Greystoke Surgery

Quality Report

Morpeth NHS Centre
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Website: www.greystokesurgery.co.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 Greystoke Surgery on 23 July 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice:

- The practice had implemented and regularly reviewed a colour coded high risk register for elderly patients, palliative care patients and those felt to be at high risk of admission to hospital, including patients who had previously attempted suicide
- The practice had developed a tiered carer's consent form to ensure a carer's level of responsibility and decision making on behalf of the patient was known.
- All patients with a long term condition, learning disability or mental health issue were routinely offered a longer appointment time.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There were enough appropriately trained staff on duty at all times to keep patients safe. The practice was clean and hygienic and there was evidence to confirm that cleaning and infection control audits were regularly completed. All staff had attended training on infection control. The practice had a chaperone policy in place and staff called upon to act as a chaperone had received the appropriate training. All staff had been checked with the Disclosure and Barring Service (DBS).

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were in line with other practices in the local Clinical Commissioning Group (CCG) and England. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice had systems in place for completing clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and all staff had received training appropriate to their roles and responsibilities. Staff received yearly appraisals which gave them the opportunity to formally discuss personal and performance issues and identify training and development needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were generally in line with or better than the national average. Patients said they were treated well and were involved in making decisions about their care and treatment. Patients had access to information

Summary of findings

and advice on health promotion, and they received support to manage their own health and wellbeing. The practice had produced a monthly newsletter, the Greystoke Gazette for some time (up to issue number 59 on the day of our inspection). This provided patients with practice updates, seasonal and other health information and information on support groups. We saw staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

Nationally reported data showed patient outcomes for this area were generally better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback about the practice was good and most stated they found it was easy to make an appointment with a GP within an acceptable timescale. The practice were taking steps to reduce emergency admissions to hospital for patients with complex healthcare conditions by ensuring these patients had fully comprehensive care plans. Systems were in place to ensure patients discharged from hospital were supported when appropriate – in particular those that had been identified for inclusion in the practice high risk register and patients who had attempted suicide. The practice had made improvements as far as possible to ensure the premises were well equipped to treat patients and meet their needs. This included the installation of a wider door to one of the consultation rooms and the purchase of a wider, heavy duty consultation couch to ensure the surgery was accessible to obese patients. Easy to understand information about how to complain was available and evidence showed the practice responded quickly and appropriately to issues raised.

Are services well-led?

Good 

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

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients, which they acted upon. The practice had an active patient participation group (PPG) which met regularly and

with whom they worked collaboratively to improve services. Comprehensive induction guidance was available for staff. Regular structured staff meetings were held and staff received yearly appraisals.

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

Outstanding ☆

The practice is rated as outstanding for the care of older patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 had a named GP and were routinely invited to attend an over 75 health check. Elderly patients felt to be at risk of admission to hospital were offered inclusion on the practices high risk register. If included the patient and their carer if appropriate would be invited to have a face to face consultation with their named GP. During this consultation an Emergency Health Care Plan (EHCP) would be agreed which documented any decision regarding end of life care and resuscitation if appropriate. With the patients agreement these plans were then shared with the Out of Hours provider. This register was colour coded so that a patient's current status was easily recognisable to multi-agency staff. For example, blue signified that the patient was receiving palliative care, yellow signified a patient was settled, pink indicated that a patient was still being assessed and red was used to indicate that a patient was felt to be at risk. Patients included in the high risk register were reviewed at monthly meetings between the lead GP, district nurses, practices nurses and social workers. The practice also actively identified and flagged palliative care patients to ensure they were supported appropriately and held monthly multi-agency palliative care meetings.

Home visits were routinely available and included reviews of long term conditions for housebound patients. The practice had developed effective working relationships with five local care and nursing homes and had identified a lead GP for each home who undertook weekly visits.

At 84.4% the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average of 73.2%.

People with long term conditions

Good ●

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

The practice was able to demonstrate comprehensive and regularly reviewed care planning for patients with long-term or complex

conditions and had a system in place to ensure patients were recalled for reviews when required. Medication reviews were routinely timed to coincide with a patients long term condition review.

