Whinfield Medical Practice

Quality Report

Whinbush Way
Darlington
County Durham
DL1 3RT
Tel: 01325481321
Website: www.whinfieldsurgery.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Whinfield Medical Practice on 24 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services that are well led.

Our key findings were as follows:

- There were comprehensive systems in place to keep people safe, which took account of current best practice. The whole team was engaged in reviewing and improving safety. There was an open culture in which all safety concerns raised by staff and patients who used services were highly valued as integral to learning and improvement.
- The practice was proactive to anticipating and managing risks.
- The team was making use of clinical audit tools, intelligence monitoring tools, appraisals, clinical supervision and staff meetings to assess the performance of the practice and its staff.
- All the patients we spoke with were positive about the care and treatment they received. The CQC comment cards and results of patient surveys showed that patients were consistently pleased with the service they received.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- There was good collaborative working between the practice and other health and social care agencies that ensured patients received the best outcomes. Clinical decisions followed best practice guidelines.
- The practice met with the local Clinical Commissioning Group (CCG) to discuss service performance and improvement issues.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had a clear vision which had quality and safety as its top priority. A strategy was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw areas of outstanding practice including:

- The practice regularly worked with multi-disciplinary teams in the management of vulnerable people, including attendance at multi-disciplinary meetings. The practice followed the gold standards framework GSF) for end of life care. Monthly GSF meetings were held to discuss the care and support needs of patients and their families. External partners such as community matron, district nurse, Macmillan nurse and staff from the local hospice attended these meetings.
- The practice had taken part in the 'You're Welcome Project' since 2012 and met with a group of young people between the ages of 15 to 18 to discuss what services and information they needed to meet their particular needs.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. The practice was an outlier for one clinical target and had outcomes that were comparable to or above the CCG average in all other clinical and QOF indicators. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice undertook clinical audit and monitored the performance of staff.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Feedback from patients about their care and treatment was positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient

Summary of findings

participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a GP or nurse, and urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and they worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were comprehensive systems in place to monitor and improve quality and identify risk. Staff were systematic in their approach to working with other organisations to improve care outcomes, tackle health inequalities and obtain value for money. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and were supported to develop in their career and into new roles.

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 was knowledgeable about the number and health needs of older patients using the service and actively reviewed the care and treatment needs of these patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients over the age of 75 had a named GP. The practice actively invited patients over the age of 75 who were not on any chronic disease register for an annual health check. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice was part of the Darlington Care Homes Initiative. The GPs visited three care homes on a weekly basis to provide support and care to residents and helped care home staff in providing care, liaising with the families of the residents and ensuring advance End of Life Care Planning was discussed with residents and their families.

The practice participated in the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme". Data showed that there had been a reduction in unplanned admissions to hospital from 30 in July 2014 to 15 in March 2015.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients. Nursing staff had lead roles in chronic disease management. The practice closely monitored the needs of this patient group. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. There was a recall programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. We heard from patients that staff invited them for routine checks and reviews. The practice followed the gold standards framework for end of life care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up

children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Child safeguarding meetings were held approximately every 12 weeks and were attended by various health care professionals, for example school nurse, health visitor and midwife. The practice offered comprehensive vaccination programmes which were managed effectively. Immunisation rates were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell were seen by the GP or nurse on the same day.

Family planning clinics were available with practice staff and the midwife provided clinics at the practice which were supported by one of the GPs. There was a midwife clinic once a week and a family planning clinic five times a week at the practice.Joint post natal check appointments were available for mothers and their babies so vaccinations could be given at the same time.

The practice had taken part in the 'You're Welcome Project' since 2012. They had met with a group of young people between the ages of 15 to 18 to discuss what services they would like and an action plan had been developed. The practice offered chlamydia checks and sexual health screening appointments.

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 this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided a range of options for patients to consult with the GP and nurse. The Practice offered extended opening hours two mornings and weekend appointments were available to the practices' patients. The practice was proactive in offering online services.

There was a veteran's protocol in place to support staff in delivering care and services to these patients to ensure they got appropriate support from the practice or other organisations if required.

Useful information was available in the practice and on the website as well as a full range of health promotion and screening that reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for patients with a learning disability. Fifty eight of the 73 patients that needed a health check had received one. The practice offered these patients longer appointments. We found that all of the staff had a very good understanding of what services were available within their catchment area, such as supported living services, care homes and families with carer responsibilities.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. They had access to the practices' policy and procedures and discussed vulnerable patients at the clinical meetings.

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). The practice maintained a register of patients who experienced mental health problems including dementia. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review. Data for 2013/2014 showed 74.8% of patients diagnosed with dementia had received a face to face review in the previous 12 months; this had increased to 81.9% by March 2015.

