Carmel Medical Practice

Quality Report

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Date of inspection visit: 18 March 2015
Date of publication: 16/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Carmel Medical Practice on 18 March 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they could get an appointment, with urgent appointments available the same day. Data and some feedback from patients showed it was not always possible to make an appointment with a named GP and to easily get through on the telephone. The practice demonstrated they were taking steps to try and address these issues.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff felt supported by all staff at the practice. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice. Some examples are detailed below:

- The practice was using innovative and proactive methods to improve patient outcomes and it linked

with other local providers to share best practice. New evidence based techniques were used to support the delivery of high-quality care and high performance was recognised by credible external bodies. Two GPs at the practice were GPs with special interests (GPSI); one in cardiology and the other in respiratory medicine. The practice was able to manage more complex patients within the practice. The GPSIs encouraged peer to peer referrals within the CCG area; both of which we were told helped reduce referrals to secondary care consultants.

- A comprehensive electronic system was in place for replacing emergency medicines that were used. The system operated on a 'real time' basis which mitigated the risk of medicines not being available or expired.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people, including attendance at multi-disciplinary meetings from the voluntary sector, for example Age Concern. Records showed these patients had been visited by the voluntary sector as part of their package of multi-disciplinary care.
- The practice actively promoted diabetic patient education schemes and a locally procured CCG scheme and could demonstrate a high uptake from patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

We met with the prescribing lead for the CCG on the day of the inspection. We were told the practice managed medicines well and was responsive to adhering to guidance and meeting targets. We were told the practice often exceeded set targets and had delivered significant cost savings in relation to medicines.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality and nationally. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Some, but not all staff were receiving clinical supervision.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. The practice was using innovative and proactive methods to improve patient outcomes and they linked with other local providers to share best practice. New evidence based techniques were used to support the delivery of high-quality care and high performance was recognised by credible external bodies. Two GPs at the practice were GPs with special interests (GPSI); one in cardiology and the other in respiratory medicine. Both GPSIs worked closely with secondary care. The practice was able to manage more complex patients within the practice by the use of in-house referrals. Peer to peer reviews were available for other practices in the CCG for them to access guidance from the GPSIs in place. Other staff were qualified and had the skills they needed to carry out their roles effectively and were supported to maintain and further develop their professional skills and experience.

Summary of findings

Staff worked with multidisciplinary teams and there was evidence that there was a coordinated approach to this. Staff were proactive in supporting people to live healthier lives and used every opportunity to identify where their health and wellbeing could be promoted.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had joined a federation with other practices in the CCG to work together to improve the outcomes for patients amidst the challenges facing general practice. The majority of feedback from patients was positive. Data and feedback showed patients could get urgent appointments on the day but access to a named GP and continuity of care was not always available quickly and they sometime had to wait. The practice was aware of this issue and was exploring ways to mitigate this issue. For example, a nurse practitioner had recently joined the practice and they were trying to secure additional GP resource. A small number of patients comments that they found it difficult to get through to the practice via the telephone. The practice was exploring ways of addressing this issue.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence that 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 practice philosophy and charter in place that was made available to patients. Staff were clear about their responsibilities in relation to this. The practice was in the process of redefining the leadership

Summary of findings

structure and vision due to recent management changes and a new staff structure. Staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, performance reviews and attended staff meetings and events. Only some staff received clinical supervision.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed outcomes for patients were good for conditions commonly found in older people, for example, data showed the uptake of flu vaccinations for the over 65 years was above the national average. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice adopted a holistic approach to the care of patients in this group which was encouraged by working closely with other services, for example the Council run 'Responsive Integrated Assessment Care Team' (Riact) which provided people with support to live independently in their own homes.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions.

Two GPs at the practice were GPs with special interests (GPSI); one in cardiology and the other respiratory. Both GPSIs worked closely with secondary care. The practice was able to manage more complex patients within the practice. The GPSIs encouraged peer to peer referrals between practices in the CCG. These roles helped the practice reduce referrals to secondary care. Both the GPSIs supported the CCG as clinical leads in their specialties. The practice offered dedicated respiratory and cardiac clinics for patients under the care of these GPs. The practice had run a respiratory pilot with an aim to improve the outcomes for patients in this area.

General Practice High Level Indicators (GPHLI) and QOF data showed outcomes for patients in this group were good. Patients were supported by GPs and nursing staff to manage their condition. The practice applied a holistic approach to the management of patients with long-term conditions. Reporting systems were in place to identify patients who were at high risk who may benefit from screening. Staff encouraged patient self-management when deemed appropriate and patients were seen to have self-management plans in place for COPD and asthma. The practice actively promoted national and local diabetic patient education schemes.

