average and 10.6% above the England average. The practice's multi-disciplinary team approach to managing long-term conditions enabled clinicians to offer co-ordinated appointments, so that patients with several medical conditions did not have to attend the practice more often than necessary. Patients with long-term conditions were offered annual reviews to check their health needs were being met and that they were receiving the right medication. Clinical staff were very good at working with other professionals to deliver a multi-disciplinary package of care to patients with complex needs. For example, they had worked in collaboration with other health and social care professionals to ensure emergency health care plans were in place to help keep this group of patients safe.

Families, children and young people

Good

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

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There were good systems in place to protect children who were at risk and living in disadvantaged circumstances. For example, where clinicians had concerns about the safety of vulnerable children, they took appropriate action by consulting local safeguarding professionals and sharing their concerns. Monthly multi-disciplinary safeguarding meetings were held where the needs of vulnerable children and families were discussed. All clinical staff had completed safeguarding training that was relevant to their roles and responsibilities.

Appointments were available outside of school hours and the practice's premises were suitable for children and babies. The practice provided a full programme of childhood immunisations. Publicly available information showed they had performed well in this area. For example, childhood immunisation rates for the vaccinations given to under two years old ranged from 95.2% to 98.2% (CCG average 95.3% to 98.1%). For five year olds rates ranged from 97.2% to 99.3% (CCG average 94.9% to 98.5%). The practice worked to encourage uptake of screening and immunisation programmes with the patients at the practice. The practice offered contraceptive and sexual health advice, and information was available within the practice, and on its website, about how patients could access specialist sexual health services. Nationally reported data showed the practice's uptake of cervical screening was, at 87%, was higher than the national average of 81.4%. A good range of health promotion leaflets was available in the patient waiting area, including information about the practice being breastfeeding friendly.

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 practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of this group of patients. Nationally reported data showed the practice had performed well in providing recommended care and treatment to this group of patients. For example, the QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them for providing care and treatment to patients who had hypertension. This was 0.3% above the local CCG average and 2.2% above the England average. Extended hours appointments were not routinely provided, although plans were being made to provide this service later in the year. Information on the practice's website, and on display in their patient waiting areas, directed patients to the out-of-hours service.

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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.

There were good arrangements for meeting the needs of vulnerable patients and there were good systems in place to help reduce emergency admissions into hospital. For example, staff had been provided with clear and thorough guidance about how to manage the needs of the practice's most vulnerable patients. The practice maintained a register of patients with learning disabilities which they used to ensure they received an annual healthcare review. Extended appointments were offered to enable this to happen. Systems were in place to protect vulnerable children from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns. Good arrangements had been made to meet the needs of patients who were also carers.

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).

There were good arrangements for meeting the needs of patients experiencing poor mental health. Nationally reported QOF data, for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. Nationally reported data analysed by the CQC showed the practice's performance with regards to carrying out reviews for patients experiencing poor mental health was comparable with other practices. For example, the data showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months, was comparable to other practices. (93.4% compared to the national average of 88.4%.) There were clinical leads for mental health and dementia, who provided staff with guidance and expertise. Patients experiencing poor mental health were provided with advice about how to access various support groups and voluntary organisations. Community psychiatric nurse appointments were available at the practice.

The arrangements for meeting the needs of patients with dementia were overall good. Nationally reported QOF data, for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. Nationally reported data analysed by the CQC showed the practice's performance with regards to the percentage of patients diagnosed with dementia,

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whose care had been reviewed in a face-to-face review, in the preceding 12 months, was comparable with other practices. However, the percentage of patients receiving a review was lower at 76.7% when compared to the national average of 84%. The practice kept a register of patients who had dementia to help make sure they received the support they required. The practice's clinical IT system clearly identified these patients to ensure staff were aware of their specific needs.

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What people who use the service say

Feedback from the majority of patients was positive about the way staff treated them. We spoke with two patients from the practice's patient participation group. They told us they were treated with compassion, dignity and respect, and felt well looked after. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 16 completed comment cards and the majority of these were positive about the standard of care provided. Words used to describe the service included: excellent; good and professional; very helpful and pleasant; pretty good service; very helpful and efficient. However, two patients commented negatively regarding access to appointments.

Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction levels with the quality of GP and nurse consultations, although below most of the local clinical commissioning group (CCG) and national averages, were broadly in line with these. However, data from the survey indicated lower levels of patient satisfaction with telephone access to the practice and access to appointments. For example, of the patients who responded to the survey:

- 93% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 87% said the last GP they saw was good at listening to them, compared to the local CCG average of 91% and the national average of 89%.
- 96% had confidence and trust in the last nurse they saw, compared with the local CCG average of 99% and the national average of 97%.
- 91% said the last nurse they saw was good at listening to them. This was just below the local CCG of 94% and the same as the national average.
- 93% said the last appointment they got was convenient. This was the same as the local CCG average and above the national average of 92%.
- 77% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 86% and the national average of 85%.
- 66% found it easy to get through to the surgery by telephone, compared with the local CCG average of 78% and the national average of 73%.

  (286 surveys were sent out. There were 113 responses which was a response rate of 40%. This equated to 0.9% of the practice population.)

Areas for improvement

Action the service SHOULD take to improve

- Continue to review and improve the practice's telephone access and appointment system.
- Provide those nursing staff who are prescribers with regular and appropriate clinical supervision.
- Keep a written record of any fire drills that take place.

Lintonville 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 adviser and a practice nurse.

Background to Lintonville Medical Group

Lintonville Medical Group provides care and treatment to 13,185 patients of all ages, based on a Personal Medical Services (PMS) contract. The practice is part of the NHS Northumberland clinical commissioning group (CCG) and provides care and treatment to patients living in Ashington, Ellington and the surrounding areas. We visited the following location as part of inspection: Lintonville Terrace, Ashington, Northumberland, NE63 9UT. The practice serves an area where deprivation is higher than the England average. In general, people living in more deprived areas tend to have greater need for health services. Most patients live in the Wansbeck ward, which is acknowledged as having higher than average national death rates. Many patients also have complex medical conditions. The practice population includes fewer patients who are under 18 years of age, and more patients aged over 65 years of age, than the England average. National data showed that 1.4% of the population are from an Asian ethnic minority background.

The practice consists of an original building which now houses the administrative team. A ground floor extension was added to this building in 1995. The extension contains 17 consultation rooms, as well as emergency, treatment and minor surgery rooms, and a large health education room. Other healthcare professionals are able to use the consultation rooms when required. There is also a pharmacy within the practice.

The practice has five GP partners (three male and two female), three salaried GPs (one male and two female), a nurse practitioner and two practice nurses (female.) The practice was also using a long-term nurse locum to support the nursing team. There were three healthcare assistants (female), an executive manager, a practice manager, a practice administrator and a large team of administrative and reception staff.

The practice is an approved training practice where qualified doctors gain experience in general practice. A GP registrar and two Foundation (Year 2) doctors were on placement at the time of our visit. The practice also offers training placements for student nurses.

The practice is open Monday to Friday between 8:30am and 6pm, and GP appointment times are Monday to Friday between 8:30am and 5:50pm.

When the practice is closed patients can access out-of-hours care via the Northern Doctors Urgent Care Limited On-Call service, and the NHS 111 service.

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 provider is meeting the legal

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 April 2016. During our visit we:

- Spoke with a range of staff, including three GPs, the executive manager, the practice manager, the assistant practice administrator, two practice nurses and some administrative staff. We also spoke with two members of the practice's patient participation group.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events, and the practice had a significant event reporting policy and recording template which reflected current best practice. Staff had identified and reported on seven significant events during the previous 12 months. We found that, following each incident, staff had completed a significant event analysis (SEA) form. These provided details of what had happened, what staff had done in response and what had been learnt as a consequence. Copies of significant event reports could be accessed by all staff on the practice intranet system. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. Learning had been disseminated and discussed during multi-disciplinary SEA meetings. There was a system for recording, investigating and learning from incidents, and this was known by the staff we spoke with.

The practice's approach to the handling and reporting of significant events ensured that the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

The practice had a good system for responding to safety alerts. All safety alerts, including those covering medicines, were forwarded to key staff, so that appropriate action could be taken in response. Records were kept of the actions taken and these were stored on the practice's intranet system. Copies of alerts were attached to the practice's weekly housekeeping minutes. These were forwarded to each member of the team, to help make sure information was effectively disseminated. Staff we spoke with were aware of the system for handling safety alerts and said it worked effectively. Where relevant, patient safety incidents had been reported to the local clinical commissioning group (CCG) via the Safeguard Incident and Risk Management System (SIRMS). (This system enables GPs to flag up any issues via their surgery computer, to a central monitoring system, so that the local CCG can identify any trends and areas for improvement.)

