Scots Gap Medical Group

Quality Report

The Surgery
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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?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Scots Gap Medical Group on 9 October 2014 and visited the main surgery in Scots Gap and the branch surgery in Stamfordham. We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

Overall, we rated the practice as good, although there were some areas where the practice need to take action. Our key findings were as follows:

- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.
- Patients said, and our observations confirmed, they were treated with kindness and respect.
- Patient outcomes were at or above average for the locality and good practice guidance was referenced and used routinely.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

We saw the following area of outstanding practice:

- The practice was considered to be outstanding in terms of their caring approach. Patients were respected and valued as individuals by the practice staff and feedback from patients reflected this.

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

Importantly, the practice must:

- Improve the way they manage medicines.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Processes were in place to identify unsafe practices and measures put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence. Staff were aware of safeguarding procedures and took appropriate action when concerns were identified. The practice must improve the way they manage medicines. Systems and processes to reduce risks associated with infection prevention and control should be improved.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Good practice guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified. The practice could show us appraisals and the personal development plans for staff. We saw staff worked well in multidisciplinary teams.

Are services caring?

Outstanding

The practice is rated as outstanding for caring. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and secured service improvements where these were needed. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice was equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and staff were clear about their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. The practice did not have an active patient participation group (PPG), however they were attempting to engage with patients in other ways. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met. The practice aimed to complete reviews for patients with more than one long term condition at the same appointment; reducing the need for patients to attend on multiple occasions. For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, A&E attendance rates for children and young people were routinely monitored. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

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

Summary of findings

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out health checks for people with learning disabilities. The practice offered longer appointments for people, if required.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.

Summary of findings

What people who use the service say

All of the 15 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system.

We reviewed 16 CQC comment cards completed by patients prior to the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Feedback on the length of time to obtain an appointment was also positive.

The latest GP Patients Survey completed in 2013 showed patients were satisfied with the services the practice offered. The results were significantly better than other GP practices nationally, with the practice ranked 2nd overall in England. The results were:

- The proportion of patients who would recommend their GP surgery– 100%
- The proportion of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment – 100%
- GP Patient Survey score for opening hours– 95.7%
- Percentage of patients rating their ability to get through on the phone as very easy or easy– 80%
- The proportion of respondents to the GP patient survey who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone – 99.2%
- Percentage of patients rating their experience of making an appointment as good or very good – 97.2%
- The proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good – 100%

The practice had also completed its own survey of 81 patients in March 2013 and had achieved similarly positive results.

Areas for improvement

Action the service MUST take to improve

The practice must improve the way they manage medicines.

Outstanding practice

The practice was considered to be outstanding in terms of their caring approach. Patients were respected and valued as individuals by the practice staff and feedback from patients reflected this.

Scots Gap 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 GP. The team also included a CQC Pharmacist Inspector and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Scots Gap Medical Group

The practice is located in Scots Gap, around 11 miles to the west of Morpeth in Northumberland. Services are provided from the main base in Scots Gap and the branch surgery in Stamfordham, around 13 miles away. The practice covers the area from Elsdon in the north to Stamfordham in the south, and east to west Mitford to Ridsdale. The practice provides services from these two addresses and we visited both during this inspection:

- Main site: The Surgery, Scots Gap, Morpeth, Northumberland NE61 4EG
- Branch surgery: 16 Grange Road, Stamfordham, Northumberland NE18 0PF (a separate report is being written for this branch, as at the time of the inspection it is registered as a separate location)

The practice at Scots Gap is based on the ground floor, with staff offices and facilities on the first floor. It also offers on-site parking, a WC, step-free access and a dispensary that provides medicines for patients who do not live near a pharmacy. The practice provides services to around 1,850 patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

The practice has two GP partners (one male, one female), a practice nurse contracted for 15.5 hours per week, a practice manager, two administrators and five staff with reception and dispensing duties.

The service for patients requiring urgent medical attention out of hours is provided by Northern Doctors.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 9 October 2014. The inspection team spent eight and a half hours inspecting the service at the practice's surgeries in Scots Gap and Stamfordham. We spoke with 15 patients and eight members of staff from the Scots Gap practice. We spoke with and interviewed the Practice Manager, two GPs, the Practice Nurse, two administrators and two dispensing staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 16 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how this practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice had defined systems, processes and standard operating procedures (SOP). We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities in the reporting of serious incidents. The practice used the safeguarding incident and risk management system (SIRMS). Staff said there was an individual and collective responsibility to report and record matters of safety. Where concerns had arisen, they had been addressed in a timely manner. We saw outcomes and plans for improvement arising from serious incidents were discussed and recorded within staff meeting minutes.