Documented care plans had also been completed for 69% of patients with other mental health problems such as schizophrenia, bipolar affective disorder and other psychoses, this was 5.9% below the CCG average. This had increased to 80.7% by March 2015. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had a primary mental health link worker and a counsellor who worked out of the practice at certain times.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 11 patients all of which were positive about the care and treatment they received from the practice. Patients said staff were polite and helpful and always treated them with dignity and respect; two patients described the service as excellent.

Patients described the service as very good and said the nurses and GPs were always professional.

We spoke with seven patients during the inspection and they also confirmed that they had received very good care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff involved them in the planning of their care and were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs.

We looked at the results of the national GP survey for 2014 where 134 patients had responded. Results showed that patients were generally positive about the service they received and the practice performed at or above the CCG (regional) average in a number of areas. For example:

- 91% of respondents find receptionists at this surgery helpful – CCG average: 89%
- 67% of respondents describe their experience of making an appointment as good – CCG local average: 76%
- 78% are satisfied with the surgery's opening hours - Local (CCG) average: 80%
- 85% of respondents describe their overall experience of this surgery as good – CCG local average: 89%
- 94% say the last GP they saw or spoke to was good at listening to them - Local (CCG) average: 91%
- 88% say the last GP they saw or spoke to was good at treating them with care and concern - Local (CCG) average: 88%
- 93% say the last nurse they saw or spoke to was good at listening to them - Local (CCG) average: 94%
- 97% say the last nurse they saw or spoke to was good at treating them with care and concern - Local (CCG) average: 94%

We looked at the results of the Practice's survey for 2013/2014 which 288 patients had completed and saw they were also positive about the services delivered.

These results were consistent with our findings on the day of the inspection.

We found that the practice valued the views of patients and saw that following feedback from surveys and from patients attending the practice; changes were made to improve the service.

Patients confirmed that they could see a doctor or nurse on the same day if they needed to, although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Outstanding practice

We saw areas of outstanding practice including:

- The practice regularly worked with multi-disciplinary teams in the management of vulnerable people, including attendance at multi-disciplinary meetings. The practice followed the gold standards framework GSF) for end of life care. Monthly GSF meetings were held to discuss the care and support needs of patients and their families. External partners such as community matron, district nurse, Macmillan nurse and staff from the local hospice attended these meetings.

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- The practice had taken part in the 'You're Welcome Project' since 2012 and met with a group of young people between the ages of 15 to 18 to discuss what services and information they needed to meet their particular needs.

Whinfield Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector and included a GP Specialist Advisor and a Practice Manager Specialist Advisor.

Background to Whinfield Medical Practice

Whinfield Medical Practice is situated in Darlington and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Darlington area. The practice provides services to 11,454 patients of all ages. There is a slightly higher percentage of the practice population in the 65 years and over age group than the England average. The practice population in the under 18 age group is the same as the England average. The overall practice deprivation score is 2% higher than the England average.

The percentage of patients with a long standing health condition is 4.8% higher than the England average and the percentage of patients with health-related problems in daily life is 11.7% higher than the England average.

The practice has four GP partners and three salaried GPs, two male and five female. There is one nurse manager, one nurse practitioner, four practice nurses, 2 health care assistants and a practice assistant. There is one practice manager and a team of secretarial, reception, data input and administrative staff.

The practice provides services to their patients through a Primary Medical Services contract.

The practice has opted out of providing out of hours services (OOHs) for their patients. When the practice is closed patients use the 111 service. Information for patients requiring urgent medical attention out of hours is available in the waiting area, in the practice information leaflets and on the practice website.

The practice is a teaching practice for 3rd and 5th year medical students.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out an announced inspection 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.

This practice had not been inspected before and was selected at random to be inspected under Darlington Clinical Commissioning Group (CCG).

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?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 24 March 2015.

During our visit we spoke with a range of staff including two GPs, the practice manager and nurse manager, a practice nurse, a health care assistant, a receptionist, the data clerk and secretary. We spoke with seven patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed 11 CQC comment cards where patients were able to share their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

Safety was a high priority for the practice and they used a range of information to identify risks and improve patient and staff safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. All the staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a staff member told us how they had reported an incident and had no concerns about doing this. The staff member told us they were supported, the incident was discussed and reviewed and the procedure was revised to reduce the risk of the incident recurring.

We reviewed incident reports and minutes of meetings all of which showed that incidents were discussed. The records we looked at and discussions with staff showed that reducing risk and improving safety was a high priority for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. All significant events relating to the practice were submitted to the North East Commissioning Support (NECS) team as required. We looked at the 5 records of significant events that had occurred during the last 12 months. The practice discussed significant events at the weekly clinical and staff meetings and staff confirmed that incidents were discussed. A dedicated meeting would be held if a significant event occurred.

