

Seaton Park Medical Group

Quality Report

Seaton Hirst Primary Care Centre
Norham Road
Ashington
Northumberland NE63 0NG
Tel: 01670 811811
Website: www.seatonparkmedicalgroup.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?

Good 

Are services well-led?

Outstanding 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a planned comprehensive inspection of Seaton Park Medical Group on 21 October 2014 at their Norham Road branch in Ashington. This branch was their head office and all patients were registered at this branch. The group also had two other branches. One was located in Nursery Park Road in Ashington and the other in Buteland Terrace in Newbiggin by the Sea.

We rated the practice overall as: Good

Our key findings were as follows:

- The practice displayed strong leadership and a patient centred culture.
- The practice was supportive of their staff and drew on their skills, experience and comments to improve the services they provided.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practice was a training practice that offered training to medical students and trainee GPs in addition to providing comprehensive training to their own staff.
- Feedback from patients was positive. They told us staff treated them with respect and kindness.

- The patient participation group were complimentary about the practice and explained their relationship with it as constructive and collaborative.
- The practice was clean, tidy and well maintained.

We saw areas of outstanding practice:

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's mission statement stated their aim was to be a top quality health care team, working with patients to enable good health, deliver excellent accessible care and continually develop to meet new challenges. All staff we spoke with were aware of this aim and their role to achieving it.
- The practice had effective governance arrangements in place that ensured all staff were aware of the nature and extent of their individual roles and responsibilities within the practice. There was clear evidence that there was a culture of openness, support and inclusiveness within the practice. The practice proactively and positively engaged with their staff.
- The practice had a comprehensive training programme for all staff that supported the needs of the practice, patients and staff.

Summary of findings

- The practice had effective systems in place to capture and monitor incidents, complaints and concern. It displayed a positive approach to learn from them and made improvements for the benefit of patients. The practice had an 'open door' policy where all staff were encouraged to raise any concerns or issues with their colleagues, managers and GP partners at any time. Staff we spoke with told us that support or guidance would be openly and freely given.
- The practice was proactive in finding and implementing ways of improving its services to patients. It regularly monitored its services and processes to ensure they were effective and made changes where necessary.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support improvement. Information about safety was highly valued and also used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Good



Are services effective?

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

Good



Are services caring?

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

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

Some patients reported difficulty in accessing appointments, but we saw the practice had implemented improvements to address these concerns and were continually evaluating this. Patients reported that they had access to a named GP. The named GP scheme the

Good



Summary of findings

practice operated ensured continuity of care, in particular to patients at care homes. Urgent appointments to see a GP were available the same day. Patients who required emergency treatment were seen quickly.

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

Are services well-led?

The practice is rated as outstanding for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included actively inviting comments from their patients about their experiences on their website, they also had a very active patient participation group (PPG).

Outstanding



Summary of findings

What people who use the service say

We spoke with two members of the practice Patient Participation Group (PPG) during the inspection. We also spoke with 10 patients. The majority of patients were complementary about the services they received at the practice. The patients we spoke with reported they felt safe and had no concerns when using the service. They told us that all staff treated them with dignity and respect. Some patients raised concerns with us about the process of booking appointments. However they told us that they could always get an emergency appointment on the same day.

The latest GP Patient Survey completed in 2013/14 showed the large majority of 117 patients who responded were satisfied with the services the practice offered. The results were:

- The last GP they saw or spoke to was good at giving them enough time - 81%
- The last GP they saw or spoke to was good at listening to them - 86%
- Surgery opening hours – 66%
- Overall satisfaction – 74%
- Patients who would recommend the practice: 62%

These results are lower than the CCG average, however the practice carried out its own survey in January 2014. The number of patients who responded was 417. The practice achieved a score of 86% for patients who considered the practice to be good or very good.

Outstanding practice

The practice was well-led. The practice had effective systems in place to capture and monitor incidents, complaints and concerns. There was a positive approach to learning from incidents, including shared learning with colleagues and other relevant agencies and making improvements.

