# Neasham Road Surgery

## Quality Report

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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 this comprehensive inspection on 25 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.
- The practice had a good understanding of the patient population and their needs.
- Patients told us they were treated with dignity and respect.
- Staff told us they felt confident and well supported in their roles.
- The practice performed well in the management of long term conditions.
- The practice had developed good continuity of care for patients in nursing homes.
- The practice promoted shared learning from incidents.
- 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 provided an additional voluntary service to hospice patients who did not already have their own GP.
- Newly registered patients with visual impairments were invited to the practice for a walk through induction.

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

The provider should:

- Ensure that documented action points arising from risk assessments are carried out.
- Explore options to improve patient privacy in the reception area.

# 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, and were 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, although it was not clear whether some documented action points had been completed. There were sufficient emergency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep people 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 people'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. They said they were treated with compassion, dignity and respect, and involved in their treatment and care. The practice was accessible for people with mobility issues. In patient surveys, the practice scored highly for satisfaction with the care and treatment provided. Patient survey views aligned with what patients told us on the day of the inspection.

**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 patient need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff. Patients told us it was

# Summary of findings

generally easy to get an appointment, although there was some negative feedback around getting appointments the same day. Saturday morning appointments were available at another practice as part of a CCG wide initiative.

**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 Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG 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**

Good

The practice is rated as good for the care of older people. The practice participated in a nursing home pilot where a named nurse practitioner carried out a 'ward round' each week in designated nursing homes, supported by a GP. 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. However the practice was not able to provide practice specific information on this to demonstrate positive outcomes for patients, such as a fall in unplanned admissions. Information was shared with other services, such as out of hours services and district nurses. Nationally reported data 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 appropriately 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. There was a named children's safeguarding lead. The practice held bi-monthly safeguarding meetings attended by health visitors and social services. Immunisation rates were high for all standard childhood immunisations. Patients could access weekly midwife-led clinics at the practice, which were supported by the on-call GP. Full post natal and six week baby checks were carried out by GP's. There was a

# Summary of findings

policy to see sick children the same day, and a minor illness clinic after school hours. There were dedicated areas on the practice website and in reception for young people. These gave information on services available, such as contraception and counselling.

**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. The practice continued to monitor access to the service on an ongoing basis. Routine appointments could be booked up to four weeks in advance, or on the day. Appointments could be made online. Repeat prescriptions could be ordered online. Saturday morning appointments were available weekly at another practice as part of a CCG wide initiative. Some early morning and evening appointments were available.

**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 returned 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 a register of patients with a learning disability and these patients were invited for an annual health check-up. Daily emergency appointments could be accessed for patients having a mental health crisis. A Primary Care Link Worker worked from the practice weekly. The practice referred as required to counselling and support services. Counselling services worked from the practice building on a weekly basis, allowing patients to be easily referred and seen.

# Summary of findings

## What people who use the service say

In the most recent NHS England GP patient survey, 88.41% reported their overall experience as good or very good (above the national average of 85.7%). 88.5% of patients said the GP was good at involving them in decisions about their care (above the national average of 81.8%), and 86.2% said the GP was good or very good at treating them with care and concern (above the national average of 85.3%). 34.73% of patients said they could usually see their preferred doctor, the national average being 37.6%.

Patients were less satisfied with the access to the service, with 65.96% saying it was easy to get through on the phone, below the national average of 75.4%, and 71.59% of patients said they were fairly or very satisfied with GP opening hours (below the national average of 79.8%). A higher than average number of patients said they could be overheard in reception, which we confirmed through our observations during the inspection.

We spoke to a member of the Patient Participation Group (PPG) and six patients during the inspection. We also collected 26 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.

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure that documented action points arising from risk assessments are carried out.
- Explore options to improve patient privacy in the reception area.

## Outstanding practice

- Enhanced care plans and communication/education with care homes including weekly ward rounds.
- The practice provided an additional voluntary service to hospice patients who did not already have their own GP.
- Newly registered patients with visual impairments were invited to the practice for a walk through induction.

# Neasham Road Surgery

**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 second CQC inspector, a specialist advisor GP, and a Practice Manager.

## Background to Neasham Road Surgery

Neasham Road Surgery provides primary medical services to approximately 11,200 patients in an urban catchment area of Darlington, within the NHS Darlington Clinical Commissioning Group (CCG) area.

There are three 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 four nursing staff, and two healthcare assistants. They are supported by a team of management, reception and administrative staff.

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 slightly higher levels of deprivation compared to the England average. There are higher levels of people with a long term health condition, claiming disability allowance, and slightly higher levels of unemployment 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?

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

# Detailed findings

- 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 a member of the Patient Participation 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 25 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. Staff described a clear chain of command which helped them identify who to speak to about an incident and what actions needed to be taken. 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. GP's 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 provider was appropriately identifying and reporting significant events.

We reviewed safety records, 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. Incidents were discussed during staff meetings, and the findings communicated to staff. The practice also held annual significant event meetings, where they analysed themes and trends. This information was then disseminated to all staff to enable wider learning within the practice.

Staff could be given feedback about incidents they had involvement in directly either verbally or via email. They could also access minutes of meetings they had not attended, which helped staff had a broad overview of safety within the practice. Staff were able to give examples of were procedures had been changed or reviewed following an incident, for instance a refresher on procedures to summon help if a patient became violent.

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. Patients were told what actions would be taken as a result.

National patient safety alerts were disseminated by email or via the intranet, and 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, which staff accessed via the computer system. They contained contact details for organisations such as social services and the police. These provided staff with information about identifying, reporting and dealing with suspected abuse. 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, and were able to describe types of abuse and how to report these.

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

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 a policy, and there was information on this service for patients in reception.

Good

# Are services safe?

### Medicines Management

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 this. Expiry dates of medicines were logged on the computer system which sent a reminder to staff a fortnight before. There was a cold chain policy and incident protocol in case of fridge breakdown. We checked medicines in the treatment rooms and found they were stored securely and were only accessible to authorised staff.

Vaccines were administered by nurses or in some cases healthcare assistants using specific 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. There were prescribing and repeat prescribing protocols which had been reviewed and updated. The practice reviewed its prescribing data through clinical audits and communication with the CCG, and had audited, for example, antibiotic use.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. For instance, there was a process to review and check medicines after a patient was discharged from hospital. GPs reviewed their prescribing practices regularly. The frequency was governed by factors such as the age of the patients, and number and type of medicines. Reviews were at least annually, or more frequently for some patients.

Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent alert. This ensured staff were aware of any changes and patients received the best treatment for their condition.

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

### 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. We saw that cleaning schedules for all areas of the practice were in place, with daily, monthly and six monthly tasks. The operations manager carried out a weekly walk-round to check for issues. There was also an identified IPC lead, who carried out full yearly audits.

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.

The practice employed its own cleaners. While 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, which had not been identified through cleaning and audit checks.

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 that other equipment such as blood pressure monitors used in the practice were 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. Contracts were in place for checks of equipment such as fire extinguishers and fire alarms. Weekly and monthly checks were carried out by practice staff to ensure fire equipment was operational. Portable appliance testing was carried out annually. Review dates for all equipment were overseen by management staff.

Good

# Are services safe?

The operations manager carried out regular checks of each room including the equipment to ensure it was working. Staff could also report faults using a form or via team meetings. 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 and protocols 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 were able to operate 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, although they could be stretched at times. The practice was actively recruiting for a practice nurse and a salaried GP, as well as training a nurse practitioner, to ensure they could continue to meet demand in the future.

### Monitoring Safety & Responding to Risk

There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment, equipment and medicines management, so patients using the service were not exposed to undue risk. Each room had an individual risk assessment which was kept under review. There was an identified health and safety lead. Health and safety was a standing agenda item at practice meetings.

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. We did find however, one instance where a risk of combustibles stored in a boiler room had been identified in three separate audits over a period of time but this had not been actioned.