There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We found all staff to be open and transparent and committed to reporting all types of incidents. For example after incorrect information was given to an external health professional about a patient the procedure was revised so staff checked all relevant clinical records before information was shared. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

The practice also reported incidents to the NECS team that had affected their patients but were caused by external organisations, this included hospitals and pharmacies. This ensured those organisations were made aware of the incidents and could investigate and learn from them. The practice had reported 30 of these incidents between April 2014 and November 2014.

The practice categorised the incidents recorded, for example medication, communication and confidentiality, which enabled them to look at patterns and trends. The practice reviewed the incidents reported regularly to confirm the measures they had taken to prevent any recurrence were continuing to work.

National patient safety alerts were disseminated by e mail to practice staff who then took any action required. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example an alert was issued relating to a piece of breathing equipment and the practice had checked to see if they had any of the equipment. They also told us that where necessary, alerts were discussed at staff meetings to ensure all staff were aware of any action that needed to be considered.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record and document safeguarding concerns, and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. Staff gave examples of concerns they had raised and how they worked with the Health Visiting, Social Services teams and the police when they had safeguarding concerns.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the

necessary knowledge to enable them to fulfil this role. Staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern and were clear who the GP leads were.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or patients with dementia.

Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health professionals such as health visitors, midwives and district nurses. Records showed safeguarding children's' meetings were held quarterly and vulnerable adults were discussed at the practice meetings.

There was a chaperone policy and information telling patients that they could ask for a chaperone was visible in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants, acted as chaperones and understood their responsibilities, including where to stand to be able to observe the examination. The policy said all staff that would chaperone would be trained, but we did not see evidence to confirm this had happened. When they carried out this role they would record this in the patient's record to show how the situation was managed and also if there had been any areas of concern. We were told that staff did not always record when a chaperone was used. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

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

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

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated and signed in March 2014 and November 2014. We saw that the nurse had received appropriate training to administer vaccines. Nursing staff who were qualified as an independent prescriber received regular supervision from a pharmacist. They also told us they had peer support meetings and received updates in the specific clinical areas of expertise for which they prescribed.

The practice had comprehensive systems in place for monitoring medicines in line with national guidance, for example the management of high risk medicines. The GPs proactively sought and promoted improvement in medicines management for the practice. Staff followed protocols to ensure the effective management of medicines at the practice. The protocol system alerted the reception staff or prescriber that a medicine review was required. The patient would then be booked an appointment and only when the medication review had been undertaken could the medicine be re-authorised.

The practice also had a system in place for managing prescriptions for patients with multiple clinical issues when they did not attend for reviews. For example, searches of patients who had not attended for an asthma review despite three reminder letters. The patients would be identified and then their prescription reduced to one issue and their regular GP would be alerted to take forward.

There was a system in place for the management of high risk medicines, for example Warfarin. This included regular monitoring of patients in line with national guidance and appropriate action being taken based on the results of blood tests to ensure patients received the correct dose of medication.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription were kept secure and handled in accordance with national guidance.

Cleanliness and infection control

Good

Are services safe?

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

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. External advice and support was available for practice staff from NHS England. All staff received induction training about infection control specific to their role and received annual updates. Staff confirmed they had completed training in infection prevention and control.

The practice monitored the standards of cleaning in the practice regularly so any areas for improvement could be identified and actioned. We saw evidence that audits had been carried out in the last two years and that any improvements identified for action were completed.

Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons. Staff were able to describe how they would use these to comply with the practice's infection control procedures. For example staff told us they wore disposable gloves when handling specimens such as blood or urine. We saw that hand wash, disposable towels and hand gel dispensers were readily available for staff.

Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests 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 used in the practice was clean.

Staff told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

The practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all medical equipment was tested and maintained regularly and we saw records that confirmed this. For example weighing scales, pulse oximeters and blood pressure machines had all been checked within the last 12 months. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date and when the next test was due. The practice had an asset and medical equipment register which enabled them to monitor when equipment and medical devices needed servicing and if any were overdue.

Staffing and recruitment

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system in place for all the different staffing groups to ensure that enough staff were on duty. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Feedback from patients we spoke with and on the CQC comment cards and surveys confirmed they could get an appointment to see a GP or nurse when they needed to.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. These included proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Two of the five files we looked at did not contain written references; however these staff had been in post for a number of years. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the

building and the environment. We saw that risk logs were kept and each team leader was responsible for ensuring any actions were followed up. For example when a leak occurred in the ceiling a builder was contacted and the ceiling repaired.

The practice had a health and safety policy which identified who the health and safety lead was and how health and safety would be managed and risks controlled. Health and safety information was displayed for staff to see.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Records showed all staff had received conflict resolution training. This would help them diffuse potentially difficult situations and minimise the risk of verbal or physical abuse to themselves or patients.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly and how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines were available; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency equipment was working and that emergency medicines were within their expiry date and suitable for use. Records confirmed that equipment was checked regularly to ensure it was working and that medicines had not expired. All the medicines we checked were in date and fit for use. All the staff we spoke with knew the location of the emergency equipment and medicines.