Overview of safety systems and processes

The practice had a range of systems and processes in place which helped to keep patients and staff safe and free from harm. The practice had policies and procedures for safeguarding children and vulnerable adults. Staff told us they were able to easily access these. Safeguarding information was also available in the consultation rooms, for ease of access. A designated member of the GP team acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to their colleagues. Staff demonstrated they understood their safeguarding responsibilities and we saw evidence that the clinical team worked in collaboration with local health and social care colleagues, to protect vulnerable children and adults. Children at risk, and vulnerable adults, were clearly identified on the practice's clinical IT system, to ensure clinical staff took this into account during consultations. Multi-disciplinary meetings were held to monitor vulnerable patients and share information about risks. Most staff had received safeguarding training relevant to their role. For example, the GPs had completed level three child protection training. All staff had completed adult safeguarding training apart from a new starter, who was shortly due to complete this.

The practice's chaperone arrangements helped to protect patients from harm. All the staff who acted as chaperones, were trained for the role and had undergone a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record, or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The chaperone service was advertised on posters displayed in the waiting area. Information about this service was also available on the practice's website.

There were procedures for monitoring and managing risks to patient and staff safety. For example, the practice had arranged for all clinical equipment to be serviced and calibrated, to ensure it was safe and in good working order. A range of other routine safety checks had also been carried out. These included checks of fire, electrical and gas systems, and the completion of an up-to-date fire risk assessment. Twice yearly fire drills were held and staff we spoke with said they had been involved in a fire drill. However, staff had not kept a written record of the fire drills they had carried out. Most staff had completed fire safety training. For the small number who had not, training had been booked and they were shortly due to complete this.

Good

Are services safe?

There were trained fire marshals with responsibilities for specific areas of the building. A range of health and safety risk assessments had been completed, and staff were able to easily access these.

Appropriate standards of cleanliness and hygiene were being maintained. Until recently, the practice had had a designated infection control lead. We were told a new lead would shortly be identified, and that they would undertake appropriate training to help them carry out this role effectively. There were infection control protocols in place and these could be easily accessed by staff. Most staff had completed infection control training. For those who had not, a team training event covering infection control was due to take place shortly. Sharps bin receptacles were available in the consultation rooms and those we looked at had been signed and dated by the assembler. Clinical waste was appropriately handled. An infection control audit had been carried out in 2015 to identify whether any further action was needed to reduce the risk of the spread of infection. Most of the actions had already been completed. Staff made use of single-use equipment. We only found one of item of this equipment that was out-of-date, but staff took immediate action to dispose of it. A legionella risk assessment had been carried out in 2010 and actions identified had been completed. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

The arrangements for managing medicines, including emergency drugs and vaccines, helped to keep patients safe. There was a good system for monitoring repeat prescriptions and carrying out medicines reviews. Prescription pads were securely stored to reduce the risk of mis-use or theft. Suitable arrangements had been made to store and monitor vaccines. These included carrying out daily temperature checks of the vaccine refrigerators and keeping appropriate records. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) Appropriate systems were in place to manage high risk medicines.

Required employment checks had been carried out for staff recently appointed by the practice. We looked at a sample of three staff recruitment files. Checks had been carried out to make sure that clinical staff continued to be registered with their professional regulatory body. Appropriate indemnity cover was in place for all clinical staff. The provider had obtained information about staff's previous employment and, where relevant, copies of their qualifications, as well as written references. The provider had also carried out a Disclosure and Barring Service (DBS) checks on each person and had obtained proof of their identity.

There were suitable arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. The practice had a large administrative team which was organised to cover key areas, including reception, records, prescriptions, computer activities and typing, to help ensure the smooth running of the practice. Day-to-day operational support for each of these sub-teams was provided by senior members of staff, who specialised in one of these areas of work. Staff also worked in other areas to make sure they were able to carry out any required tasks. At the time of the inspection, the practice had a full complement of GPs and nursing staff. An experienced locum practice nurse was being used to support the development of the new nursing team. There was occasional use of locum GP staff, but cover was usually provided by staff working extra hours.

