Betts Avenue Medical Group

Quality Report

Betts Avenue Medical Group, 2 Betts Avenue,
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Betts Avenue Medical Group on 2 December 2014. The practice has two locations registered with CQC; Betts Avenue Medical Group and Kenton Medical Centre. We visited both of these locations as part of the inspection.

Overall, the practice is rated as good. It was also good for providing services for all of the population groups.

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.
- People's 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 training 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.
- Data from the GP National Patient Survey demonstrated the practice performed better than local and national averages in a number of areas.

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

Importantly the provider should:

Summary of findings

- Ensure that blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.
- Ensure there are appropriate arrangements in place to protect staff and patients from the risk of legionella infection.

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 to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Medicines were well managed and there were arrangements in place to keep both practice locations clean and reduce the risks of the spread of infection. However, the practice should improve its approach to ensure that blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could demonstrate staff had received appraisals and had personal development plans in place. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Patients and carers were offered support to help them cope emotionally with care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice learnt from complaints and shared this with stakeholders where appropriate.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the 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, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

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

People experiencing poor mental health (including people with dementia)

Good

Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care plans in place for patients with dementia.

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

Summary of findings

What people who use the service say

We spoke with 17 patients during the inspection, including two members of the practice Patient Participation Group (PPG). We spoke with 12 patients at the Kenton Medical Centre location and five patients at the Betts Avenue Medical Group location. All the patients we spoke with said they thought the service was good and that they would recommend it to family and friends. They told us both locations were kept clean and tidy, although a number commented the surgery at Betts Avenue was looking tired and shabby.

Patients told us staff were friendly, and treated them with dignity and respect. Also, when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand.

Some patients told us that because the reception area at Kenton Medical Centre was close to the waiting room, they felt their conversations could be overheard. However, a number also commented that a separate room was available if they wished to speak with reception staff in private.

We reviewed 14 CQC comment cards completed by patients prior to the inspection. There were four completed by patients at Betts Avenue Medical Group location and 10 at Kenton Medical Centre. The majority of comments were positive. Patients commented positively on the good continuity of care and the cleanliness of the practice locations, and felt that staff treated them with dignity and respect.

The latest GP Patient Survey completed in 2013/14 showed the majority of patients were satisfied with the services the practice offered. The following results were all better than the national average:

- 91.7% described their overall experience of this surgery as good (national average 85.7%)
- 82.6% would recommend this surgery to someone new to the area (national average 78.7%)
- 87.3% were satisfied with the surgery's opening hours (national average 76.9%)
- 81.4% found it easy to get through to this surgery by phone (national average 72.9%)
- 87.5% were able to get an appointment to see or speak to someone the last time they tried (national average 85.7%)
- 93.7% said the last appointment they got was convenient (national average 91.9%)

These results were based on 109 surveys that were returned from a total of 367 sent out; a response rate of 30%.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure that blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.
- The practice should ensure there are appropriate arrangements in place to protect staff and patients from the risk of legionella infection.

Betts Avenue Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP, an additional CQC inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Background to Betts Avenue Medical Group

Betts Avenue Medical Group has two practices in the Kenton and Benwell areas of Newcastle Upon Tyne.

The practice provides services to around 10,243 patients from the two locations; Betts Avenue Medical Group, 2 Betts Avenue, Benwell, Tyne and Wear, NE15 6TQ and Kenton Medical Centre, Kenton Centre, Sherringham Avenue, Kenton, Tyne and Wear, NE3 3QP. We visited both of these locations as part of the inspection.

The Betts Avenue location is based in a converted house, with further extensions added to it over time. All patient facilities are on the ground floor. It also offers on-site parking, a disabled WC, wheelchair and step-free access.

Kenton Medical Centre practice is located in a purpose built single storey building. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

The practice has five GP partners, two nurse prescribers, a practice nurse, two healthcare assistants, a practice manager and assistant practice manager, and 14 staff who carry out reception and administrative duties.

Surgery opening times at both locations are between 8:00am and 6:30pm Monday to Friday. There are extended hours on a Monday evening and Tuesday and Thursday morning at Kenton Medical Centre and on a Wednesday morning at Betts Avenue.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

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

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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

We carried out an announced visit on 2 December 2014. We spoke with 17 patients and 12 members of staff from across both practice locations. We spoke with and interviewed three GPs, the practice manager and assistant practice manager, three members of the nursing team, a healthcare assistant and three staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 14 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, they considered reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, an incident had occurred where a home visit had been deferred until the next day, but this had not been communicated to the patient or family members. The learning from this incident included clarifying roles and responsibilities in relation to who should communicate the decision to defer an appointment to the patient to reduce the risk of this occurring again.

