Thornaby and Barwick Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Thornaby and Barwick Medical Group on 28 May 2015. Overall the practice is rated as good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led. In summary our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and most staff felt supported. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

- Ensure arrangements are in place for the safe disposal of obsolete oxygen cylinders.

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 was enough staff to keep people safe. All the staff we spoke with were knowledgeable and aware of their responsibilities in maintaining patient and visitor's safety.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. 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. 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 staff. Staff worked with multidisciplinary teams.

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. They said they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw 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 Area Team to secure improvements to services where these were identified. We spoke with ten patients who said they found it easy to make a same day appointment. However we received feedback from patients that they experienced difficulties making non-urgent appointment with the named GP of their choice with waits of up to three weeks.

Summary of findings

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 the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and support available to staff. The practice had a number of policies and procedures to govern activity and they 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 they acted on. The patient participation group (PPG) was a virtual group who were actively involved in the practice. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed outcomes for patients were good, for conditions commonly found in this age group. The practice offered proactive, personalised care to meet the needs of the older patients in their practice population. They had a range of enhanced services, for example, in dementia and end of life care. The practice responded to the needs of older people, offering home visits and rapid access appointments for those with enhanced needs. The practice provided weekly ward rounds into the local care homes. All care home patients were visited when they first registered with the practice.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. These patients had a named GP and a structured annual review to check their health and medication needs were being met. For those patients with the most complex needs, the named GP and practice nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had the highest number of children registered in the CCG area. 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. Immunisation rates were higher than the CCG average for all standard childhood immunisations. We were told and we saw that children and young patients were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 these patients had been identified. The practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care wherever possible. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. The practice did not offer extended opening times.

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. They had carried out annual health checks for these and when required they had received a follow-up appointment. Longer appointments were available for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice visited a local learning disability home to offer flu vaccines to all registered patients. 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. The practice had clinicians who were able to speak many different languages and access to an interpreter and sign language was available for patients.

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice has a recall system in place for mental health reviews and physical checks for those patients on the mental health register. The practice regularly reviewed the needs of dementia patients for those living in care homes as part of the weekly ward rounds.

Patients experiencing poor mental health could access support services within the practice as well as other voluntary organisations. There was a system in place to follow up patients who had attended accident and emergency (A&E), where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 41 CQC comments cards where we found positive comments about the practice and the staff. We saw comments about the excellent care patients and their families had received from members of the clinical team. They said they were involved in all aspects of their care and the GPs and nurses explained everything to them. Some of the comments were from people who had been patients since the practice opened. There were nine comment cards which expressed whilst they were very happy with their care and treatment, they were unhappy with the difficulties they experienced accessing appointments. They stated that these were non urgent appointments or with a GP of their choice.

We spoke with ten patients, from different population groups, plus two members of the Patient Participation Group. They all told us the staff were very helpful, respectful and supportive of their needs. They felt everyone communicated well with them; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were provided with a caring service.

76% of respondents to the GP patient survey described the overall experience of their GP surgery as good to excellent. Some of the recent patient survey results showed:

- 78 % of patients said they were treated with respect. Compared with the national average of 80%.
- 75% of respondents said the explanations given to them by clinicians were good to excellent. Compared with the national average of 80%.
- 30% of respondents stated that they were able to see a practitioner of their choice. Compared with the national average of 48%.
- 38% of respondents stated they were satisfied with telephone access. Compared to the national average of 54%.

The practice commissioned the questionnaire themselves between February and March 2015 following the results of the national survey. The practice sent or handed out 500 questionnaires to patients and received 456 responses. The practice population at the time of the survey was 21656.

Following the results of the survey the practice established an action plan to address areas for improvement. We saw a process of ongoing review of actions was in place to monitor progress of the actions.

Areas for improvement

Action the service SHOULD take to improve

Ensure arrangements are in place for the safe disposal of obsolete oxygen cylinders.

Thornaby and Barwick Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice manager and an expert by experience.

Background to Thornaby and Barwick Medical Group

The Thornaby and Barwick Medical Group is located in a purpose built building in Thornaby Health Centre, Trenchard Avenue, Stockton On Tees. There is also a branch surgery located at Barwick Medical Centre, Lowfields Avenue, Ingleby Barwick.

The practice provides General Medical Services (GMS) under a contract with NHS England Middlesbrough, to the practice population of 21, 737 patients. There were 11,703 patients registered at Thornaby and 10,034 patients registered at Barwick Medical Centre. Our information shows a large number of children and those under the age of 18 years; well above the local and national average.

The practice has a mix of male and female staff. There are eight GP Partners and three salaried GP's. The practice is a training practice and there are currently two GP registrars and one foundation year two (FY2) doctor. A GP registrar is a qualified doctor who is training to become a GP. Foundation doctors are medical practitioners undertaking a two year general postgraduate medical training which forms a bridge between medical school and specialist / general practice training. The GPs are supported by four practice Nurses and two health care assistants (HCAs) .There is an administration team and a practice and assistant practice manager.

The practice is open from 08.00–18.00, Monday – Friday at both surgeries. The branch surgery is open from 08.00-12.30 and from 13.30-1800 on weekdays. The practice has opted out of providing Out of Hours services to their patients. The practice uses Northern Doctors Urgent Care Ltd, for it's Out of hours cover from 18.00–08.00 each evening.