Summary of findings

The practice had achieved and was following the gold standards framework for end of life care. It held monthly meetings to discuss those with end stage disease. The meetings were regularly attended by external partners such as district nurses, Marie Curie and the hospice.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

All staff had received training in safeguarding children and demonstrated an acute awareness of their responsibilities to raise safeguarding concerns. They also received training in child sexual exploitation and Clare's Law. We were provided with examples where staff had raised safeguarding concerns that had been acted on. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice held quarterly safeguarding meetings with attendance from health visitors, district nurses, school nurses and midwives. We saw areas such as children looked after, high number of A&E attendances and children who did not attend appointments, for example, immunisations were discussed and action taken. Children identified at risk were coded on practice records to alert staff to this fact.

The practice had comprehensive systems in place for monitoring and managing children who did not have their immunisations booked or who did not attend their appointment and for managing the uptake of cervical smears. Immunisation rates were high for all standard childhood immunisations and cervical smears.

The practice provided a range of contraceptive, pre-conceptual, maternity and child health services with some clinical staff holding specific qualifications in these areas. The practice had a dedicated young persons' notice board in place at the practice which detailed the services available to them at the practice and the Darlington area.

GPs carried out an eight week mother and baby check and gave the appropriate vaccinations at the same time to reduce the need to attend at two separate clinics. Appointments were available outside of school hours and the premises were suitable for children and babies. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering extended opening hours and online services as well as a full range of health promotion and screening that reflected the needs for this age group. The local CCG was also piloting access to weekend appointments through the Challenge Fund.

Patients were offered cardiovascular disease (CVD) risk assessments and health checks. Patients identified at high risk or with a strong family history were invited to the practice to discuss the results. Lung health checks were also offered at these appointments and to all new patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Patients with a learning disability had care plans in place that were regularly reviewed alongside as well as having their medicines reviewed. Appointments were arranged to suit the patients' needs.

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

Systems were in place to support carers and patients and families who were bereaved.

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).

Data from QOF showed the practice performed in line with the national average in most areas; some being slightly above and some slightly below.

Summary of findings

The practice maintained a register of patients with mental ill health. Patients on this register were invited to the practice for a regular health check and alerts placed on patient's records to remind staff that certain screening was required if the patient did not attend. The practice offered dementia screening and operated the dementia screening identification scheme.

The practice had a primary mental health link worker who provided a weekly session at the practice. The practice had access to a local mental health crisis team to support and intensively treat people in crisis and to avoid admission to secondary care. The practice had the facility to refer patients to a wide range of services, for example counselling and cognitive behavioural therapy.

Summary of findings

What people who use the service say

We spoke with six patients who were using the service on the day of our inspection and reviewed thirty six completed CQC comment cards. We spoke with one member of the PPG. The majority of the feedback we received was positive. Patients described the practice as 'excellent and very good. Staff were described as excellent, helpful and respectful. The negative comments related to access to the practice via the telephone and access to a named GP of choice. The practice was aware of these issues and exploring ways to address them.

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published on 8 January 2015 showed:

What this practice does best

These are the three results for this practice that are the highest compared to the CCG average.

- 91% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: **85%**

- 88% of respondents would recommend this surgery to someone new to the area

Local (CCG) average: **82%**

- 93% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: **88%**

What this practice could improve

These are the three results for this practice that are the lowest compared to the CCG average

- 39% of respondents with a preferred GP usually get to see or speak to that GP

Local (CCG) average: **61%**

- 66% of respondents are satisfied with the surgery's opening hours

Local (CCG) average: **80%**

- 80% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: **89%**

There were 260 surveys sent out, 125 returned giving a completion rate of 48%. This equated to 1.2% of the practice patient list size.

Areas for improvement

Action the service SHOULD take to improve
Review the suitability of the phone system to improve patient and staff access.

Review patient access to a GP of choice

Outstanding practice

- The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. New evidence based techniques were used to support the delivery of high-quality care and high performance was recognised by credible external bodies. Two GPs at the practice were GPs with special interests (GPSI); one in cardiology and the other in respiratory medicine. The practice was able to manage more complex patients within the practice. The GPSIs encouraged peer to peer referrals within the CCG area; both of which we were told helped reduce referrals to secondary care consultants.
- A comprehensive electronic system was in place for replacing emergency medicines that were used. The system operated on a 'real time' basis which mitigated the risk of medicines not being available or expired.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people, including attendance at multi-disciplinary meetings from the voluntary sector, for example Age Concern. Records showed these patients had been visited by the voluntary sector as part of their package of multi-disciplinary care.
- The practice actively promoted diabetic patient education schemes and a locally procured CCG scheme and could demonstrate a high uptake from patients.

