

# White 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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the White Medical Group on 11 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. The staff team took the opportunity to learn from all internal and external incidents.
- 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.
- Overall, risks to patients and staff were assessed and well managed, and there was evidence of good governance arrangements.
- 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 committed to supporting patients to live healthier lives, through a targeted and proactive approach to health promotion.

- Outcomes for patients were consistently very good. Data from the Quality and Outcomes Framework (QOF) showed that patient outcomes in the clinical and public health indicators covered were above average, when compared to the local clinical commissioning group (CCG) and England averages. The practice had also performed well in respect of their cervical screening uptake rate, which was higher
- Patients' emotional and social needs were seen as being as important as their physical needs, and there was a strong, person-centred culture. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their treatment.

# Summary of findings

- The practice had very good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvement are:

- Ensure medicines are managed safely and appropriately. This includes making sure there is a rigorous system for recording actions taken in response to medicines safety alerts, and ensuring that all medicines requiring cool storage are stored securely.

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

- Ensure the practice's significant event reports, and 'near-miss' dispensary events, include more detail regarding the lessons to be learned from what happened, and what needs to change to achieve this.

- Carry out regular checks to confirm that nursing staff continue to be registered with their professional body. Ensure there is documentary evidence to confirm this.
- Provide information about complaints, and provide opportunities for patients to provide feedback, in the patient waiting area.
- Make sure sharps bins are signed and dated by the member of staff who sets them up.
- Carry out a lone working risk assessment.

**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?

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

The practice had a 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 managing and responding to safety alerts, with the exception of safety alerts about medicines. Overall, risks to patients and staff were assessed and well managed, and there was evidence of good governance arrangements. However, we identified concerns about the management of medicines in the practice's dispensary which could potentially have placed patients at risk of receiving an unsafe service. The premises were clean and hygienic. Required pre-employment checks had been carried out for staff recently appointed by the practice, but there was no formal system in place for monitoring the continuing registration of the nurses.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services.

Outcomes for patients were consistently very good. Data from the Quality and Outcomes Framework (QOF) showed that patient outcomes were above average, when compared to the local clinical commissioning group (CCG) and England averages. The QOF data, for 2014/15, showed the practice had performed very well in obtaining 100% of the total points available to them for providing recommended care and treatment, with a 5.3% exception reporting rate. The rate was 4% below the clinical commissioning group (CCG) average and 3.9% below the England average. The practice had also performed well in respect of their cervical screening uptake rate, which was higher at 87.07%, than the national average of 81.83%.

Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance. Clinical audits demonstrated staff's commitment to quality improvement. Staff were committed to 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 help ensure the range and complexity of patients' needs were met. Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good



# Summary of findings

## Are services caring?

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 evidence of a strong, 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 clinical commissioning group (CCG) and national averages. Patients told us they were treated with compassion, dignity and respect, and they felt well looked after. Information for patients about the range of services provided by the practice, was available and easy to understand. Staff had made very good arrangements to help patients and their carers cope emotionally with their care and treatment.

Good



## Are services responsive to people's needs?

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. Patients we spoke with, and most of those who completed Care Quality Commission (CQC) comment cards, were satisfied with access to appointments. Results from the NHS GP Patient Survey showed that patient satisfaction levels with telephone access and appointment availability was either above, or broadly in line with, the local CCG and national averages. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had a system in place for managing complaints. Information about how to complain was available on the main practice's website and in its patient information leaflet. However, there was no information in the patient waiting area about how to complain or provide feedback about the service.

Good



## Are services well-led?

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

Overall, there was evidence of good governance arrangements. 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 meetings to share information, to manage patient risk. All meetings were minuted and these were available to staff. However, we found the governance of the practice's dispensary was not sufficiently rigorous. 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. There was a clear leadership structure and staff felt

Good



## Summary of findings

very well supported by the GPs and the practice manager. Regular clinical, practice, nursing and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. The practice actively sought feedback from patients via their Friends and Family Test survey and patient participation group. There was a 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

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 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 the older patients. For example, all patients over 75 years of age had a named GP who was responsible for their care. Clinical staff undertook home visits for older patients who would benefit from these. There were good systems in place to help reduce unplanned emergency admissions into hospital. Older patients on the high-risk register were discussed at the practice's monthly multi-disciplinary meeting, and patients discharged from hospital were reviewed weekly. Arrangements had been made for housebound patients, living a mile or more from the nearest pharmacy, to have their medicines delivered on a weekly basis.

Good



### People with long term conditions

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 100% of the total points available to them, for providing care and treatment to patients with diabetes. This was 5% above the local CCG average and 10.8% above the England average. Patients with long-term conditions were offered a structured annual review, 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.

Good



### Families, children and young people

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

Good



# Summary of findings

There were systems to identify and follow up children who were at risk. For example, appointments were available outside of school hours and the main practice and branch surgeries were suitable for children and babies. The practice offered a range of contraceptive services and sexual health advice. The GPs worked in partnership with the community midwife team, to provide patients with access to ante-natal clinics and post-natal care. The practice had performed well in delivering childhood immunisations. Publicly available information showed that the majority of their immunisation rates were above 90%. Nationally reported data also showed the practice had performed very well in the delivery of their cervical screening programme. The uptake for their cervical screening programme was higher, at 87.07%, than the national average of 81.83%.

## **Working age people (including those recently retired and students)**

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

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. The practice had assessed the needs of this group of patients and developed their services to help ensure they received a service which was accessible, flexible and provided continuity of care. 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. Extended hours early morning GP appointments were offered on most days to make it easier for working patients to access appointments.

Good



## **People whose circumstances may make them vulnerable**

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. Staff demonstrated they had good knowledge of their patients with learning disabilities, and had planned services to meet their needs. This included providing patients with learning disabilities with access to an extended annual review to help make sure they received the healthcare support they needed. The practice allocated a minimum of two half-day sessions each year to enable clinical staff to carry out these reviews. A local social worker attended the practice's monthly clinical meeting to help staff keep

Good





# Summary of findings

up-to-date with the needs of their patients with learning disabilities. Staff were in the process of updating the practice's clinical IT system to ensure appropriate alerts had been added. 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)**

The practice is rated as good for the care of people experiencing poor mental health.

There were good arrangements for meeting the needs of patients with mental health needs. For example, nationally reported QOF data, for 2014/15, showed the practice had performed very well in obtaining 100% of the total points available to them for providing recommended care and treatment to this group of patients. The data showed that 93.3% of these patients had a documented care plan, which had been agreed with their carers during the preceding 12 months. This was 19% above the local CCG average and 16.1% above the England average. Patients experiencing poor mental health were provided with advice about how to access various support groups and voluntary organisations. The practice hosted a range of in-house services, including those provided by community psychiatric nurses, consultant psychiatrists and staff from the Recovery Partnership (Alcohol and Drugs). Patients were able to access in-house counselling and 'Talking Therapies' services. 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. 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. The practice had signed up to a dementia friendly initiative being promoted by a national charity and had two Dementia Champions.

**Good**



# Summary of findings

## 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 and 12 other patients. They told us they received good care and treatment. Feedback about access to appointments and appointment waiting times was mainly positive. However, a small number of patients said they had experienced difficulties getting through to the practice on the telephone. None of the patients we spoke with were aware of how to contact the out-of-hours service.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 29 completed comment cards and the majority of these were positive about the standard of care provided. Words used to describe the service included: top class; great service; wonderful care; caring and attentive without exception; excellent treatment from excellent doctors; and first class.

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, telephone access and appointment availability 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:

- 94% described their overall experience of the surgery as good, compared with the local CCG average of 88% and the national average of 85%.
- 98% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.

- 89% said the last GP they saw was good at giving them enough time. This was in line with the local CCG average and above the national average of 87%.
- 99% had confidence and trust in the last nurse they saw. This was in line with the local CCG average and above the national average of 97%.
- 89% said the last nurse they saw was good at giving them enough time. This was in line with the local CCG average, but below the national average of 92%.
- 88% said the last appointment they got was convenient, compared with the local CCG average of 93% and the national average of 92%.
- 78% described their experience of making an appointment as good, compared with the local CCG average of 76% and the national average of 73%.
- 91% 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%.
- 73% found it easy to get through to the surgery by telephone. This was in line with the national average, but below the local CCG average of 78%.
- 59% said they usually got to see or speak to their preferred GP. This was in line with the national average, but below the local CCG average of 65%.

(244 surveys were sent out. There were 121 responses which was a response rate of 50%. This equated to 2.6% of the practice population.)