All patients with a long term condition were given a named GP who took responsibility for following up on patients who did not attend appointments. Continual non-attenders were discussed at regular partner meetings.

The practice had chosen not to hold specific chronic disease management clinics so that patients had the flexibility to book review appointments at a date and time convenient to themselves, included during extended hour opening times. In addition patients with multiple chronic diseases were given one review rather than have to attend numerous appointments.

The practice regularly reviewed and updated their protocols following the issue of new guidance from the National Institute for Health and Care Excellence (NICE) and ensured this information was cascaded to all clinical staff through weekly meetings.

The practice monitored how well it performed against key clinical performance indicators such as those contained within the Quality and Outcomes Framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). The practice had achieved 98.2% of the points available to them in respect of QOF for 2013/14 which was 1% above the local CCG and 4.7% above the national averages.

The practice patient participation group (PPG) was committed to arranging educational information events for patients with long term conditions and had already hosted a session on the symptoms, diagnosis and management of psoriasis and menopause.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example looked after children or children subject of a child protection plan. The practice had identified one of the GPs as safeguarding lead who was responsible for reviewing all safeguarding related correspondence and attending or supplying reports for child protection case conferences. Monthly multi-agency meetings were held to discuss children at risk which were attended by the midwife,

health visitor, school nurse, GPs, practice nurses and practice administration staff. All A&E attendances or failures to attend hospital appointments in respect of children were routinely reviewed by the GPs.

The practice had a recall system in place for childhood immunisations and rates were above or in line with local averages for all standard childhood immunisations. For example, meningitis c vaccination rates for 12 month old children were 98.6% compared to 84.8% locally; for two year old children 98% compared to 97.1% locally; and for five year old children 94.6% as compared to 96.4% locally.

Appointments were available outside of school hours commencing at 8.15am daily and up to 8pm one night per week. Cervical screening rates for women aged 25-64 were above the national average at 90.6% (national average 81.9%).

The practice was taking steps to ensure it was young people friendly and more accessible to its under 18 patient population by working towards a 'You're Welcome' accreditation (You're Welcome is a government led incentive aimed at developing young people friendly health services and encouraging young people to be more involved in decisions about their health and care). This has involved working with local young people and IT students to develop a separate area on the practice web site for that age group and ensuring the format is compatible when accessed from mobile phones and other technology. Practice staff had attended careers fairs, devised questionnaires and met with young people to help plan and facilitate this. One of the members of the patient participation group was under 18 years of age. With support and training from other staff the two young practice apprentices had been tasked with developing the web site and were currently working on its implementation and making the text easier to read and more appealing.

Working age people (including those recently retired and students)

Good

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

Nationally reported data showed that 51.2% of the practice population either worked or was in full time education (national average 60.2%). The practice was proactive in meeting the needs of these patients by offering online services such as being able to order repeat prescriptions, book appointments and view parts of their medical records. The practice was open until 6.30pm on a Monday, Wednesday, Thursday and Friday and for extended hours until 8pm on a Tuesday. The extended hours opening was staffed by GPs and

nurses to ensure working patients had equal access to long term condition reviews. Bookable telephone consultations were also available and all clinicians routinely dealt with telephone enquiries at the end of each surgery. Repeat prescriptions could be ordered at any time either online or by phone. The practice were also involved in the Choose and Book scheme which enables patients referred to a hospital or clinic to choose the provider of their choice and at date and time which is convenient. The practice was proactive in offering NHS health checks and opportunistic health checks at cervical smear appointments

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had a register of patients aged 18 or over with a learning disability. A recall system was in place to ensure these patients were offered an annual health check and given a copy of their care plan.

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified a clinical lead for dealing with vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role. Multi-disciplinary safeguarding meetings were held on a regular basis and a multi-agency risk assessment conference (MARAC) protocol was in place to help identify and deal appropriately with concerns around domestic violence.

New mothers were routinely screened for post natal depression at their six week check-up and women who had suffered miscarriages or ectopic pregnancies were contacted to offer guidance and support. Patients who had suffered bereavement and those who had been diagnosed with a serious condition were also contacted. Monthly multi-agency palliative care meetings were held and palliative care patients were given a named GP.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (100% compared to an England average of 86%) and was in line with the England average for ensuring patients diagnosed with dementia had received a face-to-face review within the preceding 12 months.