Carmel Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two CQC specialist advisors; a GP and a practice nurse.

Background to Carmel Medical Practice

Carmel Medical Practice, Nunnery Lane, Darlington, County Durham, DL3 8SQ is situated in Darlington. The registered patient list size of the practice is 10,084. The overall practice deprivation is on the sixth most deprived decile.

There is a mix of male and female staff at the practice. Staffing at the practice is made up of six GPs, two practice nurses, a nurse practitioner and two health care assistants. There is a practice manager and a range of administration/ secretarial staff.

The practice opened on a Monday to Friday from 8.00am to 6.00pm. The practice had an arrangement with the CCG to open early on a Tuesday at 7.30am and late on a Thursday until 8.00pm under an extended hours access scheme. Patients could access weekend appointments at a neighbouring practice as part of this scheme.

The practice has a general medical service (GMS) Contract under section 84 of the National Health Service Act 2006.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Darlington CCG to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 18 March 2015. During our inspection we spoke with nine members of staff. This included three GPs, practice manager, one nurse, one health care assistant and three members of the administration team. We also met with the prescribing lead from the CCG and a member of the patient participation group (PPG). We spoke to six patients who attended the service that day for treatment. We reviewed comments from thirty six CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. We had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The local CCG told us they had no concerns regarding this practice.

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings, all of which demonstrated risks and patient safety was identified and discussed. The records and discussions with staff highlighted that monitoring of safety and risk was high on the practices agenda.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice recorded the events into categories which enabled them to look at trends. All significant events including soft intelligence were submitted to North East Commissioning Support (NECS) as required. Significant events were reviewed on a regular basis at practice meetings. Records showed the practice took the opportunity to learn from external safety incidents to help improve the patient experience. We looked at the 29 records of significant events that had occurred during the last 12 months, 10 of which were directly related to the practice. The others were events related to secondary care and independent contractors. We saw these were completed in a timely and comprehensive manner. We saw evidence of action taken as a result. For example, the practice had put new arrangements in place following a failure of the vaccine fridge. 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.

Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration. We found all staff to be open and transparent and fully committed to reporting incidents.

Arrangements were in place to disseminate national patient safety alerts. Records showed staff received information that was discussed and acted on. For example, we saw staff had had a recent alert regarding wound botulism sent to them for information. Staff we spoke with were able to give other examples of recent alerts that were relevant to the care they were responsible for.

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 all staff had received relevant role specific training on safeguarding children but not all staff had completed training on safeguarding adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff.

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 training to enable them to fulfil this role. Records showed the practice held regular safeguarding meetings to discuss patients at risk. The practice demonstrated good liaison with partner agencies in relation to safeguarding; for example health visitors, district nurses and school nurses attended these meetings. We saw areas such as children looked after, high number of A&E attendances and children who did not attend appointments, for example, immunisations were discussed and action taken.

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.

The practice had a chaperone policy which was available to staff although it was not displayed within the practice. (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). Some staff had been trained to act as a chaperone and understood their responsibilities when carrying out this task. We were told that they did not always record this interaction in patients' notes.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by suitably trained staff using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of such directions and evidence that the required staff had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision from the CCG medicines management team to support them in their role. They also received updates in the specific clinical areas of expertise for which they prescribed.

The practice had systems in place for monitoring medicines in line with national guidance, for example the management of high risk medicines. Records showed the practice actively carried out audits to improve their management of medicines. We met with the prescribing lead for the CCG on the day of the inspection. We were told the practice managed medicines well and was responsive to adhering to guidance and meeting targets. We were told the practice often exceeded set targets and had delivered significant cost savings in relation to medicines.

There was a protocol for repeat prescribing which was in line with national guidance. The practice employed prescription clerks who closely monitored patients' prescriptions. For example, the prescribing clerk would refer a patient to the GP to attend for a review if they had received their allocated number of repeat prescriptions. The practice 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 audits we looked at did not identify any risk in relation to following prescribing guidance. 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 evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patient's needs.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not always handled in accordance with national guidance in a small number of instances.

Cleanliness and infection control

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.

Identified leads for infection control were in place at the practice and all staff had received IPC training. All staff received induction training about infection control specific to their role, and received regular updates. We saw evidence that audits had been carried out and any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment was available for staff to use. There was also a policy for needle stick injury and spillage kits which could be used in the event of spillages such as blood or vomit.