## Areas for improvement

### Action the service MUST take to improve

- Ensure medicines are managed safely and appropriately. This includes making sure there is a

rigorous system for recording actions taken in response to medicines safety alerts, and ensuring that all medicines requiring cool storage are stored securely.

# Summary of findings

## Action the service **SHOULD** take to improve

- Ensure the practice's significant event reports, and 'near-miss' dispensary events, include more detail regarding the lessons to be learned from what happened, and what needs to change to achieve this.
- Carry out regular checks to confirm that nursing staff continue to be registered with their professional body. Ensure there is documentary evidence to confirm this.
- Provide information about complaints, and provide opportunities for patients to provide feedback, in the patient waiting areas.
- Make sure sharps bins are signed and dated by the member of staff who sets them up.
- Carry out a lone working risk assessment.
- Provide a defibrillator in line with current external guidance and national standards.

# White Medical Group

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a CQC pharmacist. The team included a GP specialist adviser and a practice professional with a practice management background.

## Background to White Medical Group

The White Medical Group provides care and treatment to 839 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of the NHS Northumberland clinical commissioning group (CCG) and provides care and treatment to patients living in Stamfordham and the surrounding areas. We visited the following location as part of our inspection:

Glenbriar, 12 Grange Road, Stamfordham, Newcastle, NE18 0PF.

The practice serves an area where deprivation is lower than the England average. The practice population includes fewer patients who are under 18 years of age than the England average, and more patients aged over 65 years of age, than both the local CCG and England averages. The practice had a low proportion of patients who are from ethnic minorities.

The Stamfordham surgery premises are located in a building that has been adapted to meet patients' needs. The practice had four GP partners (two male and two female), two salaried GPs (female), two practice nurses (female), three healthcare assistants/phlebotomists, a practice manager, an administrative/medicines manager,

a reception/medicines manager, a clinical manager and a small team of administrative and reception staff. When the practice is closed patients can access out-of-hours care via Northern Doctors Urgent Care Limited, and the NHS 111 service.

The practice and dispensary opening hours are:

Monday: 9am to 12:50pm and 2:30pm to 6pm.

Tuesday and Thursday: 8:45am to 12:50pm.

Wednesday and Friday: 8:45am to 12:50pm and 2:30pm and 6pm.

Appointment times are as follows:

Tuesday, Wednesday and Thursday: 8:45am to 11:15am.

Friday: 3pm to 5:30pm.

## Why we carried out this inspection

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

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

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 April 2016. During our visit:

- We spoke with a number of staff, including two GPs, the practice manager, two practice nurses, and staff working in the administrative and reception team.
- We observed how patients were being cared for and reviewed a sample of the records kept by staff.
- We reviewed 29 Care Quality Commission (CQC) comment cards in which patients shared their views and experiences of the service.
- We spoke with two patients from the practice's patient participation group and 12 other patients.

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.
- 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.)

# Are services safe?

## Our findings

### Safe track record and learning

The practice had a system in place for reporting and recording significant events. Staff had identified and reported on 26 significant events during the previous 12 months. We found that, following each incident, staff had completed a significant event audit report. These provided details of what had happened and what staff had done in response. Copies of significant event reports could be accessed by all staff on the practice intranet system. The sample of records we looked at showed the practice had managed such events consistently and appropriately. However, they did not always include sufficient detail about the lessons that had been learned by staff.

There was an effective system for managing and responding to safety alerts, with the exception of safety alerts about medicines. All safety alerts, including those covering medicines, were received by the practice manager, and then forwarded to relevant staff, including the clinical manager and GP prescribing lead. However, there was no system in place to record actions taken in response to medicines safety alerts. Staff kept a 'near-miss' record (a record of dispensing errors that had been identified before medicines had left the dispensary), and we were told that these were discussed in team meetings. But, staff could not provide us with recorded evidence of the lessons that had been learnt to prevent their re-occurrence.

Where appropriate, 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. However, the arrangements for managing medicines were not always reliable or appropriate. Prescriptions were dispensed at the Stamfordham surgery, for patients who did not live near a pharmacy.

The dispensary had standard operating procedures that were readily available (these are written instructions about how to safely dispense medicines); however, the documents did not include version control or date of review. We found the standard operating procedures were not always followed by dispensary staff. For example, one prescription had been dispensed and was awaiting collection, but had not been signed by a doctor.

The practice had signed up to the Dispensing Services Quality Scheme, and there was a named GP who provided leadership to the dispensary team. Staff were NVQ2 level trained and had annual appraisals. Staff's dispensing competency was assessed by the clinical lead as part of the annual appraisal process.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and these were managed appropriately. However, the controlled drug cupboard did not meet the relevant requirements.

The practice did not have a formal process in place to regularly check that medicines were within their expiry date. This is contrary to dispensing guidance. Expired and unwanted medicines were disposed of in line with waste regulations. Staff told us how they managed medication review dates and how prescriptions were monitored, including those that had not been collected. However, on checking, we found one prescription which had not been collected since September 2014 and two prescriptions from September 2015. Regular review of items not collected is good practice and enables staff to aid patients with compliance.

Medicines requiring refrigeration were not stored in locked refrigerators, and access was not always restricted to authorised personnel. Refrigerators were monitored appropriately, and staff were aware of what action to take if the refrigerator went out of the recommended range.

Blank prescription forms were not stored in accordance with national guidance and the system in place for tracking prescription forms after they had been received into the practice, was not rigorous.

The practice had policies and procedures for safeguarding children and vulnerable adults. Staff told us they were able to easily access these. Designated members of the GP team acted as children and vulnerable adults safeguarding leads, and provided advice and guidance to their colleagues. Staff

## Are services safe?

demonstrated they understood their safeguarding responsibilities and all had received safeguarding training relevant to their role. For example, the GPs had completed level three child protection training. All clinical staff had completed adult safeguarding training. Although non-clinical staff had not completed this training, this had been incorporated into the practice's learning plan for 2016/17.

The practice's chaperone arrangements helped to protect patients from harm. Only clinical staff acted as chaperones and they had been 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.) Although there was no information displayed in the surgery waiting area advertising the chaperone service, each consulting room contained information about this.

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 comprehensive health and safety risk assessment had been carried out in December 2015 to help identify and manage potential risks. Electrical equipment had been tested to make sure it was safe, and fire safety checks had been completed.

Appropriate standards of cleanliness and hygiene were being maintained. A cleaning audit had been completed within the last 12 months and an action plan put in place to address shortfalls identified. Lead infection control responsibilities had previously been held by the nurses who had retired towards the end of 2015. The practice had recently appointed two new nurses. We were told that, on completion of their probationary period, one of these nurses would become the designated infection control lead, and would complete extra training to help them carry out this role effectively.

There were infection control protocols in place and staff had received relevant training. A comprehensive infection control audit had been carried out in May 2015 to identify whether any further action was needed to reduce the risk of the spread of infection. Staff had prepared an action plan to address the issues identified. A legionella risk assessment had been carried out. (Legionella is a

bacterium that can grow in contaminated water and can be potentially fatal.) Sharps bins were provided for staff to safely dispose of their used needles. However, the member of staff who had set some of these up had not signed or dated them.

Required pre-employment checks had been carried out for staff recently appointed by the practice. For example, the provider had obtained information about staff's previous employment and, where relevant, evidence of their qualifications. They had also carried out DBS checks for clinical staff. Appropriate indemnity cover was in place for all clinical staff. Checks had also been made to make sure GP staff continued to be registered with their professional regulatory body. However, there was no formal system for monitoring the registration of the nursing staff with the Nursing and Midwifery (NMC).

Overall, there were suitable arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Staff rotas had been completed for a period of 12 months, to help ensure suitable staffing levels were maintained. Non-clinical staff had been trained to carry out reception, administrative and dispensing roles, to help ensure the smooth running of the practice.

Administrative staff were allocated regular 'gap time' to enable them to catch-up with their designated roles and responsibilities. We identified that, there were occasions each week, when staff worked alone at the surgery, covering the reception and dispensary. Although the practice had a lone working policy, a lone working risk assessment had not been completed. At the time of the inspection, the practice had a full complement of GPs and nursing staff, and was only using GP locum staff to cover absence due to sickness and holiday leave. GP locum staff had access to a locum pack to help prepare them for working at the practice.

### **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. All staff had completed basic life support training.

## Are services safe?

Oxygen and emergency drugs were available for use in an emergency. Staff did not have access to a defibrillator. However, arrangements were underway to provide a community defibrillator at the practice following consultation with the patient participation group and staff.

The practice had a business continuity plan for major incidents, such as power failure or building damage. This was accessible to all staff via the practice's intranet system. A copy of the plan was also kept off site by key individuals.