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. Patients with a change in their condition or new diagnoses 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 would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest. Staff could describe 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. This included details of scenarios they may be needed in, such as loss of data or utilities. 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. Medicines were separated into pouches for different emergencies, for instance convulsions or anaphylaxis, to help with locating them quickly and easily.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Treatment was considered in line with evidence based best practice, and we saw minutes of fortnightly clinical staff meetings for GPs and nurses where new guidelines and protocols were discussed. GPs also had a weekly meeting where they could review case notes, discuss the assessment of patients, and discuss new guidance. 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 computer system as assigned tasks, or via email.

All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge. Nurses attended regular updates and implemented changes as appropriate to ensure best practice. The nurses were supported by the GPs and attended clinical meetings. One nurse was being mentored and supported to become a nurse practitioner. There was a GP lead for each chronic disease area who worked with the nursing team. If a patient had more than one condition they could see the same nurse within a longer appointment.

Patients with long term conditions such as diabetes were having regular health checks, and were being 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 hospitals and other community care services for all conditions. All GP's we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen.

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 health reviews for 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.

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. Patients requiring palliative care or with new cancer diagnoses were discussed at monthly 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 people's 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 97.4%, above the England average. The data showed the practice supported patients with long term conditions such as diabetes, asthma, and chronic heart disease.

The practice had monthly QOF meetings to discuss areas which could be improved, and to ensure all staff had a good overview of the monitoring process. 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 and outcomes were discussed. The practice analysed these to see whether they could have been improved. All emergency admissions were reviewed within 24 hours of receipt of discharge information and the patients contacted to assess need. Monthly meetings were held to discuss these patients which were attended by the clinical staff from the practice, district nurses, community matrons, social services and the voluntary sector.

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, and prescribing for certain high risk medicines. Corrective actions were noted and a date for re-audit included to gauge whether patient outcomes had 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 example the practice looked at referral or prescribing data and compared these against criteria, then looked to see how patient outcomes could be improved. This data was discussed quarterly at practice meetings.

Clinical staff checked that all 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, and when patients needed routine checks related to their long term condition. Medication reviews were used as another way to check that a patient had attended all the health checks they needed to.

### Effective staffing

The practice manager oversaw a training matrix which showed when essential training was due. There was also an action plan to address training needs for staff who were returning from long term leave or who had been unable to attend sessions. We saw that mandatory training for clinical staff included safeguarding and infection control. Staff also 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.

Staff told us the practice was supportive of relevant professional development. Staff were able to access protected learning time (PLT) monthly through the CCG. We saw examples of where the practice had supported staff development, for instance one staff member was being mentored and supported to become a nurse practitioner. Other staff members had been able to access an IT higher education course, management diplomas and vocational qualifications. Nursing staff were supported to access a 'nurse master class' run once a month at a local college. GPs and nursing staff accessed weekly peer to peer review through team meetings, where unusual cases and best practice were discussed.

We saw evidence that all GP's 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 and clinical supervision 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 further training for staff.

The recruitment policy of the practice showed that relevant checks were made on qualifications and professional registration as part of the process. 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.

### Working with colleagues and other services

The practice worked proactively with other service providers to meet people's needs and manage complex cases, for instance regular multi-disciplinary meetings were held with district nurses, social services, 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.

As part of a nursing home pilot, a named link Nurse Practitioner, supported by a GP, carried out a ward round each week at designated nursing homes. The practice covered out of area patients in a local hospice on a rota basis with two other practices in the area. This was done voluntarily and not through a contractual obligation.

Patients could access additional services via the practice, for instance once a fortnight Citizen's Advice attended at the practice. Patients could also see a counselling service once a week. A warfarin clinic was run by another provider from within the practice, meaning patients could access this easily. Patients could also access midwife services. District nurses visited daily which helped enhance communication between the services.

Good

# Are services effective?

## (for example, treatment is effective)

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, 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 good. 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. All correspondence relating to patients was scanned into the clinical system on day of receipt and viewed by clinicians electronically. Any actions required could therefore be undertaken without delay. 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. All staff were able to attend a weekly team meeting for their role, and minutes were available on the computer system for staff who could not attend. The whole practice met once a month at the protected learning time sessions. There was a weekly GP meeting and bi-monthly clinical meetings, which nursing staff and healthcare assistants also attended. Staff also described daily informal meetings which they found useful. Staff said the communication and information sharing was generally good.