Staff were able to tell us how they would comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (is a term for particular bacteria which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of

infection to staff and patients. The practice had previously had a legionella test but recent changes in the water systems had not resulted in a new risk assessment being undertaken.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Arrangements were in place for testing and maintaining equipment; which included calibration and portable appliance testing. Records showed the next round of testing was planned. Examples of equipment tested included spirometer, ECG machine and defibrillator.

Staffing and recruitment

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. They told us about the arrangements for planning and monitoring the number and mix of staff to meet patients' needs. Records confirmed that maintaining adequate staffing cover was discussed at practice meetings.

The practice had a recruitment policy in place. We looked at records relating to the most recently recruited staff; clinical and non-clinical. We saw appropriate pre-employment checks such as obtaining references and a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. However, we found administration staff that had been recruited by the practice many years ago did not always have a criminal record check. We were told these staff may act as a chaperone. Arrangements to rectify this arrangement were put in place immediately on the day of the inspection. The practice had arrangements in place to assure them the clinical staffs' professional registrations were up to date with the relevant professional bodies and the required staff had medical indemnity insurance in place.

Monitoring safety and responding to risk

The practice had systems to keep them safe. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a range of policies relating to health and safety and there was information available for patients and staff to refer to.

Multiple systems were in place for managing and reducing risks to patients. We saw that any risks were discussed at practice meetings and or addressed with staff; this included records of significant events from within other practices within Darlington that were circulated by North East Commissioning Support (NECS). For example the practice used set documentation when administering childhood immunisations to reduce the risk of errors being made. This had been circulated by NECS following an incident in another practice.

The practice identified high risk patients through the use of a bespoke healthcare intelligence tool, Report Analysis Intelligence Delivering Results (RAIDR) and patient care plans. Information from this data was then reviewed at multi-disciplinary team meetings and acted on as required. The practice provided us with two case studies where their proactive intervention and working with other agencies to secure services for patients in a timely way had resulted in positive outcomes for patients. The practice accommodated those on polypharmacy with poor compliance with setting up and the on-going use of a monitored dosage system for a patients' medicine.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment appropriate for children and adults was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed it was checked regularly. Staff were aware of what action they needed to take in the event of an emergency.

Emergency medicines were available in various secure areas of the practice. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. A comprehensive electronic system was in place for replacing emergency medicines that were used. The system operated on a 'real time' basis which mitigated the risk of medicines not being available or expired. The system was also used to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place, to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and

Good

Are services safe?

mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, incapacity of staff, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, the company responsible for providing electricity to the practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and they practised regular fire drills. 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 minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs lead in specialist clinical areas such as heart disease and asthma and 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. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of conditions.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). We looked at the QOF data for this practice which was 98% compared to the national average of 94%. This showed the practice was performing above the national average.

The practice had comprehensive systems in place to manage patients who were either about to access or had accessed secondary care. The practice was proactive in monitoring referrals to and reviewing patients recently discharged from secondary care. For example, the practice worked with other partner agencies to ensure patients received the correct care and, in a timely way. We saw records to confirm patients were contacted as required and reviewed by members of the clinical staff, determined by need. Medicines were transcribed from secondary care discharge letters and reviews with the patient set based on need. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers, referred and seen within two weeks.

The practice's performance for antibiotic prescribing was comparable to similar practices. The practice showed us an audit they had completed that looked at antibiotic prescribing for certain conditions. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Discrimination was avoided when making care and treatment decisions. Interviews with all staff showed that the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. All the staff we spoke with were actively engaged in activities to monitor and improve quality and outcomes for patients. For example we talked with one member of staff whose main role was managing the patient recall process. They showed us the comprehensive systems they used to ensure patients with long term conditions were recalled to the practice for a review at the correct time. We were provided with multiple examples which demonstrated staffs commitment to working with multi-disciplinary teams to improve outcomes for patients. We were told about patients who had multiple conditions and with multi-disciplinary working their outcomes had improved. A holistic approach to the management of patients was adopted at the practice.

The practice was using innovative and proactive methods to improve patient outcomes and they linked with other local providers to share best practice. New evidence based techniques were used to support the delivery of high-quality care and high performance was recognised by credible external bodies. Two GPs at the practice were GPs with special interests (GPSI); one in cardiology and the other in respiratory medicine. Both GPSIs worked closely with secondary care. The practice was able to manage more complex patients within the practice by the use of in-house referrals. Peer to peer reviews were available for other practices in the CCG for them to access guidance

Good

Are services effective?