Arrangements to deal with emergencies and major incidents

The practice had made arrangements to deal with emergencies and major incidents. For example, there was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Staff had completed basic life support training. Emergency medicines were available in the practice. These were kept in a secure area and staff knew of their location. All of the emergency medicines we checked were within their expiry dates. Staff also had access to a defibrillator and oxygen for use in an emergency. Regular checks of the defibrillator had been carried out and a log of these had been kept.

The practice had a business continuity plan in place for major incidents, such as power failure or building damage. This was accessible to all staff via the practice's intranet system. This was underpinned by emergency management, out-of-hours policies. A copy of the plan was also kept off site by key individuals. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up-to-date with new guidelines. For example, 'Training In Protected Time On-Going Educational Scheme' (TIPTOES) monthly sessions were used to review any new guidance. One of the GPs summarised new guidance and disseminated this to the clinical team.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. These outcomes were consistently very good. (QOF is intended to improve the quality of general practice and reward good practice).

The QOF data, for 2014/15, showed the practice had performed very well in obtaining 99.8% of the total points available to them for providing recommended care and treatment, with a 13.4% exception reporting rate. The reporting rate was 4.1% above the local clinical commissioning group (CCG) average and 4.2% above the England average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)

Evidence obtained during the inspection indicated that the practice had a good patient 'call and recall' system, and there were good internal processes in place that staff reported worked well. Nationally reported data analysed by the CQC showed the practice's performance with regards to carrying out reviews for patients with dementia, and those experiencing poor mental health, was comparable with other practices.

Examples of good QOF performance included the practice obtaining:

- 100% of the total points available to them, for providing recommended clinical care to patients who had cancer. This was 0.2% above the local CCG average and 2.1% above the England average.
- 100% of the total points available to them, for providing recommended clinical care to patients who had asthma. This was 0.7% above the local CCG average and 2.6% above the England average.
- 99.1% of the total points available to them for providing recommended clinical care to patients diagnosed with a stroke or transient ischaemic attack. This was 0.7% above the local CCG average and 2.5% above the England average.

Staff were proactive in carrying out clinical audits to help improve patient outcomes. We looked at two of the six clinical audits that had been carried out in the previous 12 months. These were relevant, showed learning points and evidence of changes to practice. The audits were also clearly linked to areas where staff had reviewed the practice's performance and judged that improvements could be made. For example, the practice had carried out an audit of women with a body mass indicator (BMI) of over 35, to see whether any of them had been prescribed a combined oral contraceptive pill (COCP), without having counselling regarding potential risks. (The use of the BMI is one way of measuring whether a person has a healthy weight for their height.) Following completion of the full cycle audit, the findings had been presented to staff attending a multi-disciplinary training event. Learning from the audit included: a reminder for clinicians of the increased risk of venous thromboembolism (blood clots forming in the veins in the leg and lungs) developing in women with a high BMI taking the COCP; advice about recording accurate height and weight to ensure the BMI is calculated correctly. Plans had also been made to contact a small number of the patients involved in the audit to review their care and treatment.

The practice had carried out a range of medicine related audits, to help ensure prescribing was in line with best practice guidelines. For example, staff had identified that, for 2015/16, they wanted to achieve a reduction in total antibiotics usage of 1%. A number of actions had been identified, such as all prescribers completing an e-learning antibiotic module and the circulation of the latest North of Tyne antibiotic guidelines to all prescribers. The GP prescribing lead also attended an antimicrobial

Good

Are services effective?

(for example, treatment is effective)

stewardship education day, following which improvements were made in line with recommendations from the course. Evidence made available to us during the inspection indicated that the 1% reduction target for antibiotic prescribing had been achieved in the 3rd quarter of 2015. In addition, the practice had also participated in other medicine related audits initiated by the local CCG, to promote patient safety and more cost effective prescribing. For example, during 2015, staff had worked hard to make sure that they were following the latest NICE guidelines on lipids (blood fats) management. The practice had also achieved the target set by the local CCG for a reduction in laxative prescribing. In 2015, staff had also participated in a pilot, during 2015, aimed at promoting best practice in prescribing.