Information on unplanned admissions was collated from multi-disciplinary meetings and fed back to the CCG to identify themes and trends. The practice also held an annual review of significant events which was then shared with all practice staff.

Referrals 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). All patient information was scanned in on the day, and assigned to the referring or usual doctor. There was a buddy system for when a doctor was away. Results were received electronically and assigned via computer tasks to the relevant doctor.

There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. GPs received information each morning about out of hours attenders. This was then reviewed as a task and any necessary actions taken.

### Consent to care and treatment

We found that staff were able to describe how they would deal with issues around consent. For instance, GPs and nursing staff 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.

We did find that staff had not been given specific training around the Mental Capacity Act 2005. Staff described consent issues as being covered in other training modules, such as safeguarding and sexual health courses. Staff were confident in discussing how they would deal with consent issues.

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 seeking further advice from the GP mental health lead.

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, which 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

Good

# Are services effective?

## (for example, treatment is effective)

was given on smoking, alcohol consumption and weight management. An alcohol consumption screening template was used, with patients referred to local alcohol services as required.

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 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. Following the health check patients were referred to a GP as necessary. GPs were able to refer patients to a local slimming service where they received 12 weeks support for free, as part of a local initiative. The waiting area was used to bring healthy living information to patients. For instance we were shown an exhibition board educating patients around sugar consumption, and there was a special noticeboard for the under 16's.

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.

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 with 118 responses, 88.4% reported their overall experience as good or very good (above the national average of 85.7%). 86.2% said the GP was good or very good at treating them with care and concern (above the national average of 85.3%).

In the practice annual survey from 2014, 93% of patients said their clinician was good or very good at listening to them, and 91% said they were treated with care and concern.

We spoke to a member of the Patient Participation Group (PRG) and six patients during the inspection. We also collected 26 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. We observed that reception staff were friendly, relaxed and helpful, and maintained confidentiality as far as possible. We did observe that some conversations at reception could be easily overheard in the waiting area, and also received negative comments from patients about this. There was a room available where patients could request to speak with a receptionist in private if necessary.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, although we did not see this service advertised in reception. Nursing staff or healthcare assistants acted as chaperones where requested.

### Care planning and involvement in decisions about care and treatment

In the NHS England GP survey, 88.5% of patients said the GP was good at involving them in decisions about their care (above the national average of 81.8%). 91% of patient 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 patients with long term conditions supported staff in helping to involve people in their care. Nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment options. For example, 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 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 and 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.

People said the GP's 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. There was a poster in reception advertising this, and the booking-in system was available in other language options.

### Patient/carer support to cope emotionally with care and treatment

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

GP's referred people to bereavement counselling services. Where people had suffered bereavement, GPs were notified, and the practice had a general policy to send a sympathy card with support information. There was a link

Good

# Are services caring?

member of reception staff responsible for bereavement and carer support who could signpost to local support agencies. The practice leaflet encouraged patients who were carers to register as such so support could be offered.

The practice kept registers of groups who may need 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 people's needs and had systems in place to maintain the level of service provided. The practice had a good understanding of the needs of the practice population. Systems were in place to address identified needs, for instance travellers could access services as temporary residents.

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 could be made available for those with complex needs, for instance patients with diabetes. Young person's sexual health advice and information was available in response to identified need for the local area.

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

### Tackling inequity and promoting equality

The building accommodated the needs of patients with disabilities, incorporating features such as automatic doors and level thresholds. Disabled parking was available. The practice had carried out a full Disability Discrimination Act assessment to ensure it complied. They had also taken advice from the Patient Participation Group, for instance painting the disabled toilet door green to make it more distinguishable for visually impaired patients. Newly registered patients with visual impairments were invited to the practice for a walk through induction. There was however no hearing loop at reception to assist those hard of hearing.

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

There was a practice information leaflet available, covering subjects such as services available, staff list, and how to book appointments. 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 up to GPs when someone was living in vulnerable circumstances or at risk.

### Access to the service

Patients could access weekly pre-bookable Saturday appointments at another practice in the area as part of a CCG-wide initiative. The practice had a policy for children with acute illness to be seen on the day. There was also a minor ailment clinic from 4pm which children could access after school.