(for example, treatment is effective)

from the GPSIs in place. We were told these roles meant the practice was able to reduce referrals to secondary care within their own practice and the CCG. No data was available to confirm this as the practice did not always record such information.

The practice had a system in place for completing clinical audit cycles. The practice showed us a range of clinical audits that had been completed in the last 12 months. We looked specifically at three completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit. The three audits we looked at related to spirometery, anti-microbial respiratory and atrial fibrillation – anticoagulation and warfarin time in therapeutic range. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. There was evidence that following some audits that the findings had been shared with the CCG and implemented across other practices in the CCG. For example, the practice had developed a tool following a spirometery audit that had been implemented across the CCG. The practice initiated a respiratory pilot with an aim to improve the outcomes for patients in this area. The practice put in place a programme of training of self-management for patients and staff and a programme of pulmonary rehabilitation in the community. Data showed 95% of patients with COPD and 70% with asthma now had a self-management plan in place.

There was a protocol for repeat prescribing which was in line with national guidance. The practice employed prescription clerks who closely monitored patients' prescriptions. For example, the prescribing clerk would refer a patient to the GP to attend for a review if they had received their allocated number of repeat prescriptions. The practice 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 audits we looked at did not identify any risk in relation to following prescribing guidance. 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 evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice actively 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. The practice actively used local and national data to examine their performance and look for areas where they could improve.

Staff at the practice proactively acquired new skills and share best practice. The practice was a research practice. A GPSI at the practice liaised with Durham University and the Academic of Health Science network and also acted as CCG research and development lead. Both the GPSIs supported the CCG as clinical leads in their specialties.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The data showed positive outcomes for patients and in some instances performed above the national average. Examples of this from the QOF data showed that patients with diabetes, CHD and asthma were managed in such a way that provided no evidence of risk.

The team was making use of clinical audit tools, intelligence monitoring tools, some clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, either within the practice or at external groups such as nurse practitioners forum and prescribing forum they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement and all staff were actively engaged in activities to monitor and improve quality and outcome for patients, including the administration staff. For example, identified administrative staff led on the role of working with carers and attended a carers forum. The practice had joined a Federation with other practices in the CCG to work together to improve the outcomes for patients amidst the challenges facing general practice.

The GP with a special interest ran a dedicated respiratory clinic for their own patients, with similar arrangements being in place for patients to contact the GP lead for cardiac patients. The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and held regular meetings that were attended by external partners such as district nurses, Marie Curie and the hospice.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We noted a good skill mix among the clinical staff; both male and female. Two GPs at the practice were GPs with special interests (GPSI); one in cardiology and the other in respiratory medicine. GPs also had other additional qualifications such as Diploma of the Royal College of Obstetricians and Gynaecologists. Nursing staff also had a range of additional qualifications. Records showed staff were qualified and had the skills required enabling them to carry out their roles effectively and in line with best practice. The practice had systems in place for ensuring staff training was relevant and up to date.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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 practise and remain on the performers list with NHS England). All staff had an annual appraisal and the learning needs of staff were identified and training put in place to meet the learning needs. The nursing team and HCA were supported by the GPs and nurse practitioner to maintain and further develop their skills and experience. They met with these individuals regularly to discuss performance. For example, the emergency care practitioner was assigned a GP on a daily basis to support them in their work. We noted the nursing staff were not currently receiving formal documented clinical supervision. The practice was aware of this and was taking steps to formalise the discussions. Darlington CCG were also in the process of reinstating clinical supervision for nursing staff in their area. The practice closed for one hour once a week and this time was dedicated to staff development.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, 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. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances on the significant events within the last year that identified any results or discharge summaries that were not followed up appropriately.

The practice had joined a Federation with other practices in the CCG to work together to improve the outcomes for patients amidst the challenges facing general practice. The practice had signed up to a range of enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Examples include alcohol related risk reduction scheme, extended hours access, avoiding unplanned admissions, chlamydia screening and minor surgery. The practice had systems and identified leads in place to deliver and monitor its performance against the enhanced services and we saw completed data returns to the CCG to demonstrate the delivery of enhanced services.

Records showed the practice held multidisciplinary team meetings on a regular basis to discuss the needs of complex patients. These meetings were attended by external representatives from the voluntary sector (Age UK)) and the community matron. Staff felt this system worked well and told us how the patients and staff benefited from having established relationships with other partners to help improve the patient experience.