The dispensary had a 'near miss' log for staff to complete where the potential for harm to patients had been narrowly avoided. We saw this had been used on a small number of occasions and staff we spoke with were not clear on the thresholds for reporting such incidents.

The practice had not made any notifications to CQC since its registration in April 2013. (Registered providers must notify CQC about certain changes, events and incidents affecting their service or the patients who use it.) We found the practice manager was aware of the notifications they were required to make to CQC, but had not yet found it necessary to make any.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events and our conversations with them confirmed their awareness of this. The practice manager told us staff were made aware of their roles and responsibilities with regards to incident reporting on recruitment and during induction training. The practice manager was the person who collated this information and staff we spoke with were aware of this. The practice manager also had responsibility for assessing whether any urgent or remedial action was required.

We saw three significant events had been recorded during the last 12 months. We saw details of the event, learning outcomes and action points were noted. Staff meeting minutes showed these events were discussed within the practice, with actions taken to reduce the risk of them happening again.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice electronically and were printed and passed on to clinicians and those who needed to see them. Any actions to be taken were agreed and the practice manager kept a record of alerts received and actions taken. For example, the practice had recently received an alert on Ebola and this had been circulated to all staff.

We found learning from safety incidents was communicated externally, as well as internally within the practice when required. For example, the practice had recorded and reported an incident where a laboratory had returned a blood test result for the wrong patient.

Reliable safety systems and processes including safeguarding

The practice had a range of policies, procedures and systems to help keep patients safe. These included policies for infection control, the protection of vulnerable adults and children and the recruitment of staff.

Staff we spoke with were aware of their responsibilities if they suspected someone was at risk of abuse. They knew who to contact if they had any concerns about patients' safety. The GPs had completed level 3 safeguarding children training, however only the practice nurse had completed safeguarding vulnerable adults training. Other staff had completed safeguarding children training to the appropriate levels, but not safeguarding adults training. Staff were aware of the escalation process.

Requires improvement

Are services safe?

The practice had a chaperoning policy. The practice manager told us it would be the clinical staff who routinely acted as chaperones, although some of the dispensing and reception staff had acted as chaperones too. They said the practice's policy was for chaperones to stand inside the privacy screen with the patient and the clinician. We saw some staff had undergone chaperone training some time ago.

We asked the practice manager if non-clinical staff who acted as chaperones had been the subject of an enhanced Disclosure and Barring Service (DBS) check. The practice manager said they had not been the subject of DBS checks and risk assessments to show why a DBS check was not appropriate had not been completed. The practice manager took immediate action to ensure only staff who had been DBS checked acted as chaperones.

A notice was displayed in the patient waiting area to inform patients of their right to request a chaperone.

The practice had a system in place to ensure that patient referrals were made in a timely manner. There was also a system in place to ensure the timely recall of patients, for example, for blood tests.

Medicines Management

The practice must improve the way they manage medicines.

Arrangements for managing medicines were checked at the surgery. Medicines were dispensed for patients who did not live near a pharmacy. Staff told us that people who were eligible had the choice of having their medicines dispensed at the surgery or their local pharmacy.

The practice had a safe system for reviewing hospital discharge and clinic letters. Where changes to medicines were recommended or made, these were highlighted promptly to GPs who made the necessary changes to patients' records.

The arrangements for the review of medicines for patients with long term conditions were checked. Regular medicines reviews are necessary to make sure that patients' medicines are up to date, relevant and safe. Staff said that the GPs and practice nurse were responsible for these reviews. We saw that in some cases these reviews were done but not reported in a consistent way. There was no system in place to ensure that GPs checked and signed repeat prescriptions every time before the medicines were dispensed and issued to patients. There was a risk patients did not receive medicines safely because GPs did not have the opportunity to do a clinical check before they were dispensed.

Staff showed us the standard operating procedures (these are written instructions about how to safely dispense medicines) for managing medicines and told us that these were currently being reviewed. We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors. Medicine errors from medicines which had been supplied to patients were recorded and reviewed at Primary Health Care Team (PHCT) meetings to reduce the risk of errors being repeated. The practice also had a 'near miss log' for the dispensing process, however this was not used consistently to help ensure people received their medication correctly.

We looked at the storage and recording of blank prescriptions. Blank prescriptions were stored in a secure area and were printed directly into the dispensary from the consulting rooms. Acknowledgement on receipt of blank prescriptions into the practice was made, however records of serial numbers on blank prescription forms were not held. This could lead to diversion of blank prescription forms, and misuse of prescriptions could go undetected.

Staff told us that there was a system in place for monitoring the expiry dates of medicines. However this was not clearly recorded and we found out of date medicines on the dispensary shelves. We also found one out of date medicine in the GP's emergency bag. We were told that before any medicines were dispensed, the expiry dates would be checked twice to prevent patients receiving out of date medicines. Records showed fridge temperature checks were carried out on the vaccine fridge which ensured this medication was stored at the appropriate temperature. However no records were kept for the fridges which stored other medicines.

Appropriate records relating to the use of medicines that are liable to misuse, called controlled drugs were kept. Audits of these were completed to ensure that medication was managed safely.

Records showed staff who managed the dispensary had received appropriate training. Staff told us they had regular appraisals, however they said their competency in the

dispensing task was not checked. The practice manager showed us competencies had been checked some time ago, however they confirmed it had not been completed on a regular basis recently.

We saw a system was in place for managing national alerts about medicines such as safety issues. Records showed the alerts were distributed by the medicines manager to dispensers, who implemented the required actions as necessary to protect people from harm.

Cleanliness & Infection Control

We saw the practice was visibly clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. The practice had a range of policies and procedures relating to infection control. These included guidance on hand hygiene and the use of personal protective equipment (PPE).

The practice had a nominated infection control lead. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. We spoke with the infection control lead who told us they had not completed any infection control audits or training with staff as part of their lead role. Training records we saw supported this. For example, there had been no routine assessment or checking of hand washing techniques used by staff.

There were arrangements in place for the disposal of clinical waste and sharps, such as needles. There were also contracts in place for the collection of general and clinical waste. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place. The clinical waste bin located outside the practice was locked, but not secured to the building. All of the sharps bins we saw had not been signed or dated on assembly as required.

The cleaning of the premises was contracted to an external company. The practice manager told us a new company had been contracted recently. A daily cleaning schedule for the practice was in place and the practice manager told us any issues regarding the cleaning would be escalated as required. We saw testing of water supplies for legionella bacteria and supporting risk assessments had been completed. The practice had spillage kits available to be used to clean up any bodily fluid spills. These were stored in a cupboard in the treatment room which was clearly marked.

Staff reported there was always sufficient PPE available within the practice, should they need to use it. We saw hand gel was available throughout the practice for staff and patients to use.

Equipment

The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG) machines and fire extinguishers. We looked at a sample of medical and electrical equipment throughout the practice. We saw regular checks took place to ensure it was in working condition.

Staffing & Recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. The practice had a well established staff team, with the most recently recruited member of staff joining two years ago. We reviewed the records for this member of staff and found the appropriate checks had been completed.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)). For GPs they said the practice paid for their GMC registration by monthly direct debit, which assured them of their registration status. The practice nurse was contracted to work in the practice from their main employer, the local NHS trust. We checked the registration status of the GPs and nurse employed by the practice on the GMC and NMC websites before the inspection and found they were registered as required.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. The practice manager said when a GP was on leave or unable to attend work, a regular locum GP was used. A locum agreement was in place for this and the practice had recently reached

agreement to use a new locum GP in the near future. We saw the practice had a 'locum pack' in place to support locum GPs with their prescribing in line with the practice's prescribing policies.

We spent some time during the inspection observing how the staff dealt with patients who arrived to use the practice. We saw staff kept patients informed and confirmed who they would be seeing. This was well received by the patients.

Monitoring Safety & Responding to Risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent. The practice did not run any 'open access' clinics; however we were told patients who attended the practice on the day without an appointment would be seen by a clinician. Staff said the approach the practice took was that they 'don't turn people away'.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. This included GPs, a nurse, the practice manager, medicines dispensers and staff providing reception and administrative support. Staff we spoke with were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy. For example, within the reception area receiving patients or on the telephones.

Staff had access to a defibrillator and oxygen within the practice for use in a medical emergency. Only the clinical staff were trained in the use of the defibrillator. We also found the practice had a supply of medicines for use in the event of an emergency. Staff we spoke with knew how to react in urgent or emergency situations.