Summary of findings

The practice was committed to proactively and opportunistically offering assessment to patients at risk of dementia and depression and to continually improving the quality and effectiveness of care provided to this group of patients. This included depression and dementia screening during appropriate long term condition reviews.

Patients on the practice severe mental illness register (which included those suffering from dementia) were offered an annual physical health check, as were the carers of dementia patients.

The practice was committed to limiting the re issuing of anti-depressants by repeat prescription without a regular review by a GP.

Summary of findings

What people who use the service say

During the inspection we spoke with nine patients (including five members of the practice patient participation group) and reviewed 37 Care Quality Commission (CQC) comment cards. The feedback we received indicated the majority of patients were very happy with the care and treatment they received, they felt were treated with dignity and respect and received a service which met their needs.

Findings from the 2015 National GP Patient Survey published in July 2015 for the practice indicated most patients had a good level of satisfaction with the care and treatment they received. The results were generally in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. For example of the 134 surveys that were returned from a total of 256 that were sent out (response rate of 52%):

- 76% of respondents said the last GP they saw or spoke to was either very good or good at involving them in decisions about their care (local CCG average 78%). The same result for the nursing staff was 64% (local CCG average 69%).
- 87% of respondents said the last GP they saw or spoke to was either very good or good at treating them with care and concern (local CCG average 86%). The same result for the nursing staff was 83% (local CCG average 82%).
- 86% of respondents said the last GP they saw or spoke with was either very good or good at explaining tests and treatments (local CCG average 84%). The same result for nursing staff was 82% (local CCG average 80%).

Outstanding practice

- The practice had implemented and regularly reviewed a colour coded high risk register for elderly patients, palliative care patients and those felt to be at high risk of admission to hospital, including patients who had previously attempted suicide
- The practice had developed a tiered carer's consent form to ensure a carer's level of responsibility and decision making on behalf of the patient was known.
- All patients with a long term condition, learning disability or mental health issue were routinely offered a longer appointment time.

Greystoke Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) Lead Inspector. The team included a GP and a specialist advisor with experience of practice management.

Background to Greystoke Surgery

The practice is based near the centre of Morpeth and provides care and treatment to 9071 patients from Morpeth and the surrounding villages of Pegswood, Longhirst, Ulgham, Felton, Wingates, Netherwitton, Meldon, Whalton, Ogle, Blagdon, Stannington, Nedderton and the west parts of Guidepost and Bedlington. The practice is part of the Northumberland Clinical Commissioning Group and operates on a Personal Medical Services (PMS) contract.

The practice provides services from the following address, which we visited during this inspection:

Greystoke Surgery, Morpeth NHS Centre, The Mount, Morpeth, Northumberland, NE61 1JX

The practice is based on the first floor of Morpeth NHS Centre which opened in 2013. This is a modern, purpose built building providing accommodation for two GP surgeries and a range of other health care professionals and services including district nurses, health visitors, school nurses, and consultant led outpatient services, X-ray facilities, physiotherapists, podiatrists and occupational therapists. A large pharmacy is also situated on the ground floor. Parking, including disabled parking, is available in the on-site car park.

The building provides fully accessible treatment and consultation rooms on the first floor which are accessible by lift for patients with mobility needs. The practice is open between 8.00am to 6.30pm on a Monday, Wednesday, Thursday and Friday and from 8.00am to 8.00pm on a Tuesday.

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

Greystoke Surgery offers a range of services and clinic appointments including chronic disease management clinics, family planning, maternity services, cervical screening, NHS health checks, immunisations, vaccinations, foreign travel advice, minor surgery and cryotherapy. The practice consists of five GP partners (three male and two female), two salaried GPs (both female), four practice nurses, two health care assistants, a practice manager, office manager, medicines manager and 15 administrative staff who provide reception, typing and secretarial services. The practice is a teaching and training practice and is involved in the undergraduate education of medical students in conjunction with Newcastle University.