We reviewed safety records and incident reports, for the last 12 months. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to view these. Significant events were a standing item on the practice partner meeting agenda. We saw evidence that significant events were also discussed at dedicated 'time in' meetings to review actions from past significant events and complaints. We saw notes of these meetings for September 2014 and November 2014 which confirmed this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration as a significant event or incident and they felt encouraged to do so. Staff told us they felt confident in raising issues to be considered at the meetings and felt action would be taken. A culture of openness operated throughout the practice, which encouraged errors and 'near misses' to be reported.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked 11 incidents and saw records were completed in a comprehensive and timely manner. Where incidents and events meet threshold criteria, these were also added to the Newcastle West Clinical Commissioning Group Safeguard Incident & Risk Management System (SIRMS). This allowed the practice to contribute to and benefit from learning identified from incidents across the local area and also to share information where more than one organisation was involved.

We saw evidence of action taken as a result of significant events. For example, a system fault led to a medication error. There was evidence that the practice had taken action to address the concern and also reduce the risk of the same error occurring in the future. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were added to the practice meeting agenda, where appropriate, to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received role specific training on safeguarding. We saw evidence that GPs had received the higher level of training for safeguarding children (Level 3). We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of

safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible on the practice intranet.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or looked after children. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

The practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at A&E.

There was a chaperone policy, which was available on the staff intranet page. We saw this was also advertised on the waiting room noticeboard at the Kenton Medical Centre. (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). All nursing staff, including health care assistants, had been trained to be chaperones. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, and which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Members of the nursing staff were qualified as independent prescribers. We saw evidence they received regular supervision and support in their role. As well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient.

We spoke with staff about the security of blank prescription forms. They told us an incident had happened some time ago and as a result security had been tightened and the blank prescriptions were now stored in a secure area in a locked cupboard. However, there was no process in place to record and monitor stock. This is contrary to guidance issued by NHS Protect, which states that 'organisations should maintain clear and unambiguous records on prescription stationery stock'. The recording and audit trail of blank prescriptions was poor and there was a risk that any theft or misuse of prescriptions would be undetected.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules for both locations in place and cleaning records were kept. Patients we spoke with told us they always found both surgeries clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

We saw evidence that the infection control lead had carried out infection control audits at both Betts Avenue and Kenton Medical Centre over the last two years and that any improvements identified for action had been completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable

gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The privacy curtains in the consultation rooms were changed every six months or more frequently if necessary. The curtains were disposable. We saw the curtains were clearly labelled to show when they were due to be replaced.

The practice had a contract with the landlord for Kenton Medical Centre to ensure the premises were appropriately managed and maintained. This included the cleaning contract, maintenance and monitoring of the building. The management company held responsibility for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

The practice was responsible for the premises at Betts Avenue. We asked the practice manager to see a copy of the risk assessment for legionella at Betts Avenue. She told us that they had not conducted a risk assessment as they thought none was needed. Guidance from the Health and Safety Executive states that a risk assessment should be conducted to identify and assess sources of risk, and where needed identify the action to manage, prevent and control any risks identified. As no risk assessment had been undertaken we could not determine if the practice was taking sufficient action to reduce the risk of legionella infection at Betts Avenue. The practice should ensure there are appropriate arrangements in place to protect staff and patients from the risk of legionella infection.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were sharps disposal boxes in all the clinical areas of the practice. There were also contracts in place for the collection of both general and clinical waste.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw that where required, equipment was calibrated (adjusted for accuracy) in line with manufacturer's guidelines. For example, weighing scales and blood pressure monitoring equipment.

Staffing and 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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice manager routinely checked the professional registration status of GPs and nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. Staff told us there were effective arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies.

Good

Are services safe?

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice manager undertook an annual walk around each building to identify and manage health and safety risks at both locations. The practice also had a health and safety policy.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and was able to plan mitigating action to reduce the probability of harm.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to emergency medicines and oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment. The practice did not have a defibrillator at Kenton Medical Centre, but were able to access one on site from the local library.

Emergency medicines were available in a secure area in each of the practice locations and all staff knew of their location. There was a laminated sheet that clearly listed the contents of the trolley and this corresponded to the medicines available. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. Copies of the plans were held by the practice manager and GPs at their homes and at a partner practice so contact details were available if the building was not accessible.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed 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 disseminated, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

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. For example, we were told that patients with long term conditions such as COPD (chronic obstructive pulmonary disease) were invited into the practice to have their condition and any medication they had been prescribed reviewed for effectiveness.

The practice had a flow chart in place for non-clinical staff to assist them when speaking with patients to identify those experiencing medical emergencies who needed immediate medical assistance. This helped them identify where they needed to refer a patient to emergency services or notify a doctor immediately of the concern.