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. Four of the staff we spoke with described an incident when a patient had collapsed and how the practice had responded. There was a de-briefing session afterwards where they discussed how they had responded and any actions required.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. There was a list of foreseeable risks identified including power failure, adverse weather, unplanned staff sickness and access to the building. They had also assessed the likelihood of the risks occurring and the potential impact on the practice. The practice had made arrangements with a neighbouring practice to use their premises if they couldn't use their own and to support each other in the event of an infection outbreak. The plan also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received fire training and fire drills had been carried out. The practice had appointed fire wardens and information on what to do in the event of a fire was displayed within the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We discussed with the practice manager, GP and nurses how NICE guidance was received into the practice. They told us that this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed. Implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and the nurses that staff completed thorough assessments of patients' needs in line with national and local guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as family planning, children's health, palliative care and respiratory conditions. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GPs and nurses told us they continually reviewed and discussed new best practice guidelines, for example for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

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

Management, monitoring and improving outcomes for people

Staff from across the practice played a role in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us nine clinical audits that had been completed in the last two years. We looked specifically at two completed audit cycles where the practice was able to demonstrate the changes since the initial audit. Following each clinical audit, changes to treatment or care were made where needed. For example, after the British Society for Rheumatology (BSR) issued new guidelines for patients who were taking a specific medicine for the treatment of Gout, an audit was carried out to confirm these patients were having a blood test each year and the test result was in line with the guidelines.

The practice identified 149 patients were taking the medicine on repeat prescription and of these only 34 had had a blood test in the previous year and of these only 20 had results in line with the guidelines. The practice took action and when the audit was repeated after six months of 149 patients taking the medicine, 74 had had a blood test in the last 12 months and of these 55 had results in line with the guidelines. This demonstrated an improvement and the practice was continuing to work to achieve compliance with the BSR guidelines and a further re-audit was planned.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards

Good

Are services effective?

(for example, treatment is effective)

practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had carried out two audits in 2013 and 2014 to review their prescribing of antibiotics for respiratory conditions to determine if patients were being prescribed the medicine in line with local clinical guidelines. Results showed that prescribing rates had reduced over the two years and most patients were been prescribed antibiotics appropriately. GPs maintained records showing how they had evaluated the service and documented the success of any changes. They shared this with all prescribers in the practice and the results were reviewed at the CCG prescribing leads meeting. The practice was also carrying out a review of children with asthma following a national report published in 2014 into asthma deaths in children in the UK.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor and improve outcomes for patients. This practice was not an outlier for any QOF clinical targets. It achieved 98.6% of the total QOF target in 2013/2014, which was above the national average of 92.3%. Specific examples to demonstrate this included:

- In 2013/14 performance for chronic obstructive airways disease (COPD) patients who had had a review in the previous 12 months was 87.9% which was 4.1% below the local CCG average. The practice provided us with data up to March 2015 which showed performance had improved to 91.8%.
- In 2013/14 performance for patients with asthma who had had a review in the previous 12 months was 78.2% which was 2.2% below the local CCG average. The practice provided us with data up to March 2015 which showed performance had improved to 79.7%.

The practice also participated 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. This benchmarking data showed the practice had outcomes that were comparable to other practices in the area in most indicators. The practice was aware of the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example, along with eight other practices in the area they had high numbers of patients attending A/E and the practice was working with the CCG and the other practices to reduce A/E attendances.

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

The practice's prescribing rates were also similar to national figures. For example data for 2013/2014 showed they were prescribing appropriately for antibiotic and anti-inflammatory medicines. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. After these patients were discharged from hospital the practice reviewed the reason for their admission to determine if anything could have been done to prevent it and to amend their care if required.

The practice followed the gold standards framework GSF) for end of life care. It had a palliative care register and held monthly GSF meetings to discuss the care and support needs of patients and their families. External partners such as community matron, district nurse, Macmillan nurse and staff from the local hospice attended these meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training matrix and saw staff were up to date with attending mandatory courses such as basic life support, fire safety and

Good

Are services effective?

(for example, treatment is effective)

safeguarding children and adults. The training matrix outlined what training each member of staff had attended if any refresher training was required and when that should occur.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff told us the appraisal was an opportunity to discuss their performance, any training required and any concerns or issues they had. They also had a mid-year review to discuss progress against any objectives. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The nurses had completed training in areas specific to their role, for example asthma, diabetes, cervical smears and immunisations. The staff we spoke with confirmed they had access to a range of training that would help them function in their role, one nurse told us they had they had completed diplomas in asthma and chronic obstructive airways disease.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff described how they had shadowed other staff in the practice during their induction period so they became familiar with how the practice worked. Staff told us that role specific induction, for example immunisation training for nurses was available for new staff.