Appointments were available from 7.30am Tuesday to Friday, and until 7pm on Thursdays as an extended hours service to assist those who could not attend at other times, for instance the working population or students. Home visits and telephone appointments were available where necessary. The on-call doctor had no surgery in the morning and was only assigned home visits, therefore was able to triage and prioritise visits as they came in. This helped very ill patients to be seen sooner.

Appointments could be made in person, by telephone or online. Repeat prescriptions could also be ordered online. Appointments could be booked up to four weeks in advance, or on the day, which helped patients to plan. 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.

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.

The majority of patients we spoke to told us they could generally access appointments without difficulty. However

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

we did receive some negative feedback around getting through on the phone in the morning, and being able to get a same day, non-urgent appointment. The provider was aware of this, and had ongoing plans to address this. This included additional nurse practitioner appointments, recruitment of another GP, and trials for different clinic times.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was contained in the patient information leaflet, and also a designated 'complaints procedure' leaflet. Staff were able to signpost people to these. Patients we spoke with said they would be comfortable making a complaint if the need arose.

We looked at a summary of complaints made during 2014, and could see that these had been responded to within specified timescales, with an explanation and apology where necessary. The practice carried out regular complaints analysis meetings, where they reviewed complaints and identified any trends. Outcomes and actions taken were reviewed.

The practice had carried out yearly patient surveys. An action plan was then drawn up and agreed with the PPG, with actions such as improving waiting times through recruitment, and promoting awareness of the carer link worker. Patient Participation Group minutes and reports were available on the practice website. The group also advertised in reception. There was a box where patients could leave feedback through the 'Friends and Family' test, and a link on the website to this also.

# 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 recently formed mission statement, to provide high quality health care in a responsive, supportive, courteous and cost-effective manner. This was underpinned by values such as integrity and working as a team. These were published on the practice website. Although staff felt involved in the vision of the practice and it's values, awareness of the mission statement varied, with some staff unaware of it.

The practice had clear aims and objectives contained in their statement of purpose. Management staff had a clear plan for the next year, where they identified the main issues and how they intended to address these for the next year, such as recruiting an additional salaried GP and developing a nurse practitioner role.

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

### Governance Arrangements

Staff told us they 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. All the policies and procedures we looked at, such human resources and health and safety policies had been reviewed and were up to date.

The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks. For instance, there were named individuals for long term conditions, health and safety and operational matters.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data showed this practice was performing in line or above national standards, and the practice regularly reviewed its results and how it could improve. There was a named lead for QOF, and staff were involved in results and suggestions of how to improve.

There was a programme of clinical audit. Subjects were selected from areas such as QOF outcomes, from the CCG, incidents or from the GP's own reflection of practice. Audits were included on subjects such as prescribing of medicines for heart patients and antibiotic use.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us risk assessments and an action log which addressed a wide range of health, safety and welfare issues. However there remained an identified risk of combustibles in the boiler room that had not been actioned.

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. They valued opportunities for personal development. Staff described the culture at the practice as friendly and caring, and said they felt confident in raising concerns or feedback. The practice managing GP partner and practice manager told us they had an open door policy, and were happy for staff to enter and talk.

There was a clear chain of command and organisational structure. Staff described communication as good. We saw from minutes that team meetings were held regularly, and that staff were given the opportunity for feedback. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings, or informally. The practice could demonstrate changes to procedure as a result of staff feedback, for instance the way documents were scanned and allocated.

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

There was an active Patient Participation Group (PPG), which met quarterly with other members participating via email. Annual patient survey reports, action plans and PPG

# Are services well-led?

Good

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

meeting minutes were published on the practice website for the practice population to read. PPG members said they were kept informed and that the practice had a good understanding of patient needs and issues.

We saw some examples where the practice had made changes following patient feedback, for instance, painting of the disabled toilet door in a high visibility paint to help the visually impaired. 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

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 had completed reviews of significant events and other incidents. Staff told us the culture at the practice was one of continuous learning and improvement. A number of staff were being mentored and supported through developing their roles, extra learning or vocational qualifications.