There was clear evidence of a culture of openness, support and inclusiveness within the practice. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were familiar with the practice's mission statement and were able to describe their roles towards achieving it. The practice proactively and positively engaged with their staff.

The practice had a comprehensive training programme for all staff that supported the needs of the practice, patients and staff.

The practice was proactive in finding and implementing ways of improving its services to patients. We saw that they regularly monitored services and processes to ensure they were effective and made changes where necessary. The impact of any changes were then reviewed and the practice made further changes if required.

Seaton Park Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and second CQC inspector.

Background to Seaton Park Medical Group

The provider is a partnership of 10 GPs. There are also six salaried doctors, seven practice nurses, three health care assistants and a phlebotomist. The practice has a practice manager, quality and HR manager, a patient services manager and various administrative support staff. They are supported by the health visiting team, district nurses, midwives and other agencies who were employed by the local NHS trust. Seaton Park Medical Group is comprised of three branches. They are sited at the following locations:

Norham Road Branch

Norham Road

Ashington

Northumberland NE63 0NG

Nursery Park Branch

Nursery Park Road

Ashington

Northumberland NE63 0HP

Newbiggin Branch

Buteland Terrace

Newbiggin by the Sea

Northumberland NE64 6NS

The Norham road branch is the head office for the group and it is where we undertook our inspection. We did not have any reason to inspect the other branches.

Seaton Park Medical Group has a patient population of about 19,001 patients. The practice area covers Ashington, Newbiggin, Choppington, Guidepost, Bedlington, Wansbeck, Pegswood, Ellington, Lynemouth, Widdrington Station, Ulgham and Longhirst within Northumberland.

The practice, in collaboration with a local University, provides support and training placements to medical students. The practice is also an accredited training practice and works with the Northern Deanery to provide specialist training to trainee GPs.

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

Why we carried out this inspection

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

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

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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

We carried out an announced visit on 21 October 2014 at the Norham Road Branch. During our visit we spoke with a range of staff. This included GPs, Practice Nurses, Healthcare Assistants, Reception and Administrative staff. We also spoke with 10 patients who used the service and two members of the patient participation group. We made observations of the environment and the interactions between patients and non-clinical staff in the public areas.

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts and comments and complaints received from patients. We saw records of the analysis Significant Event Audits (SEA) from August 2007 to September 2014. SEA enable the practice to learn from patient safety incidents and 'near misses'. We saw that throughout this period processes and procedures had been changed to reduce the likelihood of incidents recurring.

We saw evidence that incidents were analysed and risk rated by GPs and senior management and reports were produced and presented to the GP partners quarterly and annually. We were told that this process had been in use since 2011. Monthly meetings to discuss additional learning and training following analysis of significant event audits had been undertaken since 2007. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events. All staff we spoke with understood their individual responsibility for reporting these events. We saw significant or critical events had been recorded in 2014. We saw details of the event, key risk issues, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at weekly meetings, key points were emailed to all GPs and relevant clinicians and a log kept of these points which ensured learning was disseminated and implemented. In addition, we saw that the practice audited safety incidents to determine any trends and any additional learning. All staff we spoke with confirmed that learning from incidents, concerns and complaints was always shared and improvements made. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw the practice had processes in place to ensure patient safety alerts were identified and acted upon. The practice manager monitored safety alerts daily and

disseminated them to relevant staff to review and action. The practice maintained a record of all alerts received that staff had access to. For example, safety alerts in respect of medicines were sent to the medicines manager and the nominated lead GP to investigate and decide on action to be taken. Action plans were drawn up and implemented.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records we saw showed that all staff had received relevant role specific training on safeguarding children and adults. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Staff told us that the contact details for other agencies was easily accessible.

The practice participated in the Multi-agency Risk Assessment Conference (MARAC) process. A MARAC is a meeting involving several agencies (including Police, Probation Service, Health and Children's Social Services) in which information is shared to try and help individuals (principally women and children) who may be at high risk of domestic violence.

The practice had safeguarding leads in place and they had all been trained to level 3 in safeguarding. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

We saw that the practice used a system where they recorded details of vulnerable patients. These patients had a named GP which enabled those patients to get immediate access to a doctor who understood their circumstances. Staff were made aware of these patients because the patient's records were flagged up to highlight their vulnerability to relevant staff. This provided patients with a higher level of support and safety.

Children who were under a child protection order and their immediate family all had a named GP.

The practice manager told us that patient records were kept in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Are services safe?

The practice used a system to enable reception staff to determine which service would best suit patients wishing to make an appointment. The practice manager emphasised that this system was an administrative device designed to efficiently direct patients to the service that best met their needs and not a triaging process. We were given an example of how the system worked, when a patient telephoned the practice complaining of chest pains, they were directed to call the emergency services using 999, but the patient refused. The call was immediately passed to the duty GP who triaged the patient. The system enabled patients to be fast tracked to speak to the emergency on call GP who decided which service was appropriate.

A chaperone policy was in place. Chaperones had received chaperone training. They were in the process of undergoing security checks by the Disclosure and Barring Service (DBS). (The DBS was formed when the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) merged). This was confirmed when a member of staff told us that they had received training from the lead GP and that the DBS had been undertaken. We saw that there was a poster in the reception area displaying information about the chaperone service.

Medicines Management

The practice had a GP lead for medicines and a medicines manager whose role included auditing and monitoring the prescribing activity of the practice. The practice had robust processes that ensured safe storage and good management of medicines.

Six members of the nursing team were qualified as independent prescribers and they received regular supervision and support in their role as well as refresher training in the specific clinical areas of expertise for which they prescribed.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw the practice held up to date copies of those directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

Monthly stock checks of vaccines were undertaken to ensure the numbers were correct and the vaccines were within their expiry dates.

There was a policy for ensuring medicines were kept at the required temperatures. The temperatures of the medicine refrigerators were checked on a daily basis to ensure that the cold chain was maintained. The refrigerators were only accessible to authorised staff.

We were told that the medicines manager regularly reviewed and monitored prescribing at the practice. For example, we saw they had recently undertaken an audit of prescriptions that had not been collected and shared that information with the GPs. We saw records which showed there were regular reviews of prescribing patterns for medicines such as antibiotics, hypnotics and sedatives. Prescribing was discussed at practice meetings and we saw records of these to confirm this. We saw evidence the practice had undertaken audits of a particular antidepressant over a 3 year period to better understand their prescribing pattern for the benefit of their patients.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Staff checked that GPs had sufficient prescriptions and logged their unique numbers for tracking and auditing.

The practice also had a process in place to restrict prescriptions to a seven day supply for those patients most at risk such as confused patients and those who abused medication. Staff told us that they also had a protocol for returning prescriptions allocated for home visits; they were checked out and back in to the practice if not used.

Are services safe?

The practice had processes for the safe disposal of medicines. We saw that the practice had undertaken an audit of their medicines in September 2014 and they had destroyed and disposed of out of date medicines in accordance with the regulations.

The medicines manager explained that they regularly met up with other medicines managers in the locality to share information and good practice.

Cleanliness & Infection Control

The practice was clean and tidy.

The practice used a cleaning contractor to clean the premises. We saw copies of the cleaning schedules and records. The practice had weekly cleaning checklists to monitor the cleaning. Cleaning staff would indicate that they had undertaken the required tasks by signing and dating the checklist. The practice manager explained that they regularly checked the cleanliness of the practice and if they had any concerns they would contact the contractor by telephone and address them. We were told that the health care assistants would deep clean the treatment rooms periodically. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Signs were displayed to remind staff of good hand hygiene techniques. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a health and safety group which met quarterly. Topics discussed included risk assessments, infection control and room audits.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. All equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Items within the emergency box were within their use by dates. We saw that the practice undertook regular audits of the emergency use medicines and the battery for the defibrillator. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of routine calibration of relevant equipment; for example

blood pressure monitors, spirometry machines (These machines are used to help diagnose lung conditions, monitoring severity and response to treatment.) and weighing scales.