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, and the practice was making referrals mostly via e-referral as this was the preferred method in the area.

The GPSIs actively shared information across the CCG area and worked with educational establishments in a two way information sharing arrangement which benefited both patients within the practice and the CCG.

The practice had systems to provide staff with the information they needed, clinical and non-clinical. Staff used an electronic patient record, to coordinate, document and manage patients' care. Staff were trained to use the system and spoke positively about the benefits. The

Good

Are services effective?

(for example, treatment is effective)

software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also used clinical reporting systems to help co-ordinate patient care.

Consent to care and treatment

Staff had not received specific training in this area. However staff demonstrated an awareness of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All 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 practice had policies in place relating to consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. Staff provided us with 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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and IUD coil insertions. Consent was considered for all areas. For example, records showed consent had been discussed at multi-disciplinary meetings and the appropriateness of sharing patient information on care plans was reviewed. We saw action had been taken to amend the care plan template to obtain patient consent for sharing information in a multi-disciplinary setting.

Health promotion and prevention

The data we looked at showed the practice performed well in the areas relating to health prevention. The GPHLI showed the practices' performance in a range of health prevention areas was at or slightly above the national average and did not present a risk. For example, diabetes retinal screening and blood pressure monitoring, cervical smears and health checks for mental illness were above the national average

New patients registering with the practice completed a detailed health questionnaire which included a lung health check. The questionnaires and results were reviewed by clinicians and invites were sent to those at risk or with a strong family history of certain conditions. Patients were offered CVD assessments and health checks.

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, carers and mental ill health. Data from GPOS showed the practice's performance in a range of areas was mostly at or slightly above the national average in most areas. For example the cervical smear uptake was slightly higher than the national average at 85% compared to the national average of 82%. The practice was aware of those patients who had not attended for a smear and was actively monitoring this to encourage attendance. The practice had similar mechanisms in place for other screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was higher in most areas than the CCG average, and again there was a clear policy for following up non-attenders by the named practice nurse.

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 results from the national GP patient survey published on 8 January 2015, thirty six CQC comment cards and the results of the friends and family test for February 2015. The evidence from all these sources showed patients were satisfied with the way they were treated and that this was with compassion, dignity and respect. The national GP patient survey showed 89% of respondent patients described their overall experience of the surgery as fairly good or very good compared to the national average of 86%. The survey also showed 90% of patients said the GP and 92% said the last nurse they saw or spoke to was good at giving them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. The majority of comments were extremely positive about the service patients experienced. Staff were described as excellent, very helpful, polite, respectful, knowledgeable and outstanding. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The negative comments related to access to the practice via the phone line and the delay in accessing an appointment to see a named GP.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. The practice clearly advertised the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

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

Nationally reported data showed a mixed response in relation to patients' involvement in planning and making decisions about their care and treatment. 91% of respondents to the GP patient survey said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 85%. 80% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was below the CCG average of 89%.

Translation services, funded by the CCG, were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Discussions with staff and feedback from patients' demonstrated staff were highly motivated and were inspired to offer care that was kind, caring and supportive. We observed person centred interactions between staff and patients on the day of our inspection.

The practice had inclusive systems in place for supporting carers. A member of the administration staff, supported by the GPs led on this work. The administrator attended a quarterly carers meeting in the CCG area. The practice had a designated notice board in place in the reception area for carers. We were told that when patients attended the practice who were carers they were asked if they wished to be referred to the carers support service at Darlington Disability Action (DAD), if not then patients had the option to self-refer. Systems were also in place for supporting patients and their family who were bereaved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Records showed service improvements were discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example the unplanned admissions avoidance scheme.

The practice had also implemented suggestions for improvements and made changes to the way they delivered services in response to feedback from the PPG. For example, new variable height chairs had been placed in the patient waiting area.

Tackling inequity and promoting equality

Staff at the practice had not completed specific training in equality and diversity. The practice had recognised the needs of different groups of patients when planning its services and supporting patients. Discussions with staff demonstrated a clear understanding of the demographic at the practice. For example, the practice had one of the highest prevalence of older people in the area and as such offered a variety of services to meet the needs of this group of patients.

Staff could access a translation service that was funded by the CCG. The electronic signing in system could be accessed in different languages and was set up to enable patients with a visual impairment to use it. The practice was situated on the ground floor. Consulting rooms and corridors were accessible to all patients which made movement around the practice easier and helped to maintain patients' independence. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were some high back chairs available for patients which had been introduced following feedback from the PPG. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Parking was made available for patients, including disabled parking spaces. The practice had put in a place a low level call bell at the front entrance so that patients in a wheelchair could ring the bell to call for assistance if required. However, there was no indicator for patients what this bell was for and when asked, patients were not aware of it. The practice also had a low level reception desk for patients to use. However, on the day of the inspection we observed reception staff did not use this facility when engaging with patients in a wheelchair.