There was a process in place to manage poor performance of staff members.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those with complex needs. It received blood test results, X ray results, and letters from the local hospital, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP or nurse who requested the test or investigation was responsible for reviewing their own results and if they were on holiday the results were sent to another doctor or nurse for review. The GP or nurse who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

There was a system in place to ensure the GP out of hours' service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

The practice held regular multidisciplinary team (MDT) meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in the patients' care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record, (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Patients could also register for access to an electronic system which gave them a summary of some of their records, for example medication, allergies and any adverse reactions they may have had.

Consent to care and treatment

We found that staff had an awareness and understanding of the implications of Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 legislation. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The GPs had completed MCA training.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice procedure for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and then documented in the electronic patient record. The consent form outlined the relevant risks, benefits and complications of the procedure and the clinician and patient both signed the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

Health promotion and prevention

It was practice policy for all new patients registering with the practice to complete a health questionnaire to assess their past medical and social histories, care needs and assessment of risk. Patients were then offered a new patient medical with the practice nurse. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were followed up if they had risk factors for disease identified at the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. QOF data for 2013/14 showed 69% of patients with mental health problems had a comprehensive care plan documented in their record; this was 5% below the CCG average. The practice provided us with data up to March 2015 which showed performance had improved to 80.7%

QOF data for 2013/2014 showed the practice had identified the smoking status of 81.6% of patients over the age of 15 and 94.4% of these patients had been offered support and treatment within the preceding 12 twelve months. Also the practice had recorded the smoking status of 81.4% of patients with conditions such as heart disease, stroke**,** hypertension, diabetes, respiratory problems, asthma and mental health conditions and 96.3% had a record of an offer of support and treatment recorded in their records within the preceding 12 months. The practice performed slightly below the local CCG average for identifying patients who smoked and was above the local CCG average for offering those identified support.

The practice provided us with data up to March 2015 and the criteria had changed so the smokers were not separated into the two separate groups. The practice had identified the smoking status of 93.4% of these patients and 99.9% had been offered support and treatment within the preceding 12 twelve months.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was 81.9%, which was the same as the local CCG average. Cervical smear uptake performance up to March 2015 was the same as 2013/14. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The nurses were responsible for following up patients who did not attend for screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance for 2013/2014 was above average for the majority of immunisations where comparative data was available. Flu vaccination rates for patients in at risk groups such as COPD, diabetes, heart disease and stroke was above 97%. This was above the local CCG average. The practice had maintained this level of performance in 2014/15.

Childhood immunisation rates for the vaccinations given to those aged 12 and 24 months and aged five were above 90%. Performance was above the local CCG average in all but one of the immunisations; Infant Men C aged 24 months which was 0.6% below the CCG average. Again there was a clear policy for following up non-attenders by the practice.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health. For a number of years the nurses in the practice had held 'know your pulse' events in the supermarket opposite the practice. The nurses would check a customer's pulse and advise them to go to their GP if required and provide leaflets on healthy lifestyles. They also did health promotion initiatives in the practice waiting room for example the British Heart Foundation Red Day and during breast cancer awareness week.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey in 2014 which had 134 respondents and the practices' patient participation group (PPG) 2013/2014 survey which had 288 responses. Data from the national patient survey showed 88% of respondents stated the last GP they saw or spoke to was good at treating them with care and concern and 94% said the GP was good at listening to them. The satisfaction rates for the nurses for these two areas were 97% and 93% respectively. This was the same or above the local CCG average.

We observed reception staff treating patients with respect and being extremely tactful when dealing with requests. Data from the national GP patient survey 2014 showed 91% of respondents found the reception staff helpful. This was above the local CCG average.

In the national GP survey 83% of respondents said their overall experience of the surgery was good and 85% said they would recommend the surgery to someone new to the area. This was in line with the local CCG average. We saw an action plan had been developed following the patient surveys which included a 'Patient Facing Skills' course for reception staff.

We received 11 completed CQC comment cards and spoke with seven patients during the inspection, including two members of the Patient Participation Group (PPG). Feedback was positive about the service and care experienced. Patients said staff were polite, caring and helpful and always treated them with dignity and respect; two patients described the service as excellent. They told us staff would always try and resolve problems for the patients. For example one patient commented they had a problem when an outside service didn't turn up which they told the practice about and the practice staff resolved it for them.

Staff were familiar with the steps they needed to take to protect a patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception area was open but we observed no confidential information being discussed from the waiting area. There was music playing in the background which helped with minimising the risk of patients being overheard. There was a room available if patients wished to discuss a matter with the reception staff in private and there were notices in the waiting area informing patients that this was available. A self-check in screen was available for patients to use if they did not want to go to the reception desk.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. The satisfaction rates for the nurses for these two areas were 94% and 93% respectively. This was in line with or above the local CCG average.