Staffing & Recruitment

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

The practice manager said that the practice had a good skills mix of staff for their service needs. The practice had arrangements in place to deal with any shortages of staff. For example, some of the administration staff worked part-time and they covered for each other. GPs also covered for each other's periods of absences. In addition if necessary non urgent appointment would be rescheduled so that patients in most need were prioritised.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included dealing with emergencies such as a fire and a patient becoming seriously ill at the practice. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and we saw that the practice had undertaken a health and safety risk assessment. The practice also held quarterly health and safety meetings.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

Arrangements to deal with emergencies and major incidents

The practice had a contingency plan to cover any emergencies that might affect its services to patients. There were arrangements in place that enabled GPs to work from home and undertake telephone consultations.

The plan contained relevant contact details for staff to refer to. It also included hard copies of clinical templates for GPs and nurses for use in the event of computer failures.

The practice had arrangements in place to manage emergencies. We saw records which showed all staff had

Are services safe?

received regular training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

We saw that a fire risk assessment had been undertaken. Staff told us that the fire alarms were tested regularly. We saw records that showed staff had fire safety training annually.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

The practice had GP leads in specialist clinical areas such as diabetes, cardiovascular disease and men and women's health, which allowed the practice to focus on specific conditions.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice available to us at the time. The QOF is part of the NHS contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored highly on clinical indicators within the QOF. They achieved 100%, which was above the England average of 96.1%.

Management, monitoring and improving outcomes for people

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) and from local commissioners. We saw minutes of practice meetings where new guidelines were discussed. The staff we spoke with and evidence we reviewed confirmed that actions taken were aimed at ensuring that each patient was given support to achieve the best health outcome for them. For example, tests to identify patients at risk of type 2 diabetes were incorporated in all health checks and chronic disease management annual reviews. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The practice had a system in place for completing clinical audit cycles. We saw that clinical audits were stored on the practice Intranet and accessible to all relevant staff. The audits were in a standardised format and included a section to record reflections on what had taken place. For example, one recent audit involved a specific medicine that was associated with causing constipation in children. The audit led to changes in prescribing at the practice. The clinical audits showed evidence of quality improvement processes aimed at improving patient care and outcomes.

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

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

Where patients required chronic disease reviews all the review templates had a prompt to remind staff to consider dementia screening. If following screening there were concerns the patient would be referred to the GP for a further review.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The practice had achieved 90.2% of the points available for the taking blood pressure readings for those patients with coronary heart disease, which was below average compared to the local area. They had however exceeded the results required to be awarded all of the QOF points for this indicator.

We saw no evidence of discrimination when they made care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Are services effective?

(for example, treatment is effective)

Effective staffing

The practice maintained a detailed training matrix that displayed the type of training undertaken and the date the training had taken place which helped them ensure that mandatory training was up-to-date. Staff were given protected time for all training. We saw from the practice's training records that staff had undertaken a comprehensive range of training courses which were tailored to specific roles such as clinical and administrative areas. All staff were up to date with their mandatory training such as cardiopulmonary resuscitation (CPR).

Practice nurses ran specialist clinics for patients with long term conditions such as diabetes. The practice upskilled staff to enable them to be more flexible and efficient in the services they provided. For example they had trained a receptionist to take blood samples from patients for testing.

All GPs had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

In collaboration with a local University the practice provided medical students' placements. The practice also worked with Health Education North East (HENE) to provide trainee GPs specialty training. HENE is an accredited training school that offers courses to postgraduate medical students and others. Staff told us that being involved in the placement process was stimulating for the practice and another way of being aware of current thinking and ideas.

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

Working with colleagues and other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. The practice held various

multidisciplinary meetings. There were weekly meeting that were attended by GPs, nurses, managers and a district nurse representative. Monthly significant event meetings were held with practice staff and depending on the subject they have included local pharmacist, district nurses and the mental health team. Quarterly meeting were held to undertake palliative care reviews with GPs nurses, Macmillan nurse, Macmillan consultant and district nurses.