Effective staffing

Overall, staff had the skills, knowledge and experience needed to deliver effective care and treatment. Most staff had received the training they needed to carry out their roles and responsibilities. This included training in basic life support, infection control and safeguarding. Where we found gaps in some staff's training records, we saw evidence confirming they were shortly due to complete the required training.

Nursing staff had completed additional post qualification training to help them meet the needs of patients with long-term conditions, including for example, training in travel & child immunisations, cervical screening and spirometry (a test that can help diagnose various lung conditions). Staff made use of e-learning training modules and in-house training to ensure they kept up-to-date with their mandatory training.

Staff had received an annual appraisal of their performance during the previous 12 months. Recent starters were due to undergo their first appraisal shortly. A member of the nursing team, who was also a nurse prescriber, told us they had only received one session of clinical supervision regarding their prescribing role, during the previous three years. We shared this with the practice team during our feedback session. This was positively received and the inspection team was assured that this would be looked at. Appropriate arrangements were in place to ensure the GPs received support to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment. The information included patients' medical records and test results. Staff shared NHS patient information leaflets, and other forms of guidance, with patients to help them manage their long-term conditions. All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and emergency services. Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. Clinical staff used 'special notes' to record important information about vulnerable patients with complex needs, so this could be shared with out-of-hours emergency professionals in a timely manner. Staff told us they also shared information formally and informally with other healthcare professionals who worked on-site.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005). When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome. Most staff had completed training in the use of the MCA. For the small number who had not, training had been booked and they were shortly due to complete this.

Supporting patients to live healthier lives

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years. There were suitable arrangements for making sure a clinician followed up any abnormalities or risks identified during these checks.

The practice had a comprehensive screening programme. For example, the QOF data showed they had performed well by obtaining 100% of the overall points available to them, for providing cervical screening services. This was

Good

Are services effective?

(for example, treatment is effective)

0.6% above the local CCG average and 2.4% above the England average. However, the uptake of cervical screening was higher, at 87%, than the national average of 81.8%. The practice also had protocols for the management of cervical screening, and for informing women of the results of these tests. These protocols were in line with national guidance. The practice had also performed well by obtaining 100% of the overall points available to them, for providing contraceptive services to women in 2014/15. This was 1.9% above the local CCG average and 3.9% above the England average.

Patients were also supported to stop smoking. The QOF data showed that, of those patients aged over 15 years who smoked, 90.2% had been offered support and treatment during the preceding 24 months. This was 1.2% above the local CCG average and 4.4% above the England average. The data also confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

The practice offered a full range of immunisations for children. Publicly available information showed they had performed very well in delivering childhood immunisations. Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two years old ranged from 95.2% to 98.2% (CCG average 95.3% to 98.1%). For five year olds rates ranged from 97.2% to 99.3% (CCG average 94.9% to 98.5%). The practice worked to encourage uptake of screening and immunisation programmes with the patients at the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients' emotional and social needs were seen as being as important as their physical needs, and there was a strong, visible, person-centred culture. Staff were highly motivated to offer care that was kind and which promoted patients' dignity.

Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone. We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations, so that conversations could not be overheard. Reception staff said that a private area would be found if patients needed to discuss a confidential matter.

Feedback from the majority of patients was positive about the way staff treated them. We spoke with two patients from the practice's patient participation group. They told us they were treated with compassion, dignity and respect, and felt well looked after. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 16 completed comment cards and the majority of these were positive about the standard of care provided. Words used to describe the service included: excellent; good and professional; very helpful and pleasant; pretty good service; very helpful and efficient. Two patients commented that it was difficult to get through to the practice on the telephone, and one of these said that it was difficult to book appointments in advance.

Data from the practice's Friends and Family Test survey for January 2016 indicated that 74% of patients were extremely likely or likely to recommend the practice to their friends and families. The percentage of respondents who indicated this in February 2016 was 80%.

Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction with the quality of GP and nurse consultations was either above, or broadly in line with, the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 93% had confidence and trust in the last GP they saw or spoke to, compared with the local CCG average of 96% and the national average of 95%.
- 89% said the last GP they saw or spoke to was good at giving them enough time. This was the same as the local CCG average and above the national average of 87%.
- 87% said the last GP they saw or spoke to was good at listening to them, compared with the local CCG average of 91% and the national average of 89%.
- 96% had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 99% and the national average of 97%.
- 81% found receptionists at the practice helpful, compared with the local CCG average of 78% and the national average of 73%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and those who commented on this in their CQC comment cards, told us clinical staff gave them enough time to explain why they were visiting the practice, and involved them in decisions about their care and treatment. Results from the NHS GP Patient Survey of the practice showed patient satisfaction levels regarding involvement in decision-making broadly in line with, the local CCG and national averages. Of the patients who responded to the survey:

- 85% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 90% and the national average of 86%.
- 82% said the last GP they saw was good at involving them in decisions about their care. This was below the local CCG average of 86% and the same as the national average.
- 91% said the last nurse they saw was good at explaining tests and treatments, compared with the local CCG average of 92% and the national average of 90%.
- 83% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 88% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Staff were good at helping patients and their carers to cope emotionally with their care and treatment. They understood patients' social needs, supported them to manage their own health and care, and helped them maintain their independence. Notices in the patient waiting room told patients how to access a range of support groups and organisations. We were told where patients had experienced bereavement, GP staff would ring them personally to offer condolences and support.

The practice was committed to supporting patients who were also carers. Staff maintained a register of these patients, to help make sure they received appropriate support. There were 214 patients on this register, which equated to 1.6% of the practice's population. The practice's IT system alerted clinical staff if a patient was also a carer, so this could be taken into account when planning their care and treatment. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. Examples of the practice being responsive to and meeting patients' needs included:

- Providing all patients over 75 years of age with a named GP who was responsible for their care. Nationally reported data available to the Care Quality Commission showed that the number of emergency hospital admissions per 1,000 of the population, for 19 Ambulatory Care Sensitive Conditions, was higher than the national average for the period 01/04/2014 to 31/03/2015. However, we found the practice had good systems in place to help reduce avoidable admissions into hospital. For example, emergency healthcare plans had been prepared in partnership with the local community matron. Monthly admission avoidance meetings were held in collaboration with health and social care colleagues, to review the needs of patients at risk of an emergency admission into hospital. We were provided with evidence which showed staff had responded promptly to one older patient's deteriorating health, due to a long-term condition they had. Staff had worked in partnership with specialist health care professionals to ensure that this patient had a condition specific emergency health care plan in place, which included access to on-site emergency medication. This co-ordinated multi-disciplinary approach had helped to prevent the patient's emergency admission into hospital.

- A multi-disciplinary team approach to managing long-term conditions which enabled clinicians to offer co-ordinated appointments, so that patients with several medical conditions did not have to attend the practice more often than necessary. Where appropriate, patients were invited to undergo relevant tests with a healthcare assistant. If necessary, patients were also invited to attend a further appointment with a nurse or GP so that they could receive appropriate care, treatment and advice about how to manage their health. Evidence shared with us during the inspection indicated that the practice had a good 'call and recall' system, which helped ensure that patients who needed a healthcare review received an invitation to attend the practice. This was supported by the good arrangements the practice had made to comply with the Quality and Outcomes Framework (QOF) performance targets. Where patients failed to respond to an initial request to make an appointment, this was followed up by a further two letters requesting that they contact the practice. Where patients were considered vulnerable, the clinical team also made further attempts to contact them.

- Making good arrangements to meet the needs of children, families and younger patients. Systems were in place to identify and follow up children who were at risk. For example, we saw evidence which confirmed that, where clinicians had concerns about the safety of vulnerable children, they took appropriate action by consulting local safeguarding professionals and sharing information of concern. A full programme of childhood immunisations was offered by the practice nursing team, and nationally reported data showed they had performed well. Appointments were available outside of school hours and the practice premises were suitable for children and babies. Plans were being made to support the nursing team to offer more flexible appointments up to 6pm. The practice offered contraceptive and sexual health advice, and information was available within the practice, and on its website, about how to access specialist sexual health services. Midwife run clinics were provided twice weekly.

- Good arrangements for meeting the needs of patients with mental health conditions. Nationally reported data, from the QOF for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. Nationally reported data analysed by the CQC showed the practice's performance with regards to carrying out reviews for patients experiencing poor mental health was comparable with other practices. For example, the data showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months, was comparable to other practices. (93.4% compared to the national average of 88.4%.) Patients experiencing poor mental health were provided with advice about how to access various support groups and voluntary organisations. Community psychiatric nurse

appointments were available at the practice. There was a clinical lead for mental health, who provided staff with guidance and expertise. Evidence from the inspection demonstrated that staff worked in collaboration with local mental health professionals to meet the needs of these patients, and help keep them safe.