The Care Quality Commission (CQC) intelligent monitoring tool placed the area in which the practice is located in the eighth (out of ten) most deprived decile. In general people living in less deprived areas tend to have a lesser need for health services.

The practices age distribution profile showed higher percentages of patients aged over 45 than the national average. Average life expectancy for the male practice population was 80 (national average 79) and for the female population 84 (national average 83).

Detailed findings

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 July 2015. During our visit we spoke with a range of staff including GPs; the practice manager; office manager; practice nurses; healthcare assistants and members of the administrative team. We spoke to four patients in the surgery waiting room and a further five who were members of the practice patient participation group (PPG). We observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We also reviewed 37 Care Quality Commission (CQC) comment cards that had been completed by patients and looked at the records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

As part of planning our inspection we looked at a range of information available about the practice including information from the latest GP Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report accidents and near misses. For example, the practice had been asked to prescribe a drug for a patient on Tamoxifen (a drug used to treat and prevent some types of breast cancer) by the patient's hospital consultant but had then learned that there could be a contra-indication between the two medicines. The practice was able to demonstrate that it had analysed how the error had occurred and discussed the issue and findings with staff at a practice meeting. As a result the practice sent a letter of apology to the patient concerned and carried out an audit of all patients to ensure there was no other instance where a patient had been prescribed the same drugs simultaneously.

We reviewed a sample of significant event audit records and serious incident reports, and minutes of meetings where these were discussed. We were satisfied that the practice had managed these consistently over time and taken all necessary action to avoid possible recurrences.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded 32 significant events/ incidents during the period 1 April 2014 to 31 March 2015 covering a wide range of issues. The practice was able to demonstrate the action taken to ensure these issues did not happen again and also how information regarding such incidents was disseminated to staff by way of minuted practice meetings. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

National patient safety alerts were cascaded to clinical staff by email and to non-clinical staff in printed format. These were then discussed as a standard agenda item at monthly meetings to ensure appropriate action had been taken such as medication reviews, contacting affected patients and amending care plans. An example we were given of this was in relation to the practice being notified that patients were taking potassium permanganate (an antiseptic solution to treat ulcers and certain skin conditions) orally rather than using it in the bath or as a soak. The practice medication manager carried out an audit and contacted all patients who had been prescribed the solution and ensured that prescription instructions were amended to make it clear that the solution was not to be taken orally.

Overview of safety systems and processes

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

- The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and had recently been reviewed. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible by all staff. One of the GPs had been identified as the lead for safeguarding vulnerable children and adults and effective working relationships had been established with multi-agency practitioners. For example, monthly multi-disciplinary meetings were held involving the GPs, practice nurses, practice manager, office manager, health visitor, school nurses and midwife. Staff we interviewed stated they would feel confident in making a safeguarding referral and were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any

relevant issues when they rang to make or attend for appointments. A&E and hospital discharge notifications in respect of children were reviewed by a GP to ensure no safeguarding concerns had been identified. If any child flagged as being at risk or subject of a child protection on the practice computer system left the practice steps were taken to ensure contact was made with the practice the child was subsequently registered to ensure concerns were shared.

