The Park Medical Group

Quality Report

Kingston Park Avenue, Kingston Park, Newcastle Upon Tyne, NE3 2HB
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Park Medical Group on 25 February 2015. The practice has two locations registered with CQC; Fawdon Park Road and Kingston Park Avenue. We visited both of these locations as part of the inspection. The practice was rated as good for all domains and population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were comprehensive safety systems in place.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Data showed that patients rated the practice higher than others for several aspects of care. We saw that staff were considerate with patients, treated them with understanding and maintained confidentiality.
- Information about services and how to complain was available and easy to understand.
- Patients we spoke with and those who completed CQC comment cards indicated they felt they could obtain appointments, including urgent appointments, when needed. The practice operated a nurse practitioner triage system and a rapid access clinic. The practice were aware of the needs of the local population and there was good continuity of care.
- 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 they acted on.

We saw one area of outstanding practice:

Summary of findings

- The practice had continually monitored and audited the appointment system over several years to ensure that patients could obtain timely appointments with a GP which suited their needs.

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. Patients and staff were protected by comprehensive safety systems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used opportunities to learn from incidents to support improvement. Information about safety was 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.

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. Patient's 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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. 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 were considerate with patients, treated them with understanding and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. There was an area of outstanding practice where the practice had continually monitored and audited the appointment system over several years to ensure that patients could obtain timely appointments with a GP which suited their needs. Patients we spoke with and who completed CQC comment cards indicated they felt they could obtain appointments, including urgent appointments, when needed. The practice operated a nurse practitioner triage system and a rapid access clinic. The practice were aware of the

Summary of findings

needs of the local population and there was good continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and held regular strategy meetings. There was a 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. The patient participation group (PPG) was active. 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 had a higher than average amount of patients over the age of 85, 3.1% compared to the national average of 1.8%. They had taken up an enhanced service, which is a service other than an essential service, for the frail elderly and 2% of this group had a care plan in place which was reviewed every three months. Hospital admissions and accident and emergency attendances for this group were monitored and discussed at MDT meetings. All patients over the age of 75 had a named GP.

The practice triage and rapid access system ensured same day access for those patients who needed it and advice could be given to those who did not wish to travel to the surgery. Home visits were offered where appropriate.

People with long term conditions

Good

The practice had a chronic disease management group where care for patients with long term conditions and QOF indicators were reviewed. All patients with long term conditions were invited for a six monthly review with the appropriate health professional and received interim reviews where needed. Medication reviews were performed on a regular basis by the GPs who then set the review intervals as required. The nurse practitioner ran weekly diabetic clinics. High risk patients in this group had a care plan in place.

Families, children and young people

Good

The practice offered baby and anti-natal clinics. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. They offered routine immunisations for babies and children under five, during clinic appointments. An Arabic speaking interpreter was used at the baby clinic at Kingston Park as there were high numbers of Arabic families in the area. The practice met with health visitors on a monthly basis to discuss safeguarding issues. The practice had appointments available after school hours.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. Appointments were available outside

Summary of findings

normal working hours; there was a late evening surgery on a Monday evening until 9:15pm at the Kingston Park surgery. The triage system allowed working patients to speak to a practice nurse or GP on the telephone. Routine appointments were bookable up to three weeks in advance.

The practice offered appointments and repeat prescriptions on-line. Repeat prescriptions could be ordered in person at the surgery or by phone. The practice offered a wide range of health promotion information and screening which reflected the needs for this age group. The practice offered contraceptive advice and GPs could fit contraceptive devices. A GP at the practice had an interest in musculoskeletal medicine and sports injuries and was able to offer advice and treatment to patients lessening the need for outside referral.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had a high number of patients with learning disabilities; there were a number of care homes in the area for these groups of patients. One of the GPs was the designated lead for patients with learning disabilities and had received specialist training in this area. Regular health checks for this group of patients were carried out. The surgery were working with 'quality health checkers' who are a team of people, some with learning disabilities who visit the surgery and give advice and guidance on how the practice can improve its services for this group of patients

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice worked closely with mental health services. The mental health lead for the practice regularly liaised with the mental health team attached to the surgery. There was access to counselling, primary care mental health workers and psychologists who provided services from both surgeries and there were also referrals onwards to services for those experiencing poor mental health.

Summary of findings

The practice supported care homes with patients who suffer with dementia and had a number of patients with dementia who lived supported in the community. There had been a learning session held recently for clinical staff to raise dementia awareness and to improve diagnosis rates.

Summary of findings

What people who use the service say

We spoke with 10 patients during the inspection, including two members of the Patient Participation Group (PPG). Of the 10 patients we spoke with four patients at the Kingston Park Avenue surgery and six at the Fawdon Park Road surgery. All of the patients were satisfied with the care they received from the practice. Words used to describe the service included outstanding, first class and great.

We reviewed 21 CQC comment cards completed by patients prior to the inspection. One was completed at the Kingston Park surgery and 20 at the Fawdon Park Road surgery. All of the comments on the cards were positive. Common words used by patients included excellent, great service and high standards.

The latest GP Patient Survey completed in 2013/14 showed most patients were very satisfied with the services the practice offered. Results were well above the national average. The results were:

- Percentage of patients who would recommend the practice – 81.8% (national average 79.1%);
- Percentage of patients satisfied with phone access – 87.7% (national average 75.4%);
- GP Patient Survey satisfaction for opening hours – 80.2% (national average 79.9%).

The practice carried out a survey of patients in late 2013. From this 97% said they would recommend the practice to friends and family.

Outstanding practice

The practice had continually monitored and audited the appointment system over several years to ensure that patients could obtain timely appointments with a GP which suited their needs.

The 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 specialist advisor, and a specialist advisor with experience of GP practice management.

Background to The Park Medical Group

The Park Medical Group has two practices in the Fawdon and Kingston Park area of Newcastle Upon Tyne. The practice provides services to approximately 11,800 patients from the two locations;

- Fawdon Park Road, Fawdon Newcastle Upon Tyne, NE3 2PE
- Kingston Park Avenue, Kingston Park, Newcastle Upon Tyne, NE3 2HB

We visited both of these locations as part of the inspection of the practice.

The area covered by both surgeries includes Gosforth, Fawdon, Kingston Park, Kenton, Blakelaw, Woolsington, Dinnington and Brunton.

Both surgeries are located in purpose built premises with patient facilities on the ground floor. There is patient parking at Fawdon and disabled parking for patients at both sites. There was short term parking close to the surgery at Kingston Park for patients. There are disabled WCs, wheelchair and step free access.

The practice has six GP partners, three salaried GPs, one nurse prescriber, four practice nurses and two healthcare assistants. There is a practice manager and 16 staff who carry out reception and administration duties. The practice is a training practice.

Surgery opening times at Fawdon are between 8:30am and 12:30pm, then 1:30pm until 6:00pm Monday to Friday. Opening times at Kingston Park are 8:30am to 12:30pm and 1:30pm to 6:00pm every weekday, except Wednesday, when the surgery is open 8:30am until 1:00pm. There is extended opening hours at Kingston Park on a Monday evening until 9:15pm.

The practice provides services to approximately 11,800 patients of all ages. The practice is commissioned to provide services within a Personal Medical Services (PMS) Agreement with NHS England.

The index of multiple deprivation (IMD) placed the practice in band five for deprivation, where one is the highest deprived area and six is the least deprived.

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

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

Detailed findings

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.

How we carried out this inspection

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

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

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

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

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

We carried out an announced visit on 25 February 2015. During our visit we spoke with a range of staff. This included GPs, practice nurses and reception and administrative staff. We also spoke with 10 patients. We reviewed 21 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

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

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. For example, it was found that there had been the mislabelling of a urine sample. The incident was recorded and lessons were learned; further training and advice was given to staff.

Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records, incident reports and minutes of meetings. These 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. They were open and transparent when there were near misses or when things went wrong. There were records of significant events and we were able to review these. The GPs and practice manager told us that significant events were discussed as soon as practicable. There was a quarterly review of significant events from which we saw a schedule of the events which had occurred, learning points, feedback from the review meeting and any action taken which was necessary. Two of the GP partners had overall responsibility for the significant event processes; they told us the practice had held significant event discussions at the practice for over 10 years.

Staff could describe recent significant events and identify the learning they had taken from them. In particular they could remember some incidents involving telephone consultations where learning came from the reporting and recording of the incident. Receptionists, administrators and nursing staff we spoke with knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts came to the practice via a generic email. The practice manager had responsibility to disseminate the alerts to the most appropriate member of staff. The practice manager would then ensure the appropriate staff read them. The practice manager said they had identified that this was an area they could improve in terms of documentation and were currently working on the process.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They met with health visitors on a monthly basis to discuss child safeguarding issues. The practice had a dedicated GP appointed as the lead for both safeguarding vulnerable adults and children. All of the GPs and the nurse practitioner working in the practice been trained to level 3 for safeguarding children.

There were comprehensive practice training records which showed that practice nurses and clinical staff were trained to level two for safeguarding children and administration staff had received training to level one. Staff 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. Contact details were easily accessible.

The practice had a chaperone policy which had been reviewed in January 2015. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone. Staff we spoke with told us that the practice nurses acted as chaperone if required.

There were monthly safeguarding meetings attended by the health visitor, the school nurse and the midwife would attend where possible. We saw minutes of these meetings logged on the practice shared information drive.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines 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, this described the action to take in the event of a potential failure. Stock control of medicines was managed by the practice nurses.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Blank prescription forms were handled according to national guidelines and were kept securely.

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. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

We saw the practice was clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The nurse practitioner was the nominated infection control lead. We saw there was an up-to-date infection control policy and detailed guidance for staff about specific issues such as needle stick injuries. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies on the shared computer drive. There were quarterly audits of infection control. The practice nurses had received specific infection control training. All other staff had received in house training from the nurse practitioner which included hand washing techniques and specimen handling; they had also completed on line training in infection control.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable and had the date written on them when they were last changed. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice had a contract with a local cleaning company for the cleaning of both surgeries. There were cleaning schedules in place for use by the contracted cleaning company and the practice manager made regular checks to ensure these were being followed.

We saw a legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessment had been carried out for both surgeries.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments which was appropriate for patient's needs. The practice had a range of equipment in which included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles) and fire extinguishers. 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.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Staff recruitment records we looked at were well organised and contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

We discussed criminal records checks which are made via the Disclosure and Barring Service (DBS) with the practice manager. All clinical staff had received a DBS check and non-clinical staff who had been employed after April 2013. However there was no documented risk assessment for non-clinical staff who had been employed prior to April 2013 as to why they had not received a DBS check. The

practice manager said they knew the rationale as to why they had not carried these out but had not formally documented this and would carry this out as soon as possible.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. We saw there was a rota system in place for each staff group to ensure there were enough staff on duty. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

There was a year planner which had been developed by the practice recording every appointment offered by each GP on each working day. These appointments were totalled on a daily and weekly basis. There were alerts in the planner which could identify when GP levels were low, for example, when GPs were on holiday or study leave. Leave could either be declined or additional sessions arranged to maintain appointment numbers. A measure was included in the audit of appointments to assess if access to routine appointments deteriorated. If this occurred appointments were added and if necessary locums were employed or extra appointments added.

The practice manager said the practice used locum GPs when this was necessary. We saw that the practice only used locums which they had vetted themselves and we were shown an example of a file of a locum GP who worked at the practice which held details of DBS and identity checks, a copy of their last appraisal and there was evidence of necessary training such as safeguarding.

There were induction packages for different job roles within the practice, for example, we saw copies of inductions for locum GPs and for administration staff.

The practice manager carried out checks to ensure that clinical staff had up to date registration with professional bodies such as the Nursing and Midwifery Council (NMC). There was also a log of medical indemnity insurance for clinical staff and the date it was due for renewal.

Monitoring safety and responding to risk

The practice had comprehensive systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety was a standing agenda item at the monthly business meetings and the practice manager carried out health and safety spot checks. There was a health and safety risk assessment which covered each room in both surgeries. There had been asbestos risk assessments carried out at both sites.

The practice manager explained that they had good arrangements with local firms who carried out any maintenance work needed to the building and they felt the arrangements they had for the cleaning of the building worked well. There was constant on going refurbishment. The surgery at Kingston Park was due for some refurbishment in the treatment and consulting rooms and the ceiling at the entrance to the building was due to be repaired where there had been a leaked water pipe.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff training records showed they had all received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where this equipment was kept and confirmed they were trained to use it. They also showed us the emergency medicines which were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether 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. This had been updated regularly and contained relevant contact details for staff to refer to, for example who to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. There were several trained fire wardens at both surgeries.

Good

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 treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE). 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.

There were care plans in place for 2% of the practice population with the most complex needs to help avoid unplanned admissions into hospital. These plans were reviewed every three months.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. The QOF is part of the Personal Medical Services (PMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had achieved a score of 95.7%, which was above with the average in England of 94.2%.

The practice had a chronic disease management group where care for patients with long term conditions and QOF indicators were reviewed. All patients with long term conditions were invited for a six monthly review with the appropriate health professional and received interim reviews where needed. Medication reviews were performed on a regular basis by the GPs who then set the review intervals as required. The nurse practitioner ran weekly diabetic clinics. High risk patients in this group had a care plan in place.

The practice supported patients with dementia in care homes and those who lived in the community. There had been a learning session held recently for clinical staff to raise dementia awareness and to improve diagnosis rates.

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 completed CQC comment cards.

We saw no evidence of discrimination 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 and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We saw five clinical audits had been carried out in the last year. There were some examples of two completed audit cycles. For example, an audit to assess how many patients who had a cardiovascular condition, were at risk of fractures or had rheumatoid arthritis were given appropriate advice. The second audit showed that the number of patients which had received advice regarding risks had increased by 32% compared to the first audit.

GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. We saw evidence of an audit carried out in 2014 of minor surgery. The audit found that the complication rate for minor surgical procedures was low. However, it identified that the practice were not meeting the criteria for informed consent. The practice put actions into place to address this issue and we saw evidence of this in a sample of patient records.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

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 practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records which were comprehensive for all job roles. We saw that all

Good

Are services effective?

(for example, treatment is effective)

staff had received training such as basic life support, fire and safeguarding adults and children, health and safety, infection prevention, manual handling, personal safety, equality and diversity and information governance.

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

The practice manager provided us with comprehensive records of staff training. Each member of staff had a staff file with training certificates and we saw staff had received an annual appraisal.

Working with colleagues and other services

The practice could demonstrate that they worked closely with other services to deliver effective care and treatment across the different patient population groups. For example, the practice mental health lead liaised with the mental health team who were attached to the surgery.

The practice held multidisciplinary team meetings every Thursday in rotation. This included meetings regarding child protection, palliative care and the discussion of care plans for patients with complex needs. These meetings were attended by the practice's GPs and nurses along with district nurses, social workers, community psychiatric nurses, drug and alcohol workers and palliative care nurses depending upon the meeting.

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.

Information sharing

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

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

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent. We also saw a consent to treatment form which the practice used for consent to investigations or specific treatment.

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

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 Mental Capacity Act (MCA). We found the GPs were aware of the MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically into the reception team. Patients could also collect a pre-registration from the surgery. The patient was then required to complete a medical questionnaire. Health checks were offered dependent upon the patient's circumstances.

Good

Are services effective?

(for example, treatment is effective)

Carers known to the practice were coded on the practice system so they could be identified. The practice referred them to the local carers centre for support where appropriate. There was information for carers available on the practice website.

The practice offered a full range of clinics; these included diabetic, contraceptive services, well person and respiratory clinics. There was information on the practice website regarding travel and flu vaccination requirements. The practice offered minor surgery which included cryotherapy (the treatment of skin lesions). A GP at the practice had an interest in musculoskeletal medicine and sports injuries and was able to offer advice and treatment to patients, lessening the need for outside referral.

The practice offered baby and anti-natal clinics. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. They offered routine immunisations for babies and children under five, during clinic appointments.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the National GP Patient Survey, scores were above all of the national averages. For example, the proportion of patients who described their overall experience of the GP surgery as good or very good was 87%, compared to the national average of 85%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 88%, the national average was 85%. Patients who said the practice nurses were good at treating them with care and concern was 93%, the national average was 90%.

We reviewed 21 CQC comment cards completed by patients prior to the inspection. One was completed at the Kingston Park Avenue location and 20 at the Fawdon Park Road location. All of the comments on the cards were positive. Common words used by patients included excellent, great service and high standards.

We spoke with 10 patients on the day of our inspection which included two members of the patient participation group (PPG). We spoke with four patients at the Kingston Park Avenue location and six at the Fawdon Park Road location. All of the patients were satisfied with the care they received from the practice. Words used to describe the service included outstanding, first class and great.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional.

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

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Information regarding patient confidentiality was in the practice information leaflet.

Care planning and involvement in decisions about care and treatment

Patients 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.

Results from the 2014 National GP Patient Survey showed that, 88% of patients said the GP they visited had been 'good' at involving them in decisions about their care (national average was 81%). The data showed that 90% of patients said the practice nurse they visited had been 'good' at involving them in decisions about their care (national average 85%)

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service, either in person or by telephone.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were compassionate, re assuring and they received considerable attention.

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.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

There was a palliative care register and regular contact with the district nurses. There were monthly palliative care meetings which involved GPs, district nurses and MacMillan nurses.

Staff told us that if families had suffered bereavement, this was followed up by the practice; the triage practice nurse would contact the family to see what support was needed. There was access to a counselling service for the bereaved.

Good

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 systems in place to maintain the level of service provided. The needs of the practice population were taken in to account. An engagement plan had been produced two years earlier looking at the demographics of the practice population and systems were in place to address identified needs. The six GP partners and many of the staff had worked at the practice for many years which enabled good continuity of care.

The practice had a higher than average number of patients over the age of 85, 3.1% compared to the national average of 1.8%. They had taken up an enhanced service, which is a service other than an essential service, for the frail elderly and 2% of this group had a care plan in place which was reviewed every three months. Hospital admissions and accident and emergency attendances for this group were monitored and discussed at MDT meetings. All patients over the age of 75 had a named GP.

The practice had a palliative care register and had monthly multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had a higher number of patients with learning disabilities than other practices; there were a number of care homes in the area for this group of patients. One of the GPs was the designated lead for patients with learning disabilities and had received specialist training in this area. Regular health checks for this group of patients were carried out. The surgery were working with 'quality health checkers' who were a team of people, some with learning disabilities who visit the surgery and give advice and guidance on how the practice can improve its services for this group of patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the practice PPG. The group had made suggestions about noticeboards in the waiting areas and action was taken to improve this.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to telephone translation services if required, for those patients whose first language was not English. The surgery at Kingston Park had a high number of Arabic patients. The practice recognised this and met their needs. An Arabic speaking interpreter was used at the baby clinic.

The practice worked closely with mental health services. The mental health lead for the practice liaised closely with the mental health team attached to the surgery. There was access to counselling, primary care mental health workers and psychologists. These teams provided services from both surgeries and there were also referrals onwards to services for those experiencing poor mental health.

Both premises had been designed to meet the needs of people with disabilities. All of the treatment and consulting rooms could be accessed by those with mobility difficulties, the front doors to both surgeries opened automatically and there was a bell to attract attention from the receptionist. The patient toilets could be accessed by patients with disabilities and there were designated disabled parking spaces in both surgery car parks close to the entrance. An induction loop system was in place at both surgeries for patients who experienced hearing difficulties.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP.

Access to the service

Surgery opening times at Fawdon were between 8:30am and 12:30pm, then 1:30pm until 6:00pm Monday to Friday. Opening times at Kingston Park were 8:30am to 12:30pm and 1:30pm to 6:00pm every weekday, except Wednesday, when the surgery was open 8:30am until 1:00pm. There was extended opening hours at Kingston Park on a Monday evening until 9:15pm. There was extended opening hours at Kingston Park on a Monday evening until 9:15pm. The National GP Patient Survey showed 80.2% of patients were very satisfied or fairly satisfied with the practice opening hours (national average 79.9%).

The practice had continually worked towards improving their appointments system. This began in 2000 when they began to triage all house call requests, this resulted in a 20% reduction in house calls. Triage is the process of determining the priority of patients' treatments based on the severity of their condition. Following the success of this,

Good

Are services responsive to people's needs?

(for example, to feedback?)

a triage system for appointments and a rapid access clinic was introduced. The practice contributed to a study "Advanced Access Collaborative" to improve quality and access as a result of the work they had carried out on their appointment system. They had carried out regular reviews over 15 years to develop the appointments system into the current system.

The practice felt the triage and rapid access clinic were costly in terms of resources, however, they recognised that this was an investment which was worthwhile to ensure patients were provided with an effective service and staff were protected from a stressful environment when patients could not obtain appointments.

Routine appointments could be booked up to three weeks in advance. If a patient needed to be seen they were offered the next available appointment. If this was not suitable they were offered the practice's triage service. These patients were contacted by a practice nurse who could then arrange house calls, book urgent appointments or book the patient an appointment at the rapid access clinic with a GP or nurse practitioner. The practice nurse could give advice for those who did not wish to travel to the surgery, organise prescriptions or signpost the patient to a more appropriate service. Each day the practice had one dedicated nurse practitioner and GP who worked in the rapid access clinic. This system was audited and managed closely to ensure that routine access was kept as close to 48 hours as possible. Nurse appointments were bookable by appointment. Home visits could be arranged if necessary.

The practice had the lowest attendance rates at the local accident and emergency department and walk in centre and they believed this was due to their rapid access clinic and triage system.

Patients we spoke with and CQC comments cards completed indicated that patients felt they could obtain appointments when needed.

Comprehensive information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. 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. Information on the out-of-hours service was provided to patients. The practice offered appointments and repeat prescriptions on-line. Repeat prescriptions could also be ordered via the telephone.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information regarding how to make a complaint was in a leaflet named complaints procedure, this leaflet signposted patients to a complaints form which was available at reception.

The practice manager supplied us with a schedule of four complaints which had been received in the last 12 months and we found these had all been dealt with in a satisfactory manner.

The practice manager explained each complaint received would be treated as urgent and discussed with the GP lead for complaints as soon as possible. Complaints were an agenda item at the monthly practice business meeting, and then reviewed annually.

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 vision to be the practice of choice in their area by offering excellent clinical service with a strong emphasis on customer care. Their aim was to work towards a more patient centred service supported by continuous professional and personal development for all members of their team.

The practice held quarterly strategy meetings where the strategy for the future of the practice was discussed. The practice leadership looked on these as 'brainstorming' sessions. However there were no formally documented minutes of these meetings. The practice knew the challenges they faced which included the patient list increasing due to local housing developments in recent years close to the Kingston Park surgery. They faced difficulties being on two sites. The practice had a documented plan for the refurbishment of the premises.

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. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

The practice used QOF data to manage performance; they were performing in line with the averages of the local CCG and across England as a whole. The practice had identified clinical leads for many of the QOF areas, for example diabetes or epilepsy and had clinical leads allocated to them. We saw that QOF data was regularly discussed at team meetings. There was a system in place for clinical audit which was also used to improve outcomes for patients.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. Incident reporting was encouraged and was reviewed frequently at all levels across the practice.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles including non-clinical area. For example, there was a lead GP for safeguarding, prescribing, safety alerts and session planning. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held business meetings every month with the partners and practice manager and one of the GP partners had protected management time. There were administration staff meetings when necessary although there were no formal minutes or set times for this. Practice nurses and health care assistants held meetings informally every week.

There were clinical meeting held every week. GPs we spoke with confirmed this, however, minutes of these were taken on an ad hoc basis, we were told that this was something the practice had identified they needed to improve on.

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us they attended staff meetings. Staff said this gave them the opportunity to give feedback and raise any concerns they had.

The practice had a patient participation group (PPG) which had been established approximately three years. This consisted of seven patients who met every three or four months, we saw minutes of the last meeting in 2014. We spoke with two members of the group who said they felt involved in the giving views and these were taken seriously.

There was also a virtual patient group of 80 members who the practice manager could go to if they wanted to obtain further views of patients.

A practice survey was carried out in late 2013. The survey was based around patients being aware of what services were available to them. There were plans to carry out a further survey in 2015.

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 staff were supported to develop through regular training, supervision and appraisal. Staff told us that the practice was supportive of their training needs.

Are services well-led?

Good

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

We saw practice staff met on a regular basis. Staff from the practice also attended the Clinical Commissioning Group (CCG) protected learning time (PLT) initiatives. This provided staff with dedicated time for learning and development. There was also in house protected learning time.