Information Sharing

The practice had systems in place for recording information from other health care providers. This included out of hours services, the ambulance service and hospitals. All letters from hospital are seen on the day of receipt by a GP.

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

The practice provided hard copies of emergency health care plans for those patients at highest risk of hospital admission. This included those living in care homes or patients who were house bound. The emergency care plans were kept in the patients own home so they could be access quickly when needed.

Consent to care and treatment

The practice told us that they were actively looking to source a formal Mental Capacity Act 2005 (MCA) training course to include in all their staff training packages.

We found that relevant staff were aware of the principles of the MCA and their duties in fulfilling it. Staff we spoke with were clear about how they obtained patients consent to care and treatment and could give examples of when this would be written, verbal or implied consent.

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

A GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young

Are services effective?

(for example, treatment is effective)

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

They also explained that decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. We found the doctors were aware of the MCA and used it appropriately.

Health Promotion & Prevention

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

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups such as the Northumberland health and sexual services.

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health for example, talking therapies, cancer awareness and emergency contraception. There were also notices on display giving details about flu clinics and mental health support services that were available.

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

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with were positive about the practice and said they were treated with respect and dignity by the practice staff.

We observed staff interactions with patients in reception. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. The reception desk was adjacent to the patient waiting area. The practice had designated an area away from the main reception desk for patients to queue up to speak to reception staff. This afforded patients more privacy in their conversations at reception.

We saw staff who worked in these areas made efforts to maintain people's privacy and confidentiality. We saw voices were lowered and personal information was only discussed when absolutely necessary. Staff were spoke with told us that they would offer patients the option of a more confidential area or private room to hold their conversations.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey Report. There were 117 respondents, 90% of respondents had confidence and trust in the last nurse they saw or spoke to and 85% of respondents say the last GP they saw or spoke to was good at treating them with care and concern. This demonstrated that patients were satisfied with the way they were treated.

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

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains and window blinds were provided in the treatment room so that patients' privacy was maintained during examinations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us that the practice made allowances for their patients. For example, in addition to routinely giving patients with specific clinical needs such as serious respiratory problems extended appointments patients could request extended appointments if they thought it necessary. Notices advertising this service were displayed in the reception/waiting room areas.

Care planning and involvement in decisions about care and treatment

We spoke with ten patients as part of the inspection. They were all complementary about the service they had received. Some of the patients said that the coordination between the practice and the services that supported patients who had recently babies had worked well. They also told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

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

In addition the practice had a 'POD'. The pod was a designated area of the practice sited adjacent to the reception area and screened off to maintain privacy and confidentiality. It contained weighing scales, an automatic blood pressure monitor and a mechanism to measure patient's height. It also had a computer touch screen which patients used to enter their readings directly into their patient records. This information was immediately accessible to the clinicians to view at appointments. It would also alert staff and patients if there was a need to make an urgent appointment. There were posters and notices on the walls of the pod giving patients health care advice.

Patient/carers support to cope emotionally with care and treatment

The practice had a carers identification protocol which guided staff to actively identify the different types of carers and to be aware of how the practice can offer support to

Are services caring?

them when required. This enabled staff to monitor and offer their services to them and guide patients to other health care and wellbeing providers such as Carers Northumberland.

The practice work with Macmillan nurses to provide emotional support to those patients who need end of life care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice from Public Health England, published in 2013. The average male life expectancy for the practice population was 76.3 years and female life expectancy was 80.4 years. The majority of patients registered with the practice were between the ages of five and 69 years old. For the patient group 62.2% had a long standing health condition. With 60.4% reporting that they had health-related problems in daily life which was higher than the CCG and England averages of 57.7% and 53.5% respectively.

There were 80.3 per 1000 people in the area claiming disability allowance. There were also 23.5% of patients reported having caring responsibilities. Staff we spoke with told us that they were working to provide their patients with high quality service that met their particular needs.