- Good arrangements for meeting the needs of patients who had dementia. Nationally reported QOF data, for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. Nationally reported data analysed by the CQC showed the practice's performance with regards to the percentage of patients diagnosed with dementia, whose care had been reviewed in a face-to-face review, in the preceding 12 months, was comparable with other practices. Staff kept a register of patients who had dementia, and the practice's clinical IT system clearly identified them to help make sure clinical staff were aware of their specific needs. There was a clinical lead for dementia, who provided staff with guidance and expertise. Clinical staff actively carried out opportunistic dementia screening, to help ensure their patients were receiving the care and support they needed to stay healthy and safe.
- Good arrangements for meeting the needs of patients with learning disabilities. The QOF data, for 2014/15, showed the practice had obtained 100% of the points available to them, for providing recommended care and treatment to patients who had learning disabilities. This achievement was in line with the local CCG average and 0.2% above the England average. There was a clinical lead for learning disabilities, who provided staff with guidance and expertise. The practice provided patients who had learning disabilities with access to an extended annual review to help make sure they received the healthcare support they needed.
- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, to access the practice. here was a disabled toilet which had appropriate aids and adaptations. Disabled parking was available.

Access to the service

The practice opening hours were as follows: Monday to Friday between 8:30am and 6pm. GP appointment times were: Monday to Friday between 8:30am and 5:50pm.

The practice had recently introduced an appointment system called Doctor First (DF), which provides patients with same-day access to a GP. Staff told us patients wishing to see a doctor would first be contacted by a GP, who would then assess their needs and invite them for a face-to-face consultation, if this was considered to be the most appropriate clinical response. In addition to this, patients were able to book routine appointments on-line, using a link provided on the practice's website. (This facility was not available at the time of our inspection due to the change of appointment system that was underway.) Extended hours appointments were not available. However, the practice manager told us extended hours would probably be available from September 2016 onwards, once the DF system had bedded in and staff and patients were familiar with how to use it.

Results from the NHS GP Patient Survey of the practice, published in January 2016, showed that patient satisfaction levels with the convenience of appointments, and appointment waiting times, were either the same as or above the local CCG and national averages. However, patient satisfaction with telephone access and appointment availability was below the local CCG and national averages. Of the patients who responded to the survey:

- 93% said the last appointment they got was convenient. This was the same as the local CCG average and above the national average of 92%.
- 81% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 74% and the national average of 65%.
- 66% said they found it easy to get through to the surgery by telephone, compared to the local CCG average of 78% and the national average of 73%.
- 77% said they were able to get an appointment to see or speak to someone the last time they tried, compared to the local CCG average of 86% and the national average of 85%.

The majority of patients who provided feedback on CQC comment cards raised no concerns about telephone access to the practice or appointment availability. To help improve

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients' access to same-day care and address feedback from the National GP Patient Survey, the GP partners had implemented the Doctor First appointment system at the beginning of April 2016. It was clear to the inspection team that the introduction of this system had required considerable commitment and flexibility from all team members, as staff and patients adapted to the new way of providing same-day access to appointments. This period of transition was ongoing and staff were fine tuning the system on a daily basis, to help make sure they continued to be able to provide a responsive service. The lower levels of patient satisfaction seen in the National GP Patient Survey, concerning telephone access and appointment availability, relate to the period of time leading up to the implementation of the Doctor First appointment system.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints. This included having a designated person who was responsible for handling any complaints and a complaints policy which provided staff with guidance about how to handle them. Information about how to complain was available on the practice's website and was also on display in the patient waiting areas. The practice had received ten complaints during the previous 12 months, and two of these were still being looked into. We looked at a sample of the records of complaints. Where the practice had identified that it could have performed better, patients were offered an apology. There was evidence that lessons were learnt as a consequence of the complaints received. Quarterly reviews of complaints were held and the outcomes were shared during multi-disciplinary team training events, to enable learning across the practice.