Access to the service

The practice opened on a Monday to Friday from 8.00am to 6.00pm. The practice had an arrangement with the CCG to open early on a Tuesday at 7.30am and late on a Thursday until 8.00pm under an extended hours access scheme. Patients could access weekend appointments at a neighbouring practice as part of this scheme. The practice closed every Tuesday between 12.30pm and 1.30pm for staff training. The GP national survey data showed 66% of respondents were satisfied with the surgery's opening hours compared to the CCG average of 80%. CQC comments cards and discussions with patients during the inspection did not identify this as an issue.

The data we reviewed and the feedback from patients showed some level of dissatisfaction in relation to accessing appointments via the telephone. Data from the national GP patient survey showed 69% of respondents found it easy to get through to the surgery by phone which was 1% above the CCG average. The practices most recent survey in 2013/2014 did not highlight this as an issue. Patients we spoke with described a queuing system on the phone which could result in the patients' call being cut off whilst queuing and then having to start the process again. Some staff also said there may occasionally be an issue with phone lines as they could not always make external calls if the phone lines into the practice were busy due to the number of lines available. Mobile phones were available if emergency calls needed to be made out of the practice. The practice was aware of this issue and was exploring the suitability of the number of phone lines the practice had access to. Patients could make their appointments in different ways, either by telephone, face to face or online, via the practice website. Consultations were provided face-to-face at the practice, by telephone or by

Good

Are services responsive to people's needs?

(for example, to feedback?)

means of a home visit by the GP which helped to ensure people had access to the right care at the right time. Patients were reminded of appointments by the use of text messaging.

Appointments were open to patients to book in advance. This had been introduced following patient feedback in an attempt to improve access. A system was in place for managing appointments; appointments being released weeks in advance, 24 hours before, on the day and additional appointments kept daily for emergency appointments. We were told all patients were seen that needed to be. This was aligned with the feedback from patients. We saw evidence to confirm appointments were blocked for use on the day of the inspection. However, 39% of respondents to the national GP survey with a preferred GP usually got to see or speak to that GP. This was significantly lower than the CCG average of 61%. The last practice survey also identified this as an issue. The practice was aware of patient feedback and described to us that staffing changes such as retirement and reduced working hours and an increased patient list size had caused some access issues. We saw evidence the practice was proactively trying to address this issue, for example a new nurse practitioner had recently been employed and the practice was engaging with the CCG. Patients had been kept informed of the difficulties regarding access and the steps the practice was taking. Of the 39 CQC comment cards we received and the six patients we spoke to, three patients raised this as an issue.

The practice coordinated their appointments to reduce the number of times a patient had to visit the practice. For example, if a patient came to see a GP and needed certain tests then these were carried out on the same day. Longer appointments were available to patients who required them and visits were made to patients' homes when required.

Information was available to patients about making appointments and what action patients should take if they required attention outside of practice opening hours or in an emergency. This was available on the practice website and in the practice leaflet. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

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

Information on how patients could make a complaint was available to patients in a number of areas; including the practice website and practice leaflet.

The practice formally reviewed complaints at dedicated complaints and significant event review meetings. The records showed the complaints had been dealt with in a timely way and the practice was open and transparent with dealing with the complaint. Complaints and lessons to be learned from them were discussed at staff meetings. Positive feedback from patients was also shared and celebrated among the staff.

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 defined philosophy. This was; We aspire to deliver excellence in medical practice and patient care, ensuring the clinical, professional and personal development of each team member, working with the people we serve through good communication and patient education, whilst managing human, financial and structural resources efficiently and effectively.

We try to preserve the values of traditional general practice whilst making the most of the opportunities afforded by developments in the Health Service.

The practice had a practice philosophy and charter in place that was made available to patients. Staff were clear about their responsibilities in relation to this. The practice was in the process of redefining the leadership structure and vision due to recent management changes and a new staff structure. We saw some records to confirm this was in progress.

We spoke with six patients, reviewed 36 completed CQC comment cards. The feedback was aligned to Carmel Medical Practice delivering its vision and strategy; although we did identify some areas that needed further development. For example, reviewing access for patients via the telephone.

Governance arrangements

The practice had a range of policies and procedures in place to govern activity and these were available to staff via any computer within the practice. We looked at a sample of these policies and procedures and the system the practice manager had in place for ensuring these were reviewed and up to date.