Feedback from patients also indicated that 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. We saw evidence that care plans were discussed with patients.

Staff told us that translation services were available for patients who did not have English as a first language. There was a notice in the reception area with information about the translation service. Google translate was available on the practice website.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices and leaflets in the patient waiting room and the practice website also told people how to access a number of support groups and organisations. This included help with mental health issues and Age UK which included services for support following bereavement. When patients registered with the practice they were all given a carers form to complete if relevant. The practice's computer system alerted GPs and nurses if a patient was a carer. The nurses told us that they would signpost patients who were carers to support groups and services that could help them.

One of the receptionists was the practice carer lead and they attended carers meetings which were facilitated by Darlington Association for Disability (DAD). There was a carers' noticeboard which gave information to patients and carers on support available. DAD attended the practice multi-disciplinary team meetings where patients were identified that would benefit from the support of DAD; we saw evidence that 12 patients had been referred to the DAD.

Patients receiving end of life and palliative care were well supported by the GPs and nurses in the practice. If a patient suffered bereavement the practice sent a condolence card and an appointment was arranged at the practice if required. A note was placed on their record for 12 months so any staff that saw the patient was aware of their bereavement. Information on support services was available for patients and carers and one nurse told us about a patient they had signposted to Cruse after they became upset during a consultation.

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 local CCG had shared the Joint Strategic Needs Assessment (JSNA) with the practice. The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The partners had invested in extending the practice premises in 2011 by adding a first floor extension to provide office accommodation thus freeing up rooms on the ground floor for clinical use. This enabled the practice to deliver their own services and also have sufficient space that external organisations could use.

Patients could see the nurse practitioner for minor ailments which freed up GP appointment time to enable them to see patients with more complex needs. The clinical triage system also enabled patients to speak to the GP or nurse practitioner so they could be assessed and arrangements made for them to access the most appropriate care. Feedback from patients confirmed they could be seen quickly when required.

The practice was part of the Darlington Care Home project. The GPs visited three care homes on a weekly basis to provide support and care to residents. They helped care home staff in providing care, liaising with the families of the residents and ensuring advanced End of Life Care planning was discussed with residents and their families. There were a total of 48 patients living in the three care homes and five had advanced care plans in place. Another five had been identified as being at high risk of hospital admissions and Unplanned Admissions Care Plans had been developed. The practice was working with the community matrons and they were in the process of visiting and completing care plans for the care home patients where appropriate, nine emergency health care plans had been completed.

The practice was also participating in the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme". This was a strategy introduced in 2014 where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. Data showed that there had been a reduction in unplanned admissions to hospital from 30 in July 2014 to 15 in March 2015. All patients who had had an unplanned hospital admission were now contacted by a GP or nurse after discharge to provide support and arrange any services or help that the patient required.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example the practice had installed more telephone lines after feedback in Patient Participation Group (PPG) surveys highlighted that patients struggled to get through on the telephone. They had also introduced a text messaging service to remind patients of their appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The majority of the practice population were English speaking but the practice had a number of patients who were Chinese. Access to online and telephone translation services were available if they were needed. Staff told us that leaflets in different languages would be made available although we did not see any available in the patient waiting area. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice was in the mid-range for deprivation and a member of staff from the Citizen's Advice Bureau came to the practice once a week to provide support and advice for any patients that needed it.

The premises and services had been designed to meet the needs of people with disabilities. The building was a purpose built health centre with all the clinical services delivered on the ground floor. Consultation rooms and corridors were accessible to all patients which made movement around the practice easy and helped to maintain patients' independence. 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

Good

Are services responsive to people's needs?

(for example, to feedback?)

available for all patients attending the practice including baby changing facilities. A hearing loop was available to assist patients who had hearing difficulties. Parking was available for patients including disabled spaces.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training and staff and we saw records confirming that all staff were up to date with equality and diversity training.

Access to the service

Patients could make appointments in different ways, either by telephone, in person or online, via the practice website. The surgery was open from 8.00am to 6.00pm Monday to Friday, routine appointments were available until 5.20pm and urgent appointments were available until 5.50pm. They offered early morning appointments from 7.00am on Wednesday and Thursday.

Comprehensive information for patients about appointments was available in the patient information leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice offered emergency appointments during the day for patients who had urgent medical problems or if their condition had become worse.

Patients confirmed that they could see a doctor or nurse on the same day if they needed to, although this might not be their GP of choice. For routine appointments they could see another doctor if there was a wait to see the doctor of their choice. Routine appointments could be booked up to four weeks in advance with the GPs and nurses. Patients could register to receive text reminders for their appointments.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring, depending on the circumstances.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Home visits were available for housebound patients and for those too ill to attend the surgery. Appointments were available outside of school hours for children and young people and staff told us children under five always had same day access to a GP or nurse practitioner.

The patient survey information we reviewed from 2014 showed patients responded fairly positively to questions about access to appointments. For example:

- 78% were satisfied with the practice's opening hours compared to the CCG average of 80%.
- 67% described their experience of making an appointment as good compared to the CCG average of 76%.
- 52% said they could get through easily to the surgery by phone compared to the CCG average of 68%.

The practice had taken action to improve access and had installed a new telephone system in March 2015 which doubled the number of lines for appointment booking, provided call queuing and enabled notification of queue position. The practice was reviewing staffing levels and rotas at the busiest times of day for the appointments line.

In conjunction with other practices in Darlington the practice was taking part in the 'Prime Ministers Challenge Fund Access Initiatives' to enable patients to have greater access to appointments and advice. There was a rota system in place which meant one of the practices taking part in the initiative would open on a weekend and patients from any practice in Darlington could arrange a pre booked appointment to be seen at that practice; patients had access to GP services seven days a week.

The practice also provided telephone consultation appointments. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse. Family planning clinics were available with practice staff and the midwife provided clinics at the practice which was supported by one of the GPs. Joint post natal check appointments were available for mothers and their babies so vaccinations could be given at the same time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients could order repeat prescriptions by post, in person, via their local pharmacy or on line. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

The practice had assessed the needs of children and young people and had taken part in the 'You're Welcome Project' since 2012 and had an 'Investing in Children's' award. They had met with a group of young people between the ages of 15 to 18 to discuss what services would be useful for them and an action plan had been developed. There was a 'young persons' noticeboard in the waiting area which displayed information relating to children and young people. Opportunistic chlamydia screening, family planning advice, smoking cessation and drugs and alcohol advice services were all available either in the practice or patients could be referred to them.

An army garrison town was located close to Darlington and a number of patients had served in the military. There was a veteran's protocol in place to support staff in delivering care and services to these patients to ensure they got appropriate support from the practice or other organisations if required. There was a register of veterans and we saw that patients had been referred to other services when required. One of the veterans was closely involved with the Veterans Connected group in Darlington and regularly sent the safeguarding lead updates and information regarding support services as they developed. This information was located in the safeguarding adults' folder. There was also an armed forces directory for Darlington and District which staff could signpost patients to.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We saw that the complaints policy had details of who patients should contact and the timescales they would receive a response by.

Information was available to help patients understand the complaints system. There was a summary in the patient information leaflet, details on the practice website and displayed in the waiting room. Patients we spoke with told us they would speak with a member of staff if they were not happy with the service. None of the patients we spoke with had ever needed to make a complaint about the practice.

Staff were aware of how to deal with concerns raised by patients and described how they would support someone who was not happy with the service.

The practice had received 13 complaints between March 2014 and February 2015. We saw that these were dealt with in a timely way and had been investigated and satisfactorily handled. We saw that where relevant GPs, nurses and the practice manager had met with the complainant to discuss the issues raised and where possible the complaint had been resolved. The practice had a summary of the different types of complaints that had occurred during the year so were able to identify trends and determine if their actions to prevent a recurrence were working. They had also provided training for staff as a result of identifying areas for improvement following complaints, for example customer care.

We saw that the practice had received cards and letters thanking staff for their kindness, support and care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality healthcare and promote good outcomes for patients. We found the philosophy was displayed in the patient information leaflet and on the practice website. It was also included in their statement of purpose aims and objectives. The practice philosophy was to provide a comprehensive and personal service of high quality in a caring environment.

We spoke with nine members of staff and they all knew and understood the practice vision and values and could provide clear examples of how this had been achieved. Feedback from patients we spoke with and on the CQC comment cards also reflected that the practice was delivering its vision and achieving its aims.

Governance arrangements

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

The practice had comprehensive quality assurance and risk management arrangements in place. This included using the Quality and Outcomes Framework (QOF), data from the CCG to measure its performance, staff supervision, internal and external peer review and effective systems and processes for managing patient recalls. The practice was performing well in the clinical targets and the practice had outcomes that were above other services in the area in most indicators. The QOF data for this practice showed it was performing well and achieved a score of 98.6% in 2013/14 which was 0.5% above the CCG average and 5.1% above the national average. We saw that QOF and CCG data was regularly discussed at the team meetings and action agreed where necessary to maintain or improve outcomes.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG and shared their learning with other practices. For example the practice had achieved a small reduction in its 'did not attend' rates. This is where patients do not turn up for appointments and do not inform the practice so the appointment is wasted and can't be given to another patient. To assist in reducing DNA rates the practice had displayed the amount of time lost as well as number of appointments lost to increase the message's impact. The data was posted on the practice noticeboards, the electronic notice board and on the website on a weekly basis. The practice also sent text messages to patients who DNA frequently. The practice manager had discussed this at the local practice managers meeting.