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 leadership, governance and culture at the practice actively encouraged and supported the delivery of high-quality, person-centre care. This included the early adoption of new ways of delivering general practice within the locality. For example, the practice was one of the first in Northumberland to offer training placements for nurse practitioners and to provide patients with access to on-site podiatry, dietetic and community nursing services. The practice had a clear vision to deliver high quality care and promote good outcomes for their patients. Staff had devised an overarching mission statement which set out what they wanted to achieve and how they would do this. The GP team was motivated and committed to exploring new ways of working and providing better patient care, and they were merging with two other local practices in order to do this. All of the staff we spoke to were aware of the practice's vision, were proud to work for the practice and had a clear understanding of their roles and responsibilities.

Governance arrangements

Very good governance arrangements were in place. Examples of these included the carrying out of evidence based assessments, the allocation of lead roles to staff to help promote good clinical leadership, and the holding of regular planned meetings to share information to manage patient risk. The practice had a forward planner of meetings for 2016. This included specific times for the GPs to meet daily, to provide each other with clinical support and time to plan home visits. Responsibilities for management, administration, accountability and reporting structures within the practice were well defined, and clearly understood by staff. To help provide and promote effective patient care, the practice had set up multi-disciplinary teams (MDT) to oversee and lead on specific clinical areas, such as the Quality and Outcomes Framework (QOF) areas. Each team was responsible for monitoring the care provided to their patient group, and for ensuring that best practice guidance, and new guidelines, were shared with the wider team. In addition to this, each MDT provided updates at staff meetings. It was clearly evident that staff at all levels were committed to helping the practice perform well.

Good arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. Clinical audits had been carried out and staff were able to demonstrate how these had led to improvements in patient outcomes. The practice actively sought feedback from patients using surveys. They also had an active patient participation group (PPG), which they encouraged to provide feedback on how services were delivered and what could be improved.

Leadership, openness and transparency

There was a clear leadership and management structure, underpinned by strong teamwork and good levels of staff satisfaction. The GPs, nurses and the practice management team had the experience, capacity and capability to run the practice and ensure high quality compassionate care. Staff we spoke with told us they felt well supported by the leadership at the practice. A culture had been created which encouraged and sustained learning at all levels. The provider had complied with the requirements of the Duty of Candour regulation. The partners encouraged a culture of openness and honesty. They were effective systems which ensured that when things went wrong, patients received an apology and action was taken to prevent the same thing from happening again. For example, we saw evidence that a patient had received a very full and detailed response to the concerns they had raised. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

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

The practice encouraged and valued feedback from patients and staff. They had a virtual PPG which provided a patient's perspective on issues, concerns and proposed developments. The practice manager told us that each year the practice wrote to 50 patients from under-represented groups of patients, to ask if they would be interested in joining the PPG. We were told that, to-date, there had been no response to the letters sent out in January 2016. We spoke with some of the PPG members, who told us they felt their views and opinions were welcomed by the practice. Staff had also gathered feedback from patients through their Friends and Family Test survey. The practice had also

Are services well-led?

Good

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

recently carried out an in-house patient survey, and produced an action plan to address the issues raised. The results of these surveys were made available on the practice's website.

It was very evident that the GP partners and practice manager valued and encouraged feedback from their staff. Arrangements had been made which ensured that all staff received an annual appraisal.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and an early adopter of new ways of delivering primary care aimed at improving the patient experience. The staff team demonstrated their commitment to supporting the development of better services for patients through their involvement in the Northumberland Vanguard project, which is piloting new ways of supporting vulnerable patients and patients with long-term conditions. The GP partners had made a decision to merge with two other practices, to help them provide better services for patients through the use of shared resources. They were working with their colleagues to develop specialisms and offer new services.

The practice actively encouraged and supported staff to access relevant training. There was a good approach to identifying, and learning from significant events. Staff carried out clinical and quality improvement audits to help improve patient outcomes. The team demonstrated their commitment to continuous learning by:

- Providing GP Registrars (trainee GPs) and medical and nursing students with opportunities to learn about general practice.
- Actively encouraging and supporting staff to access relevant training. This included staff attending in-house monthly 'Training In Protected Time On-Going Educational Scheme' (TIPTOES) sessions.
- Carrying out a good range of clinical and quality improvement audits.
- Learning from any significant events that had occurred.