Arrangements to deal with emergencies and major incidents

The practice had emergency response plans in place. The practice manager showed us the practice had a 'continuity and recovery plan'. All staff had been provided with a copy and were able to access the document at home, if required. The plan included details of how the practice would respond to events such as widespread staff illness, loss of essential services, epidemics and pandemics. They told us the practice's 'major incident response' was to move services to the practice's branch surgery in Stamfordham, for example, in the event of flood or fire. They told us how in the past the practice had worked closely with a local practice to prepare for the possibility of a swine flu outbreak.

Equipment for dealing with medical emergencies was seen to be available within the practice, including emergency medicines. Staff we spoke with told us they had been trained to perform cardiopulmonary resuscitation (CPR) and we saw records to confirm this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found care and treatment was delivered in line with recognised practice standards, local and national guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE).

GPs and other clinical staff were able to perform appropriate skilled examinations with consideration for the patient. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

Staff we spoke with described how they carried out comprehensive assessments which covered patients health needs. They explained how care was planned to meet identified needs and how patients were reviewed at regular intervals to ensure their treatment remained effective. For example, we were told that patients with long term conditions such as diabetes were invited into the practice to have their medication reviewed for effectiveness. Medication reviews were also completed opportunistically by GPs when patients attended the practice or on the telephone when repeat prescriptions required re-authorisation.

Patients we spoke with said they felt well supported by the GP and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who filled in CQC comment cards.

Patients were referred appropriately to other services, where there was a need to do so. The GPs recorded this in the patients' consultation notes.

We found processes were in place to seek and record patients' consent and decisions were made in line with relevant guidelines. Staff we spoke with were able to describe the consent process. For example, a GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people.

Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The clinical staff we spoke with were aware of and could describe audit activity across the practice. For example, the practice had completed an audit of topical ocular antibiotic usage (eye drops and eye ointment). The audit criteria stated that topical ocular antibiotics should generally be offered where conjunctivitis was severe, as a deferred option or where the patient was a child at school. The practice hoped to achieve this in 80% of cases. The audit showed evidence of improved patient care and outcomes through the review of care and implementation of change. The audit had been through two complete cycles (in February and October 2014) and covered 64 and 37 cases respectively. Results showed an improvement from 27% to 67% and concluded the standard of 80% should be achievable.

As part of our pre-inspection analysis of information, we identified the practice was an outlier in two areas. The first area was on the percentage of patients with diabetes for whom the last blood pressure was 140/80 or less in the preceding 15 months. This was based on Quality and Outcomes Framework (QOF) data from 2012/13; the latest available at the time. We saw the practice had already taken action in this area and improved outcomes for its patients through audit and re-audit. The second area related to the practice being unable to produce a register of patients aged 18 and over with learning disabilities; again based on 2012/13 data. We spoke with the practice manager about this, who told us this was due to the practice not having any such patients on their list at that time. The practice were now able to produce this information.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as fire training and cardiopulmonary resuscitation (CPR). The GPs in the practice were registered with the General Medical Council (GMC). They were up to date with their yearly continuing professional development

Good

Are services effective?

(for example, treatment is effective)

requirements and both had been revalidated. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The nurse in the practice was registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example for National Vocational Qualifications (NVQs). Staff were also supported to attend learning events and conferences. For example, as part of their role one member of staff was supported to attend a GP research forum in January 2014.

The practice nurse had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. They were supported by a member of the administrative team who was trained in phlebotomy.

We saw the practice had an induction checklist to be used when staff joined the practice. This covered individual areas of responsibility and was signed off once completed. A locum pack had also been developed to support locum GPs with their prescribing.

Working with colleagues and other services

We saw evidence and the practice staff told us they worked with other services and professionals. The GPs we spoke with all made reference to regular meetings with other healthcare professionals. These included district nurses, health visitors and midwives. GPs had also established virtual links by email with consultants and contacted them for advice and guidance when required. For example, within the fields of gastroenterology, gynaecology and dermatology. The practice hosted regular clinics where their patients could see other healthcare professionals on site, These included clinics for a podiatrist, a midwife and a health visitor.