# 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 good systems in place to keep all clinical staff up-to-date with new guidelines. In particular, staff had developed an in-house 'one-stop-shop' intranet resource. Staff could use this to access, for example, links to various palliative care resources such as the North of England 'Deciding Right' guidance on making care decisions in advance. We were provided with evidence that showed clinical staff followed up any discrepancies between national and local guidelines.

### 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 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 100% of the total points available to them for providing recommended care and treatment, with a 5.3% exception reporting rate. The rate was 4% below the clinical commissioning group (CCG) average and 3.9% below 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.) 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 diabetes. This was 5% above the local CCG average and 10.8% 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.

- 100% of the total points available to them for providing recommended clinical care to patients diagnosed with a stroke or transient ischaemic attack. This was 1.6% above the local CCG average and 3.4% above the England average.

Staff were proactive in carrying out clinical audits to help improve patient outcomes. We looked at a sample of the clinical audits that had been carried out during the previous 24 months. These were relevant, showed learning points and evidence of changes to practice. For example, an osteoporosis audit had been carried out which led to improved READ coding for fragility fractures and an improved referral pathway enabling patients to receive a DEXA scan (A DEXA scan is a special type of x-ray that can be used to diagnose bones that have become weak and fragile and READ codes are a set of clinical descriptions that practices can use to manage the data in patients' records.) Staff had also carried out a range of quality improvement audits, to help ensure patients had good health outcomes and received safe care.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. They had received the training they needed to carry out their roles and responsibilities. This included training on safeguarding vulnerable patients, basic life support and infection control. Nursing staff had completed additional post qualification training, to help them meet patients' needs, including for example, training in child immunisations and cervical screening. Staff made use of e-learning training modules and in-house training to ensure they kept up-to-date with their mandatory training. All staff had received an annual appraisal of their performance and 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. There were rigorous systems in place which ensured that incoming and outgoing patient information was dealt with in a timely manner. Important

# Are services effective?

(for example, treatment is effective)

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.

## 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 (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.

## 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. 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 1.3% above the local CCG average and 2.4% above the England average. The uptake of cervical screening was higher, at 87.07%, than the national average of 81.83%. 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, 92.9% had been offered support and treatment during the preceding 24 months. This was 3.9% above the local CCG average and 7.1% 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. For example, the majority of the immunisation rates were above 90%.

# 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, patient-centred culture. Staff were highly motivated and committed to offering 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 space would be found if patients needed to discuss a confidential matter.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 29 completed comment cards and the majority of these were positive about the standard of care provided. Words used to describe the service included: top class; great service; wonderful care; caring and attentive without exception; excellent treatment from excellent doctors; and first class. We spoke with 12 patients and two members of the patient participation group. Overall, patients were very satisfied with the care and treatment they received from the practice team. However, a very small number of patients said some of the doctors could be better at listening to them and explaining what the medicines they had prescribed were for.

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:

- 98% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.

- 90% said the last GP they saw was good at giving them enough time, compared with the local CCG average of 89% and the national average of 87%.
- 90% said the last GP they saw was good at listening to them, compared with the local CCG average of 91% and the national average of 89%.
- 99% had confidence and trust in the last nurse they saw. This was in line with the local CCG average and above the national average of 97%.
- 91% said the last nurse they saw was good at listening to them, compared with the local CCG average of 94% and the national average of 91%.
- 93% found receptionists at the practice helpful, compared with the local CCG average of 89% and the national average of 87%.

### 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 were either above, or broadly in line with, the local CCG and national averages. Of the patients who responded to the survey:

- 89% 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%.
- 84% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 86% and the national average of 82%.
- 92% said the last nurse they saw was good at explaining tests and treatments. This was in line with the local CCG average and above the national average of 90%.
- 82% 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

## Are services caring?

Staff were good at helping patients and their carers to cope emotionally with their care and treatment. They understood patients' 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.

The practice was committed to supporting patients who were also carers. Staff maintained a register of these patients, and offered them an annual healthcare review and an influenza vaccination. There were 86 patients on this register, which equated to 1.8% 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. The practice manager acted as a 'Carers' Champion', to help raise the profile of carers within the practice, and to ensure that carers had a point of contact. A member of staff also acted as a bereavement administrator to help make sure bereaved patients received follow up contact from the practice.