A wide range of services are available at the practice and on site these include: weight management, vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People whose circumstances may make them vulnerable

• People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked NHS North East and the Local Healthwatch 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. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 28 May 2015. During our inspection we spoke with the staff available on the day. This included three GPs, one GPR, and one FY2, two practice nurses, one HCA the practice and assistant manager, and five administration staff. We also spoke with ten patients who used the service and two member of the patient participation group.

We reviewed 41 CQC comments cards which had been completed where patients shared their views and experiences of the service. We observed the interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

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 where these were discussed. Staff also told us that they received notification and emails to ensure they are kept informed. The practice managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events and complaints were regularly reviewed at the weekly and the governance meeting. There was evidence the practice had learned from these events and the findings were shared with relevant staff were appropriate. 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.

Staff were able to describe and show the process for raising concerns and reporting incidents. We looked at these incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of unnecessary blood tests undertaken when patient's medicines had been changed. The process was reviewed to ensure all staff including district nursing teams were alerted of relevant changes in a patient's management and treatment. 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.

National patient safety alerts were disseminated by a variety of methods to practice staff, these included meetings, on-line tasks, emails, or by face to face contact.

Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any which were relevant to their practice and where they needed to take action.

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. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information and properly record documentation of safeguarding concerns. They told us how they would contact the relevant agencies in working hours and out of normal hours. These contact details were easily accessible.

The practice had appointed a dedicated GP as lead 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. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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.

There was a chaperone policy, which was visible on the waiting room and in consulting rooms. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. We were told that chaperoning was also carried out by trained reception staff when a member of the nurse team were not available.

Medicines management

Good

Are services safe?

We checked medicines stored in the practice and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy

for ensuring that medicines were kept at the required temperatures, 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.

The nurses and the GPs administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these and evidence that nurses had received appropriate training to administer vaccines. The HCA told us they were currently undergoing training to undertake flu vaccines in the future using patient specific directions.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Records showed room temperature and fridge temperature checks were carried out.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times

A system was in place for managing national alerts about medicines. Records showed the alerts were distributed to staff, who implemented the required actions as necessary to protect people from harm.

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. The nursing staff had a policy in place to ensure the treatment rooms and clinical areas were cleaned daily. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed the findings of audits were discussed.

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 including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. Staff described how to safely handle specimens handed into reception. There was a policy which detailed how to deal with needle stick injury and staff knew the procedure to follow in the event of an injury.

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 (this is a term for particular bacteria which can contaminate water systems in buildings). We saw records which confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. The practice had a process for checking equipment daily. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales were regularly tested.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

Good

Are services safe?

references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy which set out the standards followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Administration staff told us they covered all aspects of their roles to ensure patients had access to information when the practice was open. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We saw that staff were rotated into different roles particularly when the practice was covering absences.

The majority of 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. However some staff told us that they had felt they were continually busy and short of staff. The staff told us this had been recognised and that new staff were now been appointed to address this.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at the weekly meetings and staff were notified of issues or concerns outside of meetings by email. Staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. We saw that the plan was condensed and easy to read and covered all required information.

The practice had carried out a fire risk assessment. This included actions required to maintain fire safety. As the main practice was situated on the first and second floor we saw that evacuation chairs were also in place to use in an emergency. Records showed staff were up to date with fire training and they practised regular fire drills.

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 NICE and from local commissioners. We saw evidence that 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 each patient received support to achieve the best health outcomes 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.

We saw evidence that GPs and nurses had processes in place to continually update their knowledge and skills. Examples of these were attending the Clinical Commissioning Group (CCG) education sessions and attending external courses. The GPs told us they led in specialist clinical areas such as diabetes, 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 very open about asking for and providing colleagues with advice and support.

A nominated GP attended the CCG meetings on behalf of the practice. The practice undertook an internal peer review of referrals and also bench marked this with the neighbouring practices. We saw that care plans had been developed for patients with complex needs. These were reviewed when required. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used a referral system to refer patients into secondary care and systems were in place to continually monitor their referrals. Processes were in place for patients with suspected cancers who were referred to secondary care were seen within two weeks.

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 across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and assistant practice manager to support the practice to carry out clinical audits.

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 practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of oral antibiotics over the last two years. Following the audit, the GPs reviewed their prescribing trends and over the past two quarters of the year the prescribing of antibiotics was reduced.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 91% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The clinical staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. They spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also ensured all routine health checks were

Good

Are services effective?

(for example, treatment is effective)

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 evidence we saw confirmed the GPs, with the support from the pharmacist, had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training records and saw staff had attended mandatory courses such as basic life support, fire safety and safeguarding children and adults. We saw that training and development was identified for staff during their annual appraisals.

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.

Our interviews with staff confirmed that the practice was proactive in providing training and development for relevant courses. The nurses had completed training in areas specific to their role, for example diabetes and cervical smears. The staff we spoke with confirmed they had access to a range of training that would help them function in their role. We saw that one member of staff had been supported from an administration role through to the role of practice nurse and another to the role of health care assistant.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. 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 patient's needs and manage those of patients with complex needs. It received blood tests, X ray results, letters from out-of-hours GP and 111services and local hospitals, (including discharge summaries) 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 who requested the test or investigