Blacketts Medical Practice

Quality Report

63-65 Bondgate,
Darlington,
DL3 7JR
Tel: 01325 380640
Website: www.blackettsmedical.com

Date of inspection visit: 9 March 2015
Date of publication: 21/05/2015

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 this comprehensive inspection on 9 March 2015.

Overall, we rated this practice as good.

Our key findings were as follows:

- The practice provided a good standard of care, led by current best practice guidelines.
- Patients told us they were treated with dignity and respect.
- The practice performed well in the management of long term conditions.
- Patients could access appointments without difficulty, and were happy with the telephone and repeat prescribing systems.
- The practice had developed good continuity of care for patients in nursing homes, and good communication with home staff.
- The building was safe for patients to access, with sufficient facilities and equipment to provide safe effective services.

We saw some areas of outstanding practice including:

- Enhanced care plans and communication/education with care homes including weekly ward rounds.
- The practice manager visited management staff at nursing homes quarterly, and the practice had promoted shared training initiatives with care home staff.
- The practice was able to evidence a fall in emergency admissions to hospital as a result of these initiatives.

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

The provider should:

- Ensure systems are effective to check and identify when medicines in doctor's bags have reached their expiry date, so that these are disposed of.
- Ensure scales are checked and calibrated in accordance with manufacturers recommendations.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents, although these were not always communicated widely throughout the practice to allow additional learning opportunities. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Quality data showed patient outcomes were at or above average for the locality. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and patient's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients gave us positive feedback where they stated that they were treated with compassion, dignity and respect, and involved in their treatment and care. The practice was accessible. In patient surveys, the practice scored highly for satisfaction with their care and treatment, with patients saying they were treated with care and concern, and felt involved in their treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a good overview of the needs of their local population, and was proactive in engaging with the Clinical Commissioning Group (CCG) to secure service improvements. The practice had good facilities and was well equipped to meet patients need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff. Patients told us it was generally easy to get an appointment, with urgent appointments available the same day. Saturday morning appointments were available.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by management. The practice had published values to work to with clear aims and objectives. There were systems in place to monitor quality and identify risk. The practice had an active Patient Reference Group (PRG) and was able to evidence where changes had been made as a result of PRG and staff feedback.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice participated in a nursing home pilot where a named link GP for each nursing home carried out a 'ward round' each week, and worked closely with a community matron who visited daily and communicated with the GP. The practice manager visited management staff at nursing homes quarterly, and the practice had promoted shared training initiatives with care home staff.

The practice held monthly palliative care and multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care. Enhanced care plans had been produced for those patients deemed at most risk of an unplanned admission to hospital. Any admissions from these patients or from patients in nursing homes were analysed monthly to identify any learning points, and the practice was able to evidence a fall in admissions compared to the previous year.

Information was shared with other services, such as out of hours services and district nurses. Nationally reported data such as the Quality and Outcomes Framework (QOF) showed the practice had good outcomes for conditions commonly found in older people. The over 75's had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were monitored, and were involved in making decisions about their care. Nurses communicated with a clinical lead GP for each condition. Attempts were made to contact non-attenders to ensure they had required routine health checks.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify children who may be at risk. For instance, the practice monitored levels of children's vaccinations and attendances at A&E. Immunisation rates were high for all standard childhood immunisations. Full post natal and 6 week baby checks were carried out by GPs, and regular 'well baby'

Summary of findings

clinics were available, although these had to be accessed externally. A dedicated 'young people' area on the practice website gave information on services available, such as contraception and mental health, and gave links to support and advice organisations.

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 population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Saturday morning appointments were available on alternate weeks, or weekly at another practice as part of a CCG wide initiative. Early morning appointments were available with the nurse each Tuesday.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer appointments if needed. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Nationally reviewed data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. The practice made referrals to other local mental health services as required. The practice had identified some patients with mental health problems who were at more risk of an unplanned admission to hospital, and a mental health worker attended multi-disciplinary meetings at the practice to discuss these patients.

Summary of findings

What people who use the service say

In the most recent NHS England GP patient survey, 88.38% reported their overall experience as good or very good (above the national average of 85.7%). 73.89% of patients said the GP was good at involving them in decisions about their care (slightly below the national average of 81.8%), and 81.63% said the GP was good or very good at treating them with care and concern (slightly below the national average of 85.3%). 32.47% of patients said they could usually see their preferred doctor, the national average being 37.6%.

Patients were satisfied with the appointments system, with 91.83% saying it was easy to get through on the phone, above the national average of 75.4%, and 87.17% of patients said were fairly or very satisfied with GP opening hours (above the national average of 79.8%).

We spoke to two members of the Patient Reference Group (PRG) and six patients during the inspection. We also collected eight CQC comment cards which were sent to the practice before the inspection, for patients to complete.

The majority of patients we spoke to and the comment cards indicated they were satisfied with the service provided. They were treated with dignity, respect and care, and that staff were thorough, professional and approachable. Patients said they were confident with the care provided, and would recommend the practice to friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Ensure systems are effective to check and identify when medicines in doctor's bags have reached their expiry date, so that these are disposed of.
- Ensure scales are checked and calibrated in accordance with manufacturers recommendations.

Outstanding practice

- Enhanced care plans and communication/education with care homes including weekly ward rounds.
- The practice manager visited management staff at nursing homes quarterly, and the practice had promoted shared training initiatives with care home staff.
- The practice was able to evidence a fall in emergency admissions to hospital as a result of these initiatives.

Blacketts Medical Practice

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 specialist advisor GP, and a Practice Manager.

Background to Blacketts Medical Practice

Blacketts Medical Practice provides primary medical services (PMS) to approximately 10,100 patients in the catchment area of Darlington, which is the NHS Darlington Clinical Commissioning Group (CCG) area.

There are five GP partners and three salaried GPs, and patients can be seen by a male or female GP as they choose. There is a team of five nursing staff, a healthcare assistant and a phlebotomist. They are supported by a team of management, reception and administrative staff. The practice is a training practice and supports GP registrars, medical students and two staff on modern apprenticeship schemes.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; and treatment of disease, disorder and injury. The practice areas has a slightly higher than average proportion of patients aged 65 and above, and slightly higher levels of deprivation compared to the England average. There are higher levels of people with a long term health condition, and lower levels of employment than the CCG average.

The practice has opted out of providing Out of Hours services, which patients access through the 111 service. The practice has recently formed a federation with the ten other practices in the CCG area, which is known as Primary Healthcare Darlington. This federation successfully applied for funding under the Prime Ministers Challenge Fund to provide greater flexibility for patients to access appointments, and to provide additional care planning and support for frail elderly patients.

Why we carried out this inspection

We carried out the inspection 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.

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with two members of the Patient Reference Group. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 9 March 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GP's, nursing staff, healthcare assistants, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us a summary of significant events from the previous 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff we spoke to were aware of incident reporting procedures. They knew how to access the forms, and felt encouraged to report incidents. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. The practice worked with the Clinical Commissioning Group (CCG) in reporting incidents as necessary.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed the practice was appropriately identifying and reporting significant events.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the previous year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed, and learning points documented. We did find that this information was not then cascaded widely to enable all learning opportunities to be taken, with some staff unaware that there had been any incidents. Significant event meetings were held monthly. Learning points were shared with staff directly involved through meeting minutes or tasks on the computer, although some part-time staff said they sometimes had difficulty receiving minutes. Staff could be given feedback directly either verbally or via email. Staff were able to give examples of where procedures had changed following an incident, for instance additional fridge temperature checks.

We could see from a summary of significant events that where necessary the practice had communicated with patients affected to offer a full explanation and apology, and told what actions would be taken as a result.

National patient safety alerts were disseminated by email or via the intranet. Staff were able to give recent examples of alerts relevant to them and how they had actioned them, such as a recall of equipment.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and vulnerable adult policies and procedures in place. Staff accessed these via the computer system, and which contained contact details for organisations such as social services and the police.

The practice raised safeguarding alerts through a multi-agency computer hub, which meant information they sent was seen immediately by social services and the police. GPs demonstrated how they had followed up referrals to make sure these had been received and actioned. Multi-disciplinary safeguarding meetings were held every three months, which were attended by health visitors and district nurses.

Procedures provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access these. Staff were able to described types of abuse and how to report these. The practice had a named GP safeguarding lead, who staff were able to identify. Staff had been trained in safeguarding at a level appropriate to their role.

The computerised patient plans were used to enter codes to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

The practice had chaperone guidelines, and there was information on this service for patients in reception.

Medicines Management

Good

Are services safe?

We checked medicines in the treatment rooms and found they were stored securely and were only accessible to authorised staff. We checked medicines in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature. Refrigerated and emergency medicines we checked were in date and there was a process for checking. We found out of date medicines in a doctor's bag as this was checked by individual doctors and not overseen when the doctor was not directly employed by the practice.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a GP prescribing lead, and a senior nurse lead for controlled medicines management. Prescription queries were dealt with by a duty doctor. The practice reviewed its prescribing data through clinical audits and communication with the CCG, and had audited, for example, antibiotic use.

Prescriptions were stored securely, and there was a system in place for GPs to double check repeat prescriptions before they were generated. Any errors were logged as incidents and investigated.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. They were able to describe an example of a recent alert. This helped to ensure staff were aware of any changes and patients received the best treatment for their condition.

GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. The practice had a prescribing and medication policy which was regularly reviewed and had been agreed with the CCG medicines management team.

Cleanliness & Infection Control

Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC) and waste disposal policies, and these were reviewed and updated regularly. There was an identified IPC lead, and an infection control audit had recently been carried out. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas, as was hand sanitizer and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place, with daily, monthly and six monthly tasks. The practice employed its own cleaners. Whilst on the whole we observed areas of the practice to be clean, tidy and well maintained, we did find some minor cleanliness issues in one room. This had not been identified through cleaning and audit checks. Although a legionella risk assessment had been carried out, it was unclear whether all documented risks had been satisfactorily resolved.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw other equipment such as blood pressure monitors used in the practice was clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

We found that equipment such as spirometers, ECG machines (used to detect heart rhythms) and fridges were checked and calibrated yearly by an external company. However weighing scales were not included on this schedule so these were overdue for checks. After the inspection the practice contacted us to say checks had now been carried out.

Contracts were in place for checks of equipment such as the lift, fire extinguishers, and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager.

Good

Are services safe?

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the 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 there was enough staff 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. Some staff operated in dual roles, for instance administration/reception, therefore this allowed some flexibility in cover and planning. Staff said there were generally sufficient staff numbers for the effective operation of the practice.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and mainly monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk.

Patients with a change in their condition or new diagnosis were reviewed appropriately and discussed at clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk. Therefore the practice was positively managing risk for patients. Information on such patients was made available electronically to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff who used the defibrillator were regularly trained to ensure they remained competent in its use. This helped to ensure they could respond appropriately if patients experienced a cardiac arrest. Staff described the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

A business continuity plan and emergency procedures were in place which had been recently updated, which included details of scenarios they may be needed in, such as loss of data or utilities. Key staff kept a copy of this document at their homes to ensure they could access it. Weekly fire alarm checks took place and fire drills every six months.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. There was also a defibrillator and oxygen available. Processes were in place to check emergency medicines were within their expiry date, although we did find items of emergency medication in a doctor's bag which had expired.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into their practice and disseminated via the computer system as assigned tasks, or via email.

Treatment was considered in line with evidence based best practice, and we saw minutes of fortnightly clinical staff meetings where new guidelines and protocols were discussed. All the GPs interviewed were aware of their professional responsibilities to maintain their knowledge. Two chronic disease nurses had qualifications in all the clinical areas, allowing patients to be seen for multiple conditions. The nurses attended regular updates and implemented changes as appropriate to ensure best practice. The nurses were supported by the GPs and attended clinical meetings.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates which were kept under review, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness. The practice could produce a list of those who were in need of palliative care and support, and held end of life planning discussions.

Patients with long term conditions such as diabetes had regular health checks, and were referred to other services or discussed at multi-disciplinary meetings when required. Feedback from patients confirmed they were referred to other services or hospital when required. National data showed the practice was in line with referral rates to secondary care (hospital) and other community care services for all conditions. All GPs we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen.

The practice had identified their 2% of most vulnerable patients, who were at risk of an unplanned admission to hospital, and had produced enhanced care plans for these. These were regularly reviewed and discussed, for instance after an admission, to ensure they were accurate and addressed the needs of those patients. The practice was able to demonstrate 41 less emergency admissions from the same period the year before; suggesting this had a positive impact on patients. Staff were able to give specific examples of where a discussion of needs assessment had resulted in improved care for an individual, for instance referral to a falls team or support services.

Patients requiring palliative care or with new cancer diagnosis were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. Latest QOF data from 2013-14 showed the practice had an overall rating of 94.7%, slightly above the England average. The data showed the practice supported patients with long term conditions such as diabetes, asthma, and chronic heart disease appropriately.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We saw minutes of meetings where clinical complaints were discussed and the outcomes and practise analysed, to see whether they could have been improved.

The practice was proactive in participating in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For instance the practice looked at referral or prescribing data and compared these against criteria, then looked to see how patient outcomes could be improved.

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). The practice carried out some clinical

Good

Are services effective?

(for example, treatment is effective)

audits, examples of which included antibiotic prescribing, an audit of hospital admissions, and a review of prescribing for heart patients. Audits did not always include a date for future re-audit to gauge the success of any changes made.

Clinical staff checked that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued. Similarly when patients needed to attend for routine checks related to their long term condition.

Effective staffing

The practice manager oversaw a computerised training matrix which showed when essential training was due. Staff told us the practice was supportive of relevant professional development, and weekly time was taken on Fridays for staff training. Staff were also able to access protected learning time (PLT) monthly through the CCG.

We saw evidence that all GPs had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored as part of the appraisals process, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice.

We saw evidence that clinical and non-clinical staff had yearly appraisals, which identified individual learning needs and action points from these. We saw where changes had been made through the appraisal feedback process, for instance the upskilling of non-clinical staff which allowed them more job variety and also to be more flexible. New starters had a six week induction period during which time they received mentoring and training, and a 'mini-appraisal' after three months.

On starting, staff commenced an induction comprising health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

We saw that the mandatory training for clinical staff included safeguarding and infection control. Staff had access to additional training related to their role.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Working with colleagues and other services

The practice worked proactively with other service providers to meet patients' needs and manage complex cases. For instance regular multi-disciplinary meetings were held with district nurses, health visitors and GPs to identify and discuss the needs of those requiring palliative care, or safeguarding issues. The practice was involved in the cancer GOLD standards framework, an external training and accreditation scheme for those approaching end of life, which involved holding monthly multi-disciplinary meetings.

A mental health worker attended some multi-disciplinary meetings to discuss patient's specific needs. The practice had developed a close working relationship with the local drug and alcohol treatment service and mental health services, in response to patient need, and referred to these.

As part of a nursing home pilot, a named link GP carried out a ward round each week at designated nursing homes, and worked closely with a community matron who carried out daily rounds. GPs had spent time with nursing home staff and had a proactive approach to advanced care planning. The practice manager also visited the homes quarterly to meet with home management staff. We saw evidence from a nursing home that this collaborative approach was well received by residents and their relatives, and had improved the knowledge and development of home staff.

The practice had recently formed a federation with the ten other practices in the CCG area, called Primary Healthcare Darlington. This federation successfully applied for funding under the Prime Ministers Challenge Fund to provide greater flexibility for patients to access appointments, and to provide additional care planning and support for frail elderly patients. This had resulted in all the Darlington practices working more closely together, and initiatives such as a GP to GP email advice service, and patients of this practice being able to access Saturday appointments at another designated practice.

Regular clinical and non-clinical staff meetings took place and staff described the communication within the practice as generally good, although some part-time staff said they

did not always receive minutes of meetings they had missed. The practice manager and nursing staff were able to attend forums each month held in the CCG area which allowed sharing of best practice and information.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant doctor, or the duty doctor, or where necessary a procedure for scanning documents was in place. There was a system to ensure scanned documents were not sent to a doctor who was on leave, and the GPs operated a buddy system to check each other's results if one was off. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information Sharing

Information was shared between staff at the practice by a variety of means. GPs held management and clinical meetings. Nursing and clinical staff such as healthcare assistants held clinical meetings and had representatives from these groups attend the GPs meetings. Non-clinical staff had either weekly meeting or ongoing communication due to the open plan office. The whole practice was able to meet during the monthly PLT sessions. Staff said the communication and information sharing was generally good.

Information on unplanned admission was collated from multi-disciplinary meetings and fed back to the CCG to identify themes and trends.

Referrals were completed using an electronic system, and these were completed within appropriate protocols. Referrals could be made using the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate, and a new project to share information with ambulance teams.

Consent to care and treatment

We found that staff had received training around the Mental Capacity Act 2005, and were able to describe key aspects of the legislation and how they would deal with issues around consent. Further information was available for staff on the practice intranet.

For instance, GPs explained examples where people had recorded advance decisions about their care or their wish not to be resuscitated. Where those with a learning disability or other mental health problems were supported to make decisions, this was recorded. If someone had lasting power of attorney concerning a patient this was recorded on the computer and in the patient's plan.

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary.

Staff were able to discuss the carer's role and decision making process. Verbal consent was documented on the computer as part of a consultation, and staff were able to explain how they would discuss a procedure, detailing risks and benefits. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, this allowed patients to make an informed choice.

Health Promotion & Prevention

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP. Nurses used chronic disease management clinics to promote healthy living and ill-health prevention in relation to the person's condition.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. The practice website contained information on a number of long term conditions, with links to support organisations.

In addition to routine immunisations the practice offered travel vaccines, and flu vaccinations in line with current national guidance. Data showed immunisation rates were broadly comparable with the CCG area.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was comparable to the CCG and England average. There was a policy to follow up patients who did not attend for cervical smears and the practice audited rates for patients who did not attend.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

In the most recent NHS England GP patient survey, 88.38% reported their overall experience as good or very good (above the national average of 85.7%), and 81.63% said the GP was good or very good at treating them with care and concern (slightly below the national average of 85.3%).

In the practice annual survey from 2013, of 303 responses, 290 patients said their clinician was good or very good at giving them enough time, and 292 that they were listened to adequately.

We spoke to two members of the Patient Reference Group (PRG) and six patients during the inspection. We also collected eight CQC comment cards which were sent to the practice before the inspection for patients to complete.

The majority of patients we spoke to and the comment cards indicated they were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. Patients said they were confident with the care provided, and would recommend the practice to friends and family.

The practice phones were located away from the reception desk which helped keep patient information private. There was a room available where patients could request to speak with a receptionist in private if necessary. We observed that reception staff were friendly, relaxed and helpful, and maintained confidentiality as far as possible.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were used in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and leaflets advertising the service in reception and consulting rooms. Nursing staff acted as chaperones where requested, and other non-clinical staff had also been trained.

Care planning and involvement in decisions about care and treatment

In the NHS England GP survey, 73.89% of patients said the GP was good at involving them in decisions about their care, and 280 out of 303 responses in the practice survey stated their clinician was good or very good at involving them in their care.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin, or the level of ongoing intervention the patient wished for their condition. Extra time was given during appointments where possible to allow for this.

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. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us there was a translation service available for those whose first language was not English. A laminated card was available at reception for patients to select the language they needed to be connected to a telephone translation service.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support service to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service.

GPs referred patients to bereavement counselling services, and had helped secure links with the local bereavement service. This information was available in reception. When the practice had won the 'Darlington Intersurgery annual

Good

Are services caring?

quiz' they had donated the prize money to the local bereavement care service. When patients had suffered bereavement, GPs were notified, and the practice had a general policy to visit the person or send a sympathy card.

The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice worked closely with the CCG to discuss local needs and priorities. Longer appointments were made available for those with complex needs, for instance patients with diabetes. Patients could book with a specific GP to enable continuity of care.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow them up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Saturday morning appointments were available on alternate weeks at the practice which benefitted the working population and parents bringing children outside of school hours. Patients could access weekly Saturday appointments at another practice in the area as part of a CCG-wide initiative. Patients could access early morning nurse appointments from 7:30am each Tuesday. Home visits and telephone appointments were available where necessary.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as level access, automatic doors and level thresholds. Treatment and consulting rooms were on the ground and first floors, with patients able to access a lift between. A number of disabled parking spaces were available in the car park outside. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There was a practice information leaflet available. However patients had to request these from reception. It covered subjects such as services available, staff list, and how to book appointments. There was a hearing loop at reception to assist those hard of hearing.

The practice had recognised the needs of different groups in the planning of its services. For instance GPs worked closely with the local drug and alcohol service. Patient records were coded to flag to GPs when someone was living in vulnerable circumstances or at risk.

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

Appointments could be made in person, by telephone or online. Repeat prescriptions could be also be ordered online. The practice promoted its online services via the practice leaflet and website. Appointments could be booked up to four weeks in advance, which helped patients to plan.

Appointments were available from 8:30am until 5:30pm Monday to Friday, with Saturday morning appointments available on alternate weeks. Patients we spoke to told us they could generally access appointments without difficulty. Opening times and closures were advertised on the practice website, with an explanation of what services were available. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

During core times patients could access a mix of doctors, nurses & health care assistants, or clinics such as family planning and for chronic conditions.

Listening and learning from concerns & complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. Information on how to complain was contained in the patient information leaflet in reception, and staff were able to signpost people to this.

We looked at a summary of complaints made during 2014, and could see that these had been responded to with an explanation and apology, although some responses did not include all necessary information, such as timescales for a full response in the initial acknowledgement, or ombudsman details. The practice carried out a patient survey in 2013. An action plan was then drawn up and agreed with the PRG, with actions such as advertising the electronic prescription service and publicising the PRG to try to recruit members' representative of the practice population. Results of this survey were available on the practice website. Information on how to make a complaint was available in the practice leaflet, and there was a box where patients could leave feedback through the 'Friends and Family' test.

The practice summarised and discussed complaints with staff at practice meetings, and was able to demonstrate changes made in response to feedback. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

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 clear aims and objectives to improve the health and well-being of patients and provide good quality care contained in their statement of purpose. Management staff had a clear plan for the next year, and had 'headlines' from the previous year where they identified the main issues and how they intended to address these for the next year. These included recruiting an additional salaried GP and succession planning, and upskilling of staff.

Staff had specific individual objectives via their appraisal which fed in to these, such as clinical staff looking to develop their knowledge in a certain area to be able to offer additional service.

Governance Arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system, which logged who had read reports. All the policies and procedures we looked at, such as chaperone policy, Mental Capacity Act policy and human resources policies had been reviewed and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed it was performing in line or above national standards. The practice regularly reviewed its results and how to improve. The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks, and had a coherent strategy and aims for the future. There was a programme of clinical audit, subjects selected from QOF outcomes, from the CCG, following an incident or from the GP's own reflection of practice. Audits on subjects such as prescribing of medicines for heart patients, antibiotic use and admissions to hospitals were recorded; although these did not always include a date for re-audit to gauge the success of actions.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us an action log which addressed a wide range of health, safety and welfare issues, such as legionnaires risk assessment or recruitment checks for staff. These did not always include a completed date; therefore it was not always possible to ascertain from this whether actions had been completed by the target date.

From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture. We saw evidence that they used data from various sources including incidents, complaints and audits to identify areas where improvements could be made.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest, and said they felt confident in raising concerns or feedback.

GP partners described a major business strength of having a strong, cohesive staff team, and this was echoed by staff who described strong supportive team working within their areas. There was a clear chain of command and organisational structure. Staff described communication as generally good, although some part-time members of staff said they sometimes found it difficult to keep up to date.

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

There was an active Patient Reference Group (PPG), which met on average every other month. Annual patient survey reports and action plans were published on the practice website for the practice population to read. The practice was actively advertising to recruit to the group to ensure it was representative of the practice population.

We saw some examples where the practice had made changes following patient feedback. Action plans completed from the patient survey included a date for completion and that it had been agreed by the PRG. Members of the PRG confirmed they were consulted.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. Staff told us they generally felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

Are services well-led?

Good

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where necessary. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice was a training practice and supported medical students, GP registrars and also had two staff on modern apprenticeship schemes. The practice had completed reviews of significant events and other incidents. Staff told us the culture at the practice was one of continuous learning and improvement.