# 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. There were good systems in place to help reduce unplanned emergency admissions into hospital. Nationally reported data showed the practice's performance, in relation to the number of emergency admissions per 1000 patients with specific healthcare conditions, was comparable with other practices. Older patients on the high-risk register were discussed at monthly multi-disciplinary meetings, and patients discharged from hospital were reviewed weekly. High-risk patient care plans were in place to help reduce unplanned admissions into hospital and keep patients safe. A register was kept of patients requiring palliative care and staff carried out an annual audit of patients who had died to help identify whether there were any common themes or patterns. Arrangements had been made for housebound patients living a mile or more from the nearest pharmacy, to have their medicines delivered on a weekly basis.
- Good arrangements for meeting the needs of patients with long-term conditions (LTCs). Staff maintained registers for the clinical conditions covered by the Quality and Outcomes Framework (QOF), and used these to help them plan services and deliver appropriate care. The GPs held lead roles for each of the LTCs covered by the QOF, to help provide clinical leadership and oversight. A good call and recall system was in place which helped to make sure that patients received an invitation to attend an annual healthcare review. 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, we were told the clinical team also made further attempts to contact them.
- Good arrangements for meeting the needs of patients with mental health needs. Patients experiencing poor mental health were given advice about how to access various support groups and voluntary organisations. The practice hosted a range of in-house services including those provided by community psychiatric nurses, consultant psychiatrists and staff from the Recovery Partnership (Alcohol and Drugs). Patients were able to access in-house counselling and 'Talking Therapies' services. A consultant psychiatrist had recently attended a practice meeting, to help staff better understand the range of mental health services available to patients.
- Good arrangements for meeting the needs of patients who had dementia. Staff kept a register of these patients, and the practice's clinical IT system clearly identified them to help make sure clinical staff were aware of their specific needs. 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. Staff demonstrated they had a good knowledge of their patients who had learning disabilities, and they had planned services to meet their needs. This included providing these patients with access to an extended annual review to help make sure they received the healthcare support they needed. The practice allocated a minimum of two half-day sessions each year to enable clinical staff to carry out reviews of patients with learning disabilities. A local social worker attended the practice's monthly clinical meeting to help staff keep up-to-date with the needs of these patients.
- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, to access the practice. The surgery provided ground floor consultation and treatment rooms, to make it easier for patients with disabilities to access them. A ramp was provided for patients requiring wheelchair access. A toilet was provided. However, there were no hand rails and the space available was limited. Disabled parking was not available. There was no loop system for patients with a hearing impairment. When we spoke to staff about this, they told us they had never experienced any problems and knew their patients well and how best to communicate with them. Although staff

# Are services responsive to people's needs?

## (for example, to feedback?)

had access to a telephone translation service and interpreters should they be needed, there was no information on display about this. Staff were able to access this service via the Ponteland practice.

- Making good arrangements to meet the needs of children, families and younger patients. There were systems to identify and follow up children who were at risk. For example, the practice maintained a register of vulnerable children and contacted families where a child had failed to attend a planned appointment. Appointments were available outside of school hours and the main practice and branch surgeries were suitable for children and babies. The practice offered a range of contraceptive services as well as sexual health advice. Staff told us they worked closely with the health visitor team and the local Sure Start Children's Centre, to help ensure important information about children at risk was shared. Recent changes to the nursing team meant the practice had been able to increase the number of childhood immunisation clinics it offered. The GPs worked in partnership with the community midwives team, to provide patients with access to ante-natal clinics and post-natal care. Breast feeding and baby changing facilities were not available in the surgery due to the size of the premises.

### Access to the service

The practice and dispensary opening hours were:

Monday: 9am to 12:50pm and 2:30pm to 6pm.

Tuesday and Thursday: 8:45am to 12:50pm.

Wednesday and Friday: 8:45am to 12:50pm and 2:30pm and 6pm.

Appointment times were as follows:

Tuesday, Wednesday and Thursday: 8:45am to 11:15am.

Friday: 3pm to 5:30pm.

All consultations were by appointment only and could be booked by telephone, in person or on-line. Patients could access urgent, same-day appointments and they could book more routine appointments, up to six weeks in advance. (Patients using the automated telephone booking system were able to book appointments up to 14 days in

advance.) Although a formal system was not in place for carrying out telephone consultations, staff told us they regularly had telephone contact with patients wishing to discuss health issues or concerns.