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

Discrimination was avoided when making 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 or race were not taken into account in this decision-making unless there was a specific clinical reason for this.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us 10 clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice had carried out an audit on the prescribing of antibiotics for children. The aim of the audit was to ensure the practice was appropriately prescribing antibiotics to reduce the risk of antibiotic resistance in the future. The first audit demonstrated that 5.7% of contacts with children had resulted in a prescription being issued for antibiotics. A second clinical audit was completed one year later which demonstrated a reduction in the prescribing of antibiotics to children. The percent of contacts which had resulted in a prescription for antibiotics had reduced to 4.9% and the number of prescriptions had reduced by 20%.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing for patients taking medicines for the treatment of hypothyroidism (where patients have an underactive thyroid gland). Following the audit, the GPs carried out reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors. The practice met all the minimum standards for QOF in the management of long term conditions such as asthma,

Are services effective?

(for example, treatment is effective)

chronic obstructive pulmonary disease (lung disease) and epilepsy. The practice had achieved 100.0% of the points available for clinical results; this was above the national averages of 96.4%. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice had in place clinical templates to guide staff in the assessment, monitoring and treatment of patients with long term conditions. Practice staff told us that they took action to encourage patients to attend. Where patients did not attend during the year, these were identified and invited to another appointment at the end of the year.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that generally the practice was performing the same as, or better than average, when compared to other practices in England. For example, a higher proportion of patients over the age of 65 (76.5%) had received the seasonal vaccination compared to the national average (73.2%).

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. We saw there was a documented induction process for new employees.

Once a month the practice closed for an afternoon for Protected Learning Time (PLT). A part of the time during these afternoons was dedicated to training. The practice also invited external experts to deliver training during these sessions. For example a representative from the local Clinical Commissioning Group (CCG) had recently attended to talk with staff about the Mental Capacity Act 2005. A further session was being planned to cover Deprivation of Liberty Safeguards.

Role specific training was also provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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 can the GP continue to practice and remain on the performers list).

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported.

The practice manager told us of two examples where they had supported staff through personal emergencies to help maintain their health and wellbeing.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs.

We saw various multi-disciplinary meetings were held. For example, a weekly clinical team meeting was held, this included GPs, nurses and the district nursing team. Child protection and palliative care review meetings were held every month. There were well established links with local Macmillan nurses. This helped to share important information about patients including those who were most vulnerable and high risk.

Are services effective?

(for example, treatment is effective)

The practice was a member of a group of GP practices located in the West of Newcastle who met regularly to build relationships and share learning with the aim of improving patient care. The practice team felt this had been beneficial for both themselves and their patients.

Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out of hours' provider and the ambulance service. The practice often undertook joint visits to patients on the palliative care register, with the palliative care consultant from the local hospital.

Information sharing

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

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. 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 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for the fitting of contraceptive implants and routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Health promotion and prevention

New patients were offered a 'new patient check'. The initial appointment was scheduled with one of the Healthcare Assistants, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting areas of both practice locations. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice's website also provided some links for patients on health promotion and prevention.

We found patients with long term conditions were recalled to check on their health and review their medications for

Are services effective?

(for example, treatment is effective)

effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. MMR vaccination rates for five year old children were 95.3% compared to an average of 92.7% in the local CCG area. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was in line with the national average.

There was a lead GP who engaged with local prisons to ensure information was shared about the healthcare of patients who were sent to or discharged from prison.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a recent survey of 50 patients undertaken by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 91.7% of those surveyed described their overall experience of this surgery as good. The practice was also rated well on satisfaction scores on consultations with doctors and nurses. For example, 99.3% had confidence and trust in the last GP they saw or spoke to. This compared with a national average of 92.5% and a local Clinical Commissioning Group (CCG) area average of 94.1%. Also, 91.1% had confidence and trust in the last nurse they saw or spoke to. This compared with a national average of 86.2% and a local CCG average of 90.0%. In the practice's own survey 98% of those who responded thought the practice was good, very good or excellent.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 CQC comment cards completed by patients prior to the inspection. There were four completed by patients at Betts Avenue Medical Group location and 10 at Kenton Medical Centre. The majority of comments were positive. Patients commented positively on the good continuity of care and the cleanliness of the practice locations, and felt that staff treated them with dignity and respect. Two comments were less positive but there were no common themes identified.

We spoke with 17 patients during the inspection, including two members of the practice Patient Participation Group (PPG). We spoke with 12 patients at the Kenton Medical Centre location and five patients at the Betts Avenue Medical Group location. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 79.3% of practice respondents said the GP was good at involving them in care decisions and 91.2% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG area and national averages.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 17 CQC comment cards we received was also positive and supported these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We spoke with an interpreter during our inspection, who told us they frequently visited the practice to interpret for patients who did not have English as a first language. One of the GPs was Polish. Staff told us that a high number of patients who were Polish chose to see this doctor as he was able to speak to them in their native language.

The practice had a leaflet available for patients to explain advance directives. These are where patients can set out in advance their preference for medical treatment should they lack capacity or be unable to communicate their views in the future.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91.2% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. We saw staff responded well towards patients who were in distress.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations.

The practice routinely asked patients if they had caring responsibilities. This was then noted on the practice's computer system so it could be taken into consideration by clinical staff. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff were familiar with the individual needs of their patients and the impact of the local socio-economic environment. Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, smoking cessation programmes, and advice on weight and diet.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey from 2014 confirmed this. 90.3% of patients felt the doctor gave them enough time, 91.9% felt they had sufficient time with the nurse. These results were above the national averages (85.3% and 80.2% respectively).

The practice had a well-established Patient Participation Group (PPG). We spoke with two members of the group who said they felt the practice valued their contribution. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For example, following feedback from the PPG the practice arranged for all staff to attend customer service training. The PPG members we spoke with told us this had resulted in improved customer service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended and across both locations, the practice had early morning and evening appointments. This helped to improve access for those patients who worked full time.

Services had been designed to reflect the needs of the diverse population served by the practice. The practice had access to and made frequent use of translation services, for those patients whose first language was not English. One GP spoke Polish and a high number of the patients he saw were Polish.

The premises and services had been adapted to meet the needs of people with disabilities. At both locations all patient facilities were at ground floor level and there was wheelchair and step free access. At Kenton Medical Centre there were automatic doors and a bell so patients could alert staff if they were having difficulty entering the building. There were also parking spaces designated for patients with disabilities.

We saw that the waiting areas were 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.

Access to the service

Appointments were available from 8:00am and 6:30pm Monday to Friday. There were extended hours on a Monday evening and Tuesday and Thursday morning at Kenton Medical Centre and a Wednesday morning at Betts Avenue.

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

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The majority of patients we spoke with, and those who filled out CQC comment cards, said they were satisfied with the appointment systems operated by the practice. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 87.5% were able to get an appointment to see or speak to someone the last time they tried and 93.7% said the last appointment they got was convenient. 87.3% of patients who responded were satisfied with the opening hours this compared with a 76.9% national average.

Listening and learning from concerns and complaints

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

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 complaints policy was outlined in the practice leaflet and was available on the practice's website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

Of the 17 patients we spoke with on the day of the inspection and the 14 CQC comment cards, none raised concerns about the practices approach to complaints.

We saw the summary of complaints that had been received in the 12 months prior to our inspection. We found these had been reviewed as part of the practice's formal annual review of complaints. 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. Changes had been implemented where necessary. For instance, following a complaint the practice clarified the process for sending urgent referrals to hospital consultants.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was set out in the practice's annual business plan. The plan set out the key priorities for the practice and how they would be achieved. This was made available to all staff on the practice intranet. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded.

We spoke with 12 members of staff and they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures and saw they had been reviewed regularly and were up-to-date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical and internal audits, including a review of infection control and health and safety arrangements. The results of these audits and re-audits demonstrated outcomes for patients had improved.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and GP had leads in areas such as health and safety, sexual health and mental health. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities.

We saw from minutes that staff meetings were held regularly. Staff told us that there was an open culture within the practice and they were actively encouraged to raise any incidents or concerns about the practice. This ensured honesty and transparency was at a high level.

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this. There was a clear and positive approach to seeking out and embedding new ways of providing care and treatment. For example, the practice was investigating the reasons for patient attendance at A&E where patients could have otherwise been seen at the practice to support the reduction of unnecessary A&E attendance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff and found these were used to govern activity. These were easily accessible to staff via a shared intranet on any computer within the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comments boxes and complaints received.

The practice had an active patient participation group (PPG). The practice had a patient charter, which the PPG had helped to develop. There was a PPG action plan in place. Key priorities for 2014-15 included improving the process for communicating appointments for podiatry and retinal screening; improving the experience for patients using on-line services and improving liaison with local pharmacies in relation to the Electronic Prescribing Service. The practice published an annual report into the work of the PPG and this was available on the practice website.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended

Are services well-led?

Good

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

staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT, there were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

We saw a practice newsletter was produced quarterly. This contained a wealth of information about the practice, the staff and any changes which affected patients. For example, the most recent newsletter included details about flu vaccination, the friends and family test and highlighted the complaints process and comments box.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place. Staff members had personal development plans. Staff told us that the practice was very supportive of training and that they had staff training sessions where guest speakers and trainers attended.

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