The needs of the practice population were understood and systems were in place to address these identified needs. For example the practice told us that all care homes have one or two named GPs allocated to them. In addition the senior nurse prescriber also visited the homes and worked in collaboration with them to ensure patients care and medicines remained appropriate.

Patients could also request extended appointments if they thought they were necessary and for those with long term conditions. Home visits were made to patients who experienced difficulty in attending the practice.

The practice had provided a nurse led express clinic for patients experiencing minor ailments such as chest infections and respiratory problems, new skin rashes and urinary tract infections. The nurse prescriber was able to prescribe medication at these express clinic appointments when necessary. The practice also offered nurse led telephone appointments and home visits by nurses.

As part of the inspection we spoke with two representatives of the Patient Participation Group (PPG). In collaboration with the practice the group had produced a free magazine

4 times a year. We saw the publication for the period Autumn 2012 to Autumn 2014. The magazines provided a range of information and advice to patients from helpful telephone numbers such as the Northern Doctors out of hours and the practice's 24hour prescription line. There had been feature articles such as the Pharmacy First scheme which explained the benefits to patients of seeking advice and help from community pharmacists when suffering from minor ailments. The most recent publication included details for the walk in flu clinics and other vaccinations that were available.

The practice also produced a sign posting document to online resources for supporting patients with self-care. We saw that it included details of how to access a range of useful websites, including NHS Choices Your Health, Your Way for patients with long term conditions and Propriety Association of Great Britain for patients to download leaflets about common ailments

The practice worked collaboratively with other health care agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example, for patients that were at a high risk of emergency hospital admission the practice has produced emergency health care plans that summarise their medical condition(s) and medication and wishes about the future. Those plans were readily available to other relevant agencies. The practice also held regular multidisciplinary meetings with other health care agencies to discuss cases, issues and concerns.

Tackle inequity and promote equality

The practice had recognised the needs of the different groups in the planning of its services.

The practice had made arrangements so that people with physical disabilities were able to access the service. Consultation and treatment rooms were on the ground floor. There was parking near to the practice.

For those patients who did not speak English as their first language. There were arrangements in place to access interpretation services. In addition instructions on how to record the readings taken by patients in the pod was available in 16 languages.

Access to the service

Appointments were available from 8:30 am to 6:00 pm on weekdays. The main branch is closed on Wednesday afternoons from 1.00pm to 2pm and all afternoon on the

Are services responsive to people's needs?

(for example, to feedback?)

third Thursday in every month for staff training. The Newbiggin branch remains open at these times. There were also enhanced surgery opening hours for pre-booked services and enquiries on Tuesdays and Wednesdays from 6.30 to 8.00pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

In an attempt to provide better access to appointments the practice undertook a three month trial with an open surgery approach where patients turned up for non-routine appointments on the day. The patients reported that they did not like the system and the GPs felt it was not a safe system. The trial was stopped and was succeeded by a GP telephone triage system. Throughout the period of the trial the practice analysis showed there was no adverse impact on accident and emergency admissions.

Data available for the practice from Public Health England, published in 2013, showed that 62.9% of patients reported a good overall experience of making an appointment. This is lower than the England average of 76.3%. Some of those patients we spoke with told us that they found it hard to make an appointment. However, they all said that they could get an urgent appointment quickly if needed. The practice told us that they were aware of this and were continually thinking of ways to improve access to their services for all their patients. They also explained that if a patient needed to be seen on the day they would be seen.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Patients were made aware of how to make a complaint in the practice's leaflet, notices and the practice website. In April 2014 the practice appointed a patient services manager with a dedicated role as the complaints manager. They were supported by the lead GP for complaints. The manager explained that they were in the process of improving the overall approach to handling complaints. They gave us an example of where a prescription for a medical device had not been processed in a timely manner. The complaint was fully investigated and their processes were changed to limit the likelihood of a recurrence and were now more patient focussed.