The practice had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example fire safety. The practice monitored risks on a regular basis to identify any areas that needed addressing and documented the findings in the individual team risk logs.

The practice had completed clinical and non clinical audits which it used to monitor quality and systems and to identify where action should be taken. These demonstrated outcomes for patients had improved. For example the practice had undertaken audits for the prescribing of antibiotics. This ensured they were using these medicines in line with clinical guidelines and were using the most cost effective treatment available.

Comprehensive arrangements were in place for identifying, recording and managing risks, internal and external to the practice. For example significant events were recorded that related to the patient experience of using secondary care and the electronic prescription service. The practice had reported 73 incidents in 2014 to the local commissioning support unit that involved external organisations.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles for all staff groups and for different areas of practice. For example, there was a lead

Are services well-led?

Good

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

nurse for infection control and the GP partners had lead roles for safeguarding and governance. The staff we spoke with were all clear about their own roles and responsibilities.

We saw from minutes that staff meetings for all staff were held regularly, at least monthly and these were used for staff to raise concerns, to share information and to discuss lessons learned from incidents. There were a range of other meetings held on a regular basis. These included safeguarding, palliative care, GP and nurse meetings, QOF, palliative care and avoiding unplanned admissions. Many of these meetings included multi-disciplinary attendance, for example health visitors, district nurses and Macmillan nurses. Staff told us there was a very open culture within the practice and they had the opportunity and were happy to report incidents and raise issues at team meetings so improvements could be made for patients and staff.

The partners and practice manager also met monthly and we saw from minutes they discussed changes that would impact on the practice. For example the nurse manager was due to retire and they had talked about succession planning for this role.

The GPs, nurses and practice manager were also actively involved in external meetings. One of the GPs was the CCG clinical quality lead and another GP was the CCG lead for end of life care. The practice clinical lead for mental health attended meetings with the local mental health trust. One of the nurses was a member of the Darlington respiratory group which did overviews of respiratory care in the local area and shared learning with staff in the practice.

The practice manager was responsible for human resource procedures and one of the GP partners was the lead for staff personnel issues. We reviewed a range of policies and procedures that were in place to support staff, for example induction, disciplinary issues and bullying and harassment. We saw that mechanisms were in place to support staff and promote their positive wellbeing. Staff told us that they had raised concerns about pressure on staff when a team member was on long term sick leave and extra support was provided. All the staff we spoke with told us they felt valued, were well supported and the staff worked well as a team.

Seeking and acting on feedback from patients, the public and staff

The practice had gathered feedback from patients through the Patient Participation Group (PPG), surveys and complaints received.

The practice had an established PPG which had agreed to meet twice a year and in between to communicate via e mail. We spoke with two members of the PPG and one told us that they could request extra face to face meetings and had done this on two occasions and this had been arranged. One of the PPG members was also a member of the CCG council of representatives.

There was information on the practice website and there was a dedicated noticeboard in the waiting room encouraging patients to become involved in the PPG. The two members we spoke with were very positive about the role they played and told us they felt engaged with the practice. We saw changes had been made following feedback from the PPG. For example, the practice had installed a new telephone system which had doubled the number of lines available. This was in response to patient survey results which showed patients had difficulty getting through on the phone to make appointments.

We saw the results of the last patient survey, which was considered in conjunction with the PPG. An action plan was agreed with the PPG and the results and action plan were available on the practice website. We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was a suggestion box in the waiting area and patients could also provide feedback through the practice website. We found that the practice was very open to feedback from patients. The practice had also commenced the Friends and Family feedback project and results were available on the practice website.

The practice gathered feedback through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Our discussions with staff demonstrated a high level of staff satisfaction and a confidence that their views were listened to.

Are services well-led?

Good

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at appraisal records and saw they included a personal development plan. Staff told us that the practice was very supportive of training, for example one of the reception team told us they had completed leadership skills and appraisal training following a promotion. The practice had protected learning time one afternoon each month and all staff commented on how valuable this was. Arrangements were in place to cover the phone lines during this time. Staff told us they also had the opportunity to attend Darlington wide events, for example one staff member told us they had attended an event on safeguarding.

The practice was a teaching practice for third and fifth year medical students.

The practice had comprehensive systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice had completed reviews of significant events and other incidents and shared the learning with their own staff at meetings and with other organisations where necessary to ensure the practice improved outcomes for patients. For example, after the introduction of the electronic prescription system (EPS) for repeat prescription requests the practice identified a problem. The practice did an analysis of this and revised the process which resulted in a reduction of lost prescriptions and patient complaints. The practice liaised with the pharmacy manager so they were engaged in the review process and the shared learning.