We saw evidence that the governance and performance management arrangements were proactively reviewed and reflected best practice. The practice held regular practice meetings where matters such as performance, quality and risks were discussed. A range of other meetings were held on a regular basis, examples of which included, safeguarding, Gold Standards Framework, Multi-disciplinary, GP and nurse meetings, administration, whole staff meetings, QOF and avoiding unplanned admissions, many of which included multi-disciplinary attendance and representatives from the voluntary sector. Staff spoke positively about the level of engagement and the governance arrangements at the practice. The practice demonstrated how they took a systematic approach to working with other organisations to improve care outcomes for patients, how they worked to tackle health inequalities and how they also considered the financial aspects for the practice and the NHS.

The practice had comprehensive quality assurance and risk management arrangements in place. Examples of these included the use of RAIDR, QOF, staff supervision, peer review (internal and external) to the practice and robust systems and processes for recalls and medicine management. The practice carried out clinical and non-clinical audits which demonstrated outcomes for patients. The practice was actively engaged with the CCG and other practices to provide support with an aim to deliver improvement for patients within other practices in Darlington.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards and was above the national average with a score of 98% compared to 94%. Staff had lead roles in managing QOF and regular meetings were held to monitor the practices performance.

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. We saw evidence that succession planning was discussed. Recent changes in staffing at the practice had been planned to mitigate impact on patients and we saw evidence that further succession planning was being discussed. Records showed changes for primary medical services were discussed with staff and discussions around how the practice would manage these challenges whilst continuing to meet the practices vision and values.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff were involved in a range of meetings as the practice was keen to involve all staff in improving the quality of care and patients experiences. For example, members of the administration team attended QOF meetings and carers meetings, PPG were represented at CCG meetings and nurses attend CCG lead meetings, such as prescribing. Staff told us there was an open culture

Are services well-led?

Good

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

within the practice and they had the opportunity and were happy and encouraged to raise issues. Staff told us there was no hierarchy at the practice and they were all treated equally.

The practice manager was responsible for human resource policies and procedures and had systems in place to ensure these were reviewed and read by staff. We reviewed a range of policies to support staff in their role, for example disciplinary procedures, induction policy, bullying and harassment and the management of sickness) which were in place to support staff. Staff could access these on any computer at the practice. A staff handbook was available to staff and staff knew where to find these.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received). More recently the practice had introduced the Friends and Family Test and shared the results of the survey with patients on the practice website and in the practice itself.

The practice had an active patient participation group (PPG). We met with a member of PPG who provided us with numerous examples of how they had been involved in delivering change at the practice. For example, the introduction of high rise chairs and a door bell at a lower height for patients in wheelchairs. We were told by the PPG representative that the practice was open to ideas and suggestions and if they could not take them forward then they would tell you why. We were told a PPG representative also attended a monthly CCG meeting to enable them to represent the views of Carmel Medical Practice from a PPG perspective.

The practice had gathered feedback from staff 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. Some staff told us how they had asked for specific training and they had been supported to do this. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 the practice supported them to maintain their clinical professional development through training and mentoring. Staff said they normally received annual appraisals and historical records confirmed this. We looked at staff files and saw that regular appraisals took place; although we noted some of these had taken place over a year ago. The practice was aware of this and told us this was being addressed and was due to the changes that had been taking place at the practice in recent months; both in terms of the structure of the building and staffing changes. Some but not all staff were receiving clinical supervision. Staff told us the practice was supportive of training. The practice closed every Tuesday for one hour for dedicated staff training time and once a month for protected learning time. We were provided with examples where staff had been supported to progress in their role and that opportunities were made available at the practice to support staff to do this. For example administration staff were supported into clinical roles. All the GPs we spoke with spoke about the drive for continuous improvement, for example the recruitment of a nurse practitioner.

The practice had comprehensive systems in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were reviewed on a regular basis with a dedicated meeting held to review them. The practice took the opportunity to learn from external safety incidents to help improve the patient experience. For example the practice recorded significant events that were related to secondary care. The significant events we looked at clearly demonstrated the practice had acted and learned from incidents.

The practice demonstrated a common focus on improving quality of care and people's experiences. The practice had embedded a wide range of systems to ensure the practice was continually learning and improving; this included staffing structures to support to the operation of the practice, for example the employment of a nurse practitioner, engagement with other professionals, engagement with patients and quality monitoring systems. The practice provided evidence to show they were planning for the future and changes to PMS.