The practice had systems are in place for recording information from other health care providers. This included from out of hours services and secondary care providers, such as hospitals. We saw there was effective communication and information sharing about patients between services. For example, both of the GPs reviewed the list of patients test results, including bloods. If tests needed repeating, the practice would make contact the patient and generate a 'practice note'. This note would remain in place until the patient had been successfully contacted. Letters received by the practice, for example, hospital discharge information, was read by both GPs, date stamped, signed then scanned. Important information was then entered in the patients notes on the practice system.

The practice was a member of a group of GP practices located in the West of Northumberland who met regularly to build relationships and share learning with the aim of improving patient care. The practice manager told us they met on a monthly basis with other practice managers and they felt this had been beneficial for both themselves, the practice and their patients. For example, practice-based warfarin monitoring had been introduced through the work of this group.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their

Good

Are services effective?

(for example, treatment is effective)

practice. All clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all immunisations and minor surgical procedures, a patient's formal written consent was obtained. One of the GPs we spoke with told us they had audited the practice's minor surgery consent forms and found all had been completed correctly. Verbal consent was taken from patients for examination. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. These were completed by the GPs. The GP completed the 'new patient assessment' which involved explaining the service to the patient, reviewing their notes and medical history and the recording of basic information about the patient. For example, confirming any medicines they were currently taking. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, children would be placed within the immunisation programme at the appropriate point.

Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

Some of the patients we spoke with told us they were on regular medicines. They confirmed they were asked to attend the practice sometimes to review their conditions and the effectiveness of their medicines.

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention leaflets, for example, on smoking cessation and alcohol consumption. There was also information available for carers and on dementia type illnesses.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on CQC comment cards reflected this. Of the 16 CQC comment cards completed, 15 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included professional, friendly, polite, supportive, caring and respectful. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in the reception dispensary area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. The reception area fronted directly onto the patient waiting area. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients were taken by administrative staff in an area where confidentiality could be maintained.

GPs we spoke with had recently had their annual appraisals. As part of these processes they had been rated highly for compassion and empathy. For example, the GPs would routinely visit the practice's palliative patients out of hours, despite the service having a contracted out of hours service.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. The practice had installed a touch screen check in facility for patients. The practice manager told us one of the benefits of this was it helped patient flow in the small reception area. This in turn reduced the risk of personal conversations being overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. The practice had been ranked 2nd nationally in the latest national patient survey results published on 3 July 2014. For example, the survey showed 100% of respondents had confidence and trust in the last GP they saw or spoke to and 100% would recommend the surgery to someone new in the area. The survey also showed 95% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. These results were significantly better compared to the CCG area and national averages. The results from the practice's own satisfaction survey in May 2013 showed that 96.8% of patients said they were satisfied with the practice overall.

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

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive. Patients also

Outstanding ☆

Are services caring?

commented they felt staff regularly went beyond the call of duty and exceeded their expectations. For example, when supporting families and helping them to cope with illnesses throughout the family.

Notices in the patient waiting room also signposted people to a number of support groups and organisations.

Support was provided to patients during times of bereavement. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. They had links with counselling services at a local hospice and a local vicar provided bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice from Public Health England, published in 2013. The practice had a lower percentage of patients under the age of 18 than the England average and a higher percentage of patients aged 65+ than the England average. The majority of the practice's population were of working age.

We found the practice, including the consulting rooms were accessible to patients with mobility difficulties. There was also a toilet that was accessible for disabled patients. There was a small waiting room with some seating; the consulting rooms were all close by and could be accessed from the waiting area.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home. Patients could also make appointments with the GP of their choice. An interpreter service was available for those patients whose first language was not English and the practice had an induction loop system to assist those with hearing difficulties.

Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

Patients received support from the practice following discharge from hospitals or following the return of test results. This included through the timely provision of post-operative medicines and follow-up appointments with a GP or nurse as required. Patients who filled in CQC comment cards mentioned how pleased they were with the support provided by the practice. For example, the care provided allowed a relative to remain in their own home to the end of their life.

The practice did not have a patient participation group (PPG). The practice manager told us they knew patient engagement could be improved. They had recently contacted some patients who had agreed to join an initiative described to us as 'Have Your Say'. The practice manager explained these patients would be contacted for their views on any proposed changes to the way the practice operated.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide an early and late surgery each week. This helped to improve access for those patients who worked full time. The practice also had access to telephone translation services if required, for those patients whose first language was not English.

The premises and services had been adapted to meet the needs of people with disabilities, as far as the constraints of the building allowed. Reasonable adjustments made included a ramp to allow for wheelchair access and handrails installed at the entrance to help those with mobility difficulties.