Patient feedback about access to appointments and appointment waiting times was mainly positive. However, a small number of patients said they had experienced difficulties getting through to the practice on the telephone. None of the patients we spoke with were aware of how to contact the out-of-hours service. However, information about how to contact the local out-of-hours service was available on the practice's website and in the patient waiting area.

The majority of patients who provided feedback on CQC comment cards said they were satisfied with access to appointments. Results from the NHS GP Patient Survey of the practice, published in January 2016, showed that patient satisfaction levels with telephone access and appointment availability were either above, or broadly in line with, the local clinical commissioning group (CCG) and national averages. Of the patients who responded to the survey:

- 91% 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%.
- 73% said they found it easy to get through to the surgery by telephone. This was in line with the national average and below the local CCG average of 78%.
- 91% 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%.
- 88% said the last appointment they got was convenient, compared to the local CCG average of 93% and the national average of 92%.
- 78% described their experience of making an appointment as good, compared to the local CCG average of 76% and the national average of 73%.

### 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 received by the practice and a complaints policy which provided staff



## Are services responsive to people's needs? (for example, to feedback?)

with guidance about how to handle complaints. Information about how to complain was available on the main practice's website and in its patient information leaflet. However, there was no information about how to complain or provide feedback to the practice on display in

the waiting area. The practice had received four complaints during the previous 12 months. We looked in detail at one complaint and saw that it had been appropriately handled. Staff had carried out an annual review of complaints to determine whether there any common themes or patterns.

# 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 GP partners and practice manager had a clear vision to deliver high quality care and promote good outcomes for their patients. Staff had devised an overarching mission statement and a statement of purpose, which set out what they wanted to achieve and how they would do this. Staff we spoke with were aware of the practice's vision for providing high quality care, and said they felt involved in the day-to-day operation of the practice.

### Governance arrangements

Overall, there was evidence of good governance arrangements. 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 meetings to share information, to manage patient risk. All meetings were minuted and these were available to staff. However, we found the governance of the practice's dispensary was not sufficiently rigorous.

The practice had performed consistently very well in the clinical and public health indicators covered by the Quality and Outcomes Framework (QOF). Members of the clinical and non-clinical teams had been allocated responsibilities for overseeing the practice's QOF performance. Staff we spoke with were clear about their roles and responsibilities in relation to the QOF.

### Leadership, openness and transparency

Clinical staff and the practice manager, had the experience, capacity and capability to run the practice and ensure good quality care. Our interviews with staff showed they were committed to providing safe, high quality and compassionate care. The GP partners and practice manager encouraged a culture of openness and honesty. Staff told us they were encouraged to report concerns, so they could be handled quickly and without blame. There was a clear leadership structure and staff were satisfied with how they were supported.

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

The practice encouraged and valued feedback from patients and staff. There was an active patient participation group (PPG) which consisted of eight members who met quarterly. We spoke with two of the PPG members. They told us they felt their views and opinions were welcomed by the practice. However, one person said they would like a representative from the practice team to attend the meetings on a more regular basis. They said topics for discussion at PPG meetings included telephone consultations, ordering repeat prescriptions and the recruitment of clinical staff. Staff had also gathered feedback from patients through their Friends and Family Test (FFT) survey. Data for the previous three months indicated that all of the 11 patients who had completed FFT feedback forms, reported that they would recommend the practice to families and friends.

Good arrangements had been made which ensured that staff received an annual appraisal of their performance. Staff we spoke with told us their feedback was welcomed and listened to. Staff said they would feel comfortable raising concerns with the practice manager or the GP partners.

### Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team had taken on lead roles to help improve how primary care services were delivered within their locality. For example, the practice manager chaired the Northumberland Practice Manager Meetings and represented the local CCG at local NHS England meetings. Clinical staff attended local commissioning meetings to help influence the development of local primary care services. The practice demonstrated their commitment to improving patient outcomes through their involvement in clinical research programmes. For example, they had agreed to participate in a local project to improve how primary and secondary healthcare professionals accessed patients' medical records. The practice actively encouraged and supported staff to access relevant training. Staff carried out a range of clinical and quality improvement audits, to help improve patient outcomes. Although not a training practice, staff occasionally offered learning opportunities to trainee healthcare professionals to learn about general practice.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	<b>The provider failed to make proper and safe arrangements for the management of medicines.</b>
Maternity and midwifery services	Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Surgical procedures	
Treatment of disease, disorder or injury	