- A chaperone policy was in place and information about this was displayed in the practice waiting room. The nursing staff and some reception staff had received training on their roles and responsibilities as a chaperone (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure) and all staff had received Disclosure and Barring Service (DBS) check. Generally a member of the nursing staff would act as chaperone but if this was not possible only a receptionist who had received the relevant training would be called upon.
- There were procedures in place for assessing, monitoring and managing risks to patient and staff safety and a member of staff had been identified as the Health and Safety lead. The practice had up to date fire risk assessments and the fire alarms were tested on a weekly basis. Regular fire evacuation drills were carried out, the last one being 2 July 2015. All electrical equipment was checked to ensure the equipment was safe to use (next test due December 2015) and clinical equipment staff used to carry out diagnostic examinations, assessments and treatments, such as the defibrillator (a device used to restart the heart in an emergency), spirometer (a device that measures the volume of air inspired and expired by the lungs) and oxygen was regularly inspected and serviced.
- The premises were clean and hygienic throughout. A cleaning schedule was in place and audits of cleaning standards were carried out on a regular basis. An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. One of the GPs and the senior practice nurse had been designated as infection control leads and provided advice and guidance to colleagues as and when required as well as providing feedback during practice meetings on the results of inspection control audits. Both clinical and non-clinical staff had received infection control training. The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and cleaned every six months or more regularly if required. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms and were appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, hand soap, antimicrobial spray and wipes and hand towel dispensers to enable clinicians to follow good hand hygiene and infection control practice. The practice had an arrangement in place with NHS Prop Co (who owned and managed the building) for the safe disposal and management of clinical waste. All waste bins were visibly clean and in good working order. NHS Prop Co were also responsible for carrying out risk assessments and testing for legionella (a bacterium that can grow in water and can be potentially fatal) and we saw records to confirm this was being done.
- Effective arrangements were in place to ensure medicines requiring cold storage, such as vaccines, were stored appropriately. A policy was in place to ensure refrigerator temperatures were checked and recorded twice daily and cold chain audits were carried out to ensure that medication stored in the refrigerators was safe to use. The practice maintained a computer record of emergency drugs held on the premises, which was checked monthly. These drugs were stored appropriately with restricted access. During our inspection we found that a process was in place to check these drugs on a monthly basis to ensure they were in date, destroyed appropriately and re-ordered when required. Patients were able to re-order repeat prescriptions in a variety of ways including ordering at the practice, by telephone, online or by post. The medicines manager was the lead for dealing with repeat prescriptions but all staff were well aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and

were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect and medicines incidents and prescribing errors were recorded by the practice as significant events to ensure that similar incidents did not recur.

- The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included seeking proof of identification, evidence of a legal entitlement to work in the UK, references, qualifications, licence to practice if appropriate and Disclosure and Barring (DBS) checks. We viewed staff files and found this to be the case. We also checked the General Medical (GMC) and Nursing and Midwifery Council's (NMC) records to confirm that all of the clinical staff were licensed to practice. DBS checks had been carried out for all practice staff.
- The office manager told us about the arrangements that were in place to ensure there were enough staff on duty at all times which included the use of a buddy/deputy system for non-clinical staff, a colour coded rota for clinical staff. In addition the GP partners tried to arrange their leave so only one was off at any one time, part time partners were flexible in the hours that they worked and planned leave was discussed in weekly held clinical meetings. This had resulted in seldom having to use locum GPs but when this was necessary we saw evidence of a comprehensive locum induction pack and locum handbook. Staff and patients we spoke to on the day of our inspection told us they felt there was enough staff to maintain the smooth running of the practice and to keep patients safe.
- Patients' records were kept on an electronic system which stored all relevant medical information. As well as flagging vulnerable children and adults the system also flagged patients with dementia, mental health issues, learning difficulties and those who were carers or receiving palliative care which helped ensure risks to patients were clearly identified and reviewed.
- Staff were able to easily access the practice's policies and procedures. This helped to ensure that when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies and staff had received training in basic life support.

Emergency equipment was available including a defibrillator and oxygen. Emergency medicines held on site were in line with national guidelines, stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks and a reciprocal arrangement was in place with a neighbouring practice to provide accommodation and consultation rooms should the need be required. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The practice carried out a fire risk assessment on an annual basis, fire extinguishers had been subject to an annual check and fire exits were clearly signposted.

Staff were able to tell us of the process they would follow if there was a medical emergency on site. The member of staff alerted about the incident would activate an alarm which would in turn alert clinical staff that their immediate attendance was required. Emergency bags and equipment were readily available. We were told of an incident the practice had dealt with when there were concerns that a patient attending the surgery may have had a highly contagious disease. Practice staff had immediately isolated the patient in a separate room well away from other patients; the patients of the GP attending the matter were immediately transferred to another GP and immediate contact was made with the Infectious Disease and Hazardous Area Response Team at the local hospital as well as Public Health England. The patient was subsequently transported to hospital for further tests and the room used for isolation purposes had been sealed and withdrawn from use until it could be sterilised appropriately. The practice had received praise on how it

Good

Are services safe?

had dealt with the matter from Public Health England, the local CCG and the hospital and it was evident that practice staff had remained calm and in control and had clearly been aware of their roles and responsibilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The clinical staff were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health and Care Excellence (NICE) guidelines and had access to a number of clinical tools to aid with diagnosis and assessments. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Practice staff regularly attended training courses and sessions and learning would then be disseminated to colleagues through weekly clinical meetings which also covered discussions such as new guidelines, case and medication reviews and safety audits. The clinical meeting was also used to host the practice journal club where clinicians took it in turns to present articles of interest from medical journals and publications for discussion and as a training and professional development aid. The practice had also taken steps to ensure there were effective protocols in place to monitor the prescribing of antibiotics and other drugs. We saw evidence of two cycle audits covering the use of dovobet (an ointment or gel used to treat Psoriasis) and non-steroidal anti-inflammatory drugs in the over 75 age group. This helped to ensure that these drugs had not been over prescribed.

Chronic disease management clinics were held to cover a wide variety of diseases and the practice delivered these in such a way that patients with multiple chronic diseases need only attend one review clinic on a date and time convenient to them. A process was in place to ensure patients with certain chronic diseases, such as chronic obstructive pulmonary disease (COPD) and diabetes, held their own self-management plans.

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency assessments of children and young people (Gillick competence is a term used in medical law to decide whether a child aged 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity using a template adopted by the practice and, where appropriate, recorded the outcome of the assessment. The practice also liaised with social care teams at relevant local authorities who would also assist in mental capacity assessment if required.

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Protecting and improving patient health

There was a range of information on display within the practice reception area which included a number of health promotion and prevention leaflets, for example on mental health, dementia, sexually transmitted diseases, stress and addictions. The practice website also included links to a range of patient information including family health, long-term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 at 90.6% was above the national average of 81.9%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was above or in line with the averages for the CCG. For example, meningococcal C (Men C) vaccination rates for 12 month old children were 88.9% compared to 84.7% locally; for two year old children 98% compared to 97.1%; and for five year old children 92.9% as compared to 96.4% locally. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 63.8% (national average 52.2%) and the percentage of patients aged 65 or older who have received a seasonal flu vaccination was 84.4% compared to a national average of 73.2%.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS health checks for patients between the age of 40 and 74 and new patient health checks. Between the period 1 April 2014 and 31 March 2015 the practice had invited 538 patients for a NHS health check and had carried out 305 checks (take up rate of 56%).

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and its intranet system. This included care and risk assessments, care plans, medical records and test results. Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that a variety of minuted multi-disciplinary team meetings took place on a regular and scheduled basis and that care plans were routinely reviewed and updated.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results showed the practice had achieved 98.2% of the total number of points available to them. This practice was not an outlier for any QOF (or other national) clinical targets. Data from the QOF results for 2013-14 showed:

- Performance for diabetes related indicators were better than or comparable with the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- Performance for mental health related conditions were better than the national average
- The dementia diagnosis rate was comparable to the national average.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of five GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, fire safety, information governance, safeguarding, equality and diversity, infection prevention and control and more clinical based training for clinical staff.

The GPs were up to date with their yearly continuing professional development requirements and 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). The practice nurses reported they were supported in seeking and attending continual professional development and training courses.

All staff undertook annual appraisals that identified learning needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses and staff training files confirmed this.

We looked at staff cover arrangements and identified that there was always sufficient GP cover on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. The GPs, management team and reception staff covered for each other and the practice rarely relied on the use of locum GPs. When the practice had needed to use a locum GP a comprehensive locum induction pack and handbook was in place.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients said they were treated with respect and dignity by the practice staff. Comments made by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 37 CQC comment cards completed 33 were wholly positive. Words used to describe the practice and staff included outstanding, first class, sympathetic, efficient, professional, impressive, welcoming and caring. The other four cards were generally complimentary about the practice but did include comments regarding:

- A delay in getting an appointment with a named GP
- That it was a 'bit slow' to get an appointment
- There had been a delay in being seen at the allocated appointment time
- There was sometimes a delay in getting a timely appointment for something that was neither an emergency nor routine.

Data from the latest National Patient Survey, published in July 2015, showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors. For example:

- 91% said the GP gave them enough time compared to the CCG average of 88%
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 93%
- 87% said they felt they were treat with care and concern by the GP compared to the CCG average of 86%
- 83% said they felt they were treat with care and concern by the nurse compared to the CCG average of 82%

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times. National GP Patient Survey results showed that 86% of respondents found the receptionists at the practice helpful compared with the CCG average of 89% and national average of 87%.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A separate room was available if a patient wished to speak to a receptionist in private.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

Staff were aware of the need to keep records secure and maintain confidentiality. We saw that patient records were computerised and systems were in place to keep them safe in line with data protection legislation. One of the GP partners was nominated as a Caldicott Guardian (a person responsible for protecting the confidentiality of a patient and enabling appropriate information sharing).

The practice's computer system alerted staff if a patient was also a carer. Carers were routinely offered immunisations and signposted to relevant support services. The local carers association, Carers Northumberland attended the practice on a monthly basis to provide support and advice and the practice waiting room had a dedicated carer's stand containing useful information. The practice was working to the carers consent model and had developed a patient consent form to ensure a carer's level of responsibility and decision making on behalf of the patient was known. This form had a scoring system to establish the level of responsibility held by the carer (for example, whether the carer held power of attorney, was able to make medical decisions on behalf of the patient or could order and collect repeat prescriptions).

One of the practice GPs produced a monthly patient newsletter, the Greystoke Gazette, which contained practice updates and useful information. We saw copies of the latest two issues on the day of our inspection (issues 58 and 59) covering May to August 2015. Examples of information contained in the newsletter included seasonal and other health advice, information and links to support groups, information for carers and advice for the parents/carers of overweight children.

Good

Are services caring?

Staff told us those relatives who had suffered bereavement, regardless of whether they were a patient of the practice or not, were contacted or visited by a GP to offer support and signposting to appropriate services.

Young people had been consulted to help with the development of a young people friendly leaflets and a dedicated area of the practice website as part of the practices commitment to working towards the You're Welcome accreditation.

Care planning and involvement in decisions about care and treatment

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

Results from the National GP Patient Survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results for practice GPs and nurses were generally above the national averages. For example:

- 91.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88.5% and national average of 86.3%.
- 86.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84.9% and national average of 81.5%
- 90.1% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90.8% and national average of 89.7%.
- 92.5% said the last nurse they saw was good at treating them with care and concern compared to the CCG average of 92.3% and national average of 90.4%

Staff told us that translation services were available for patients who did not have English as a first language and a notice was displayed in the reception area informing patents this service was available.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example the practice had develop a high risk register and pathway to ensure patients at risk of hospital admission had fully comprehensive care plans which were discussed and reviewed at monthly multi-disciplinary team meetings.

There was an active patient participation group (PPG) consisting of approximately 15 patients who met on a bi-monthly basis. The PPG had been proactive in arranging health promotion events at the practice covering topics such as psoriasis and the menopause as well as assisting with patient surveys, flu immunisation clinics and the You're Welcome campaign. The PPG had identified their priorities for the coming year as liaising with the local authority to improve the access to the health centre, traffic system and road junction on the access road. This was felt necessary as there were a number of proposed housing developments in the area that would see approximately 6,000 new homes being built and a population increase of some 23%.

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

- The practice had extended opening up to 8pm every Tuesday for patients who could not attend during normal opening hours
- All patients with a long term condition, learning disability or mental health issue were routinely offered a longer appointment time.
- Home visits were available for patients unable to physically attend the surgery.
- Urgent access and 24 hour appointments were available. The practice also offer 'sit & wait' appointments at the end of every morning surgery.
- Pre bookable and same day telephone appointments were available with both the GPs and practice nurses. A recent audit had shown that the practice provided 600 GP and 400 nursing appointments per week.
- There were disabled facilities, hearing loop and translation services available.
- The practice had a supply of commonly used easy read health information and support service information leaflets.
- The practice were able to offer daily multiple long term condition reviews
- One of the practice consultation rooms had facilities for obese patients including wider doors and a bariatric consultation couch
- The practice offered over 75, new patient and NHS Health Checks.

Access to the service

The practice was open between 8.00am and 6.30pm on a Monday, Wednesday, Thursday and Friday and from 8.00am to 8.00pm on a Tuesday. In addition to pre-bookable appointments that could be booked up to eight weeks in advance, urgent and same day appointments were also available.

We looked at the practice's appointments system in real-time on the day of the inspection. Routine appointments and telephone appointments with a GP or a nurse were available the same day. Urgent same-day appointments were made available for patients each day and if these had all been taken the practice also offered a 'sit and wait' appointment system at the end of morning surgery. This helped to improve same day access to the service for the practice's patients.

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

- 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 76%.
- 97% of patients said they could get through easily to the surgery by phone compared to the CCG average of 78% and national average of 74%.
- 88% of patients described their experience of making an appointment as good compared to the CCG average of 75% and national average of 74%.
- 84% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 74% and national average of 65%.

Listening and learning from concerns and complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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

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

The practice had received 15 complaints during the period 1 April 2014 to 31 March 2015 and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. Formal reviews of complaints received by the practice were completed on a quarterly basis.

The practice was also able to demonstrate that it recorded and acted on what they classed as 'soft intelligence'. An example this was when the practice had become aware that the samples taken at a number of smear tests had not been sufficient to allow a laboratory analysis resulting in the patients having to be recalled. The practice had immediately responded to this by ensuring additional in-house training was delivered.

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 mission statement that was printed in their practice information leaflet and a number of aims and values that were central to the services they provided. These included:

- To provide comprehensive and high quality medical services
- To make effective and economic use of both financial and clinical resources
- A commitment to operate according to the ethos of equality
- To treat all patients with dignity and respect
- To respect patient choice and help patients make the right treatment decisions for themselves by sharing options clearly and comprehensively
- To consider patient views when developing services and to encourage patient feedback

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

The practice had identified a number of key clinical and non-clinical business objectives as part of its 5 year business plan. Non-clinical objectives included plans for succession, planning, recruitment and accommodating the continuing expansion of the population of Morpeth which was expected to increase by 25-30% as the result of the building of approximately 6,000 new homes in the area. Clinical objectives included extending the use of care plans to other diseases and medical conditions.

Governance arrangements

The practice had an overarching governance policy. This outlined the structures and procedures in place. Governance systems in the practice were underpinned by:

- A clear staffing structure and a staff awareness of their own roles and responsibilities.
- The implementation of comprehensive policies and procedures that all staff could readily access.
- A system of reporting and recording significant events and incidents without fear of recrimination and being able to demonstrate learning had been identified and acted upon
- A system of continuous audit cycles which demonstrated an improvement on patients' welfare.
- Clear methods of communication and regular and structured meetings that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- Proactively gaining patients' feedback and engaging patients in the delivery of the service. Acting on any concerns raised by both patients and staff.
- The GPs were all supported to address their professional development needs for revalidation and all staff in appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints.
- Named members of staff took on lead roles. For example, there was a lead GP for areas such as safeguarding, infection control, medicines management and QOF.
- The practice had a meetings charter in operation which dictated the nature, frequency and objectives of meetings. This included weekly business, clinical and admission avoidance meetings in addition to a twice weekly referral review meetings. Monthly palliative care team and educational meetings were also held as well as a quarterly pharmacist meeting.

Innovation

The practice were able to demonstrate several areas of innovation that were felt to have a positive impact on its patient population. This included;

- The monthly practice newsletter, the Greystoke Gazette which gave patients practice updates, seasonal and other health information and details of support services.
- The implementation and regular review of a colour coded high risk register for elderly patients, palliative care patients and those felt to be at high risk of admission to hospital, including patients who had previously attempted suicide
- Consultation and working with young people to work towards gaining the 'You're Welcome' accreditation by ensuring the practice was more accessible to children and young people
- The development of a tiered carers consent form to ensure a carer's level of responsibility and decision making was known.

This section is primarily information for the provider

Enforcement actions

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.