The practice recorded complaints and compliments and analysed the information to determine any trends so that they could be addressed. The patient services manager told us that complaints and concerns were discussed at various team meetings and the learning was shared with staff. Staff we spoke with told us there was an open culture at the practice and confirmed that the learning from complaints was openly discussed at relevant team meetings.

Are services well-led?

Outstanding



(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. We found details of the vision and practice values were part of the practice's 3 year business plan. These values were clearly displayed in the waiting areas, the staff room, in the offices, on their website and in their practice leaflet. The practice's mission statement stated their aim was to be a top quality health care team, working with patients to enable good health, deliver excellent accessible care and continually develop to meet new challenges.

We spoke with various members of staff including GP partners, salaried GPs, nurses, health care assistants, managers, and administration staff and they all knew and understood the practice's vision and values and knew what their responsibilities were in relation to these.

To help the practice achieve their vision they offered staff comprehensive training. They had created an open culture where staff and patients are listened to. We saw evidence of constructive staff engagement such as complaints, incidents and concerns being readily and openly discussed with appropriate staff. We saw that compliments were also shared with staff. The practice promoted innovation by awarding prizes to the best ideas.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to staff via the Intranet on any computer. In addition at induction all staff were made aware of the practice's mission statement, business plan and told who does what in respect of GP specialists and colleagues areas of responsibilities. We saw that all staff had clearly defined roles and responsibilities and there were clear pathways explaining how matters were to be escalated if necessary.

The policies were updated immediately when changes occurred or annually as required. For example, we saw that the recruitment and selection policy and procedure was last reviewed in April 2014. Staff were notified of any changes. Where significant changes had taken place relevant staff were asked to indicate that they had read and understood the policy.

The practice had effective arrangements for identifying, recording and managing risks. We saw that the practice

analysed risks to the service and patient care. We looked at the Annual Incidents Report summary 2014 which covered incidents in 2013. The practice categorised the events and risk rated the level of risk. The information showed a decrease in the number of significant risks and highlighted that human error and not following procedures were emergent themes. Action plans were formulated to address those themes.

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 or higher than national standards. We saw QOF data that showed the practice had consistently scored highly over the last three years. The most recent record showed a score 100% for total QOF points which was higher than the averages for England and the Clinical Commissioning Group (CCG) which were 96.1% and 97.7% respectively.

The staff we spoke with were clear on their roles and responsibilities. All of them demonstrated an understanding of their area of responsibility. We found that managers in the practice understood their role in leading the organisation and enabling staff to provide good quality care. We found that the practice valued well-structured and effective management in support of their staff and patients to ensure that patients received a high quality service. For example, in April 2014 they appointed a Patient Services Manager whose role included managing and analysing complaints, producing reports for the practice to discuss and developing action plans to address the issues arising.

Leadership, openness and transparency

We saw that the practice promoted its mission statement and values. Staff we spoke with were able to explain these to us. The practice told us that it had an 'open door' policy where all staff were encouraged to raise any concerns or issues with their colleagues, managers and GP partners at any time. Staff we spoke with told us that if they needed help, support or guidance they would use these lines of support and it would be openly and freely given. In addition we were told that the practice manager was always available for confidential discussions with any member of staff who wished to speak in private with them. We saw that the practice held monthly significant event analysis meetings where relevant staff openly discussed and shared their experiences with their colleagues and other relevant interested parties such as local pharmacists and district nurses.

Are services well-led?

Outstanding



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

The practice kept records of various meetings that regularly took place these included staff meeting, nurses meetings and GP meetings. Those records were kept on computer and readily accessible to appropriate staff for reference.

We were shown a clear leadership structure which had named members of staff in lead roles. In addition to their routine activities the practice had nominated lead GPs to take responsibility for identified areas such as clinical governance, patient experience, dementia and thyroid diseases. In total there were 67 areas that the practice had a GP lead for. We saw that the GPs were supported with their roles by a structured management and clinical teams, support staff and numerous policies and procedures. Staff we spoke with were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice for assistance or to raise any concerns.