The practice manager told us they used the practice's website to help to break down barriers for patients to be able to access information. This included information on the clinics and services offered, including the provision of online appointment booking for patients who had registered for this service.

Access to the service

Patients we spoke with and those who filled out CQC comment cards all said they were satisfied with the appointment systems operated by the practice. This was reflected in the results of the most recent GP Patient Survey (2013/14). This showed 97% described their experience of making an appointment as good and 100% said the last appointment they got was convenient. These results were based on the responses of 113 patients and were above the weighted CCG (local area) averages. The practice had completed its own survey of 81 patients in May 2013. Results from those who responded were similarly positive about the convenience of their appointment, with 91.9% being satisfied.

Patients could make appointments in a number of ways. They could call into the practice in person, request an appointment over the telephone or book an appointment online (once they had registered for this service). The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on the practice's website. Out of hours enquiries were redirected

Good

Are services responsive to people's needs?

(for example, to feedback?)

to the practice's contracted out of hour's provider, Northern Doctors. The practice offered a late surgery until 7.30pm once a week at the Stamfordham branch, in addition to being open until 6pm on other weekdays at either Scots Gap or Stamfordham. Appointments were also available from 7am on Thursdays at Scots Gap and from 9am at either Scots Gap or Stamfordham on other weekdays. This had been a result of the practice surveying patients with regards to the opening hours offered. This allowed people who worked during the day or were unable to get to the practice a choice of when they wanted to see a clinician.

Consultations were provided face to face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time.

Listening and learning from concerns & complaints

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

We saw the practice had not received any formal complaints within the last 12 months. The practice manager explained there had been an occasion where a matter had been resolved with a patient. This had been done in partnership with the local PALS (Patient Advice and Liaison Service) department. We saw the matter had been resolved amicably and the patient requested they remained registered with the practice.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly. We saw the practice had a 'comments box' in place for patients to use.

None of the 15 patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 16 CQC comment cards completed by patients indicated they had felt the need to complain.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was not formally documented, however it was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded.

We spoke with eight members of staff and they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance Arrangements

Staff were aware of what they could and could not make decisions on. We also found clinical staff shared responsibilities within the practice, for example, for the vaccination of patients when required.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We asked some of the staff we spoke with to show us how they accessed these and all were able to do so.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. Performance in these areas was monitored by the practice manager, supported by the administrative staff.

The practice had completed a number of clinical audits, for example on topical ocular antibiotic usage and blood pressure measurements of patients with diabetes. The results of these audits and re-audits demonstrated outcomes for patients had improved.

We spoke with the practice manager and GPs about how the practice planned for the future. They told us a practice risk register was not routinely maintained, although risk management was on-going within the practice on a daily basis. For example, when staff had gone on maternity leave in the past, their temporary replacement was recruited before they left to ensure a timely and thorough handover could be completed.

The practice manager and GPs told us forward planning was discussed regularly, although this hadn't been formally documented. This had included looking at the options available to the practice with regards to increasing the physical size of the premises in response to an increasing patient list size.

Leadership, openness and transparency

The practice had a leadership structure in place. The GP partners led equally on clinical matters and the practice manager led on staffing and financial matters. The practice had nominated leads in a small number of areas. For example, there was a lead nurse for infection control. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time, including at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. A number of policies had recently been updated and some were still in the process of being reviewed or implemented. For example, the practice had a template to construct a whistleblowing policy, however this work was still to be completed. Staff we spoke with knew where to find the practice's policies if required.

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

The practice had carried out a patient survey in May 2013 and reviewed its findings. They were largely positive and were reflected by the latest GP patient survey results, where the practice was ranked 2nd overall in England. Patients reported they were very happy with the services provided.

Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. We saw copies of minutes taken to confirm this. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points.

Are services well-led?

Good

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

The practice didn't have a patient participation group (PPG). The practice manager told us they were aware of the need to improve methods of gathering feedback from patients. They had already started this process by compiling a list of patients who were happy to be contacted for their views on any proposed changes to the way the practice operated.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.

The practice nurse employed by the practice was part of the Rothbury nursing team and shared any learning from meetings of this group with practice staff. The practice manager also met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of medicines. How the regulation was not being met: The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, handling, using and dispensing of medicines used for the purposes of the regulated activity. Regulation 13