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

The practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with two representatives of the PPG who explained their role and how they worked with the practice.

They explained that the group met monthly and the meetings were chaired by patients. The first part of the meeting was for members of the PPG only. With practice staff joining at a later time. We were given copies of patient magazines the group had produced. There were 9 Issues covering a period from Autumn 2012 to Autumn 2014. The magazines contained lots of useful information including details about free flu vaccinations, out of hours contacts, and a feature articles such as local healthcare services. The representatives told us that the practice was open and supportive of the PPG. For example, they worked in collaboration to produce the magazines. In addition the PPG were made aware that the main theme of complaints to the practice concerned appointment times. They also told us that the group had input into the refurbishment of the reception area. The representatives explained that the PPG helped with the running of the recent flu clinics by publishing and distributing 500 copies of their magazine which included details about the clinics and they helped out on the day.

We saw that the practice had undertaken a local survey in January 2014. They received 417 responses. Of the patients who responded 86% considered the practice to be good or very good. The practice identified five areas for improvement and developed an action plan to address the issues. The actions were agreed to by the PPG. The areas of improvement were, to increase the choice of times that patients can be seen, increase awareness of nurse appointments, reach out and engage more with patients in the 17-24 year old age group, enable online access to book appointments, order prescriptions and view medical records and improve telephone access for patients. A patient services manager was recruited in April 2014 whose role included helping to implement some of those changes. We saw evidence that the practice had received 49 compliments about their services during the period April to October 2014, including compliments about the website prescription service.

The practice regularly published an electronic staff newsletter. We saw the October 2014 publication, which was Issue 79. There were various sections which included good news sections from the partners and management, and also from the various departments. In addition to the practice information there were details of forthcoming staff birthdays and congratulations to a member of staff who recently had a baby. The practice manager explained that they have a staff suggestions box and gave prizes out to the best suggestions that were implemented. This demonstrated that the practice actively and positively engaged with their staff to improve the service for the benefit of patients and staff.

Management lead through learning & improvement

The practice is a training practice accredited by Northumbria Vocational Training Scheme (NVTs) and is reaccredited every 3 years. Under the scheme the practice provides training placements to GP Registrars. GP Registrars are medical doctors who are training to become GPs. There were two GP trainers at the practice. This process enabled the practice to review their knowledge and skills. We were told that the knowledge gained from delivering the training was shared with colleagues at the practice.

We saw records from 2012 to date that demonstrated that the practice undertook weekly educational programmes for their clinical and non-clinical staff. The topics covered

Are services well-led?

Outstanding



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

were numerous and varied. They included patient complaints, clinical reflections, frail and elderly pathways and fit note protocols for the clinicians. Fit notes allow doctors to give patients more information about how health conditions affecting their ability to work, that patients give to their employers. Topics for the non-clinical staff included the prescription process, personalised care planning and navigation and customer service. The programmes were delivered in a variety of ways such as a lecture or presentation, discussions, role play and small group work.

The practice was aiming to improve patient access to appointments when they introduced a 3 month trial for the open surgery approach. Patients could turn up at the surgery without having already booked an appointment. However, this was not popular with the patients or the GPs and the trial ended without the open surgery approach being implemented. This demonstrated that the practice

had considered improving patient access to appointments and taken action to do so but also recognised when it had not worked and learned from their experience. The practice told us they are continuously looking for ways to improve patient access to appointments.

We saw that the practice had audited the nurse led express clinic in June 2013 to determine its effectiveness. The audit showed that for the period 1 May 2013 to 28 June 2013 there had been 300 consultations. The consultations covered broadly 6 areas which included chest infections and skin rashes. This detailed audit indicated that the number of patients who had returned within 2 weeks for the same problem had reduced since the previous analysis and the percentage of patients referred to a GP on the same day remained the same at 8%. This demonstrated that the practice actively reviewed their methods of working to see how they could be improved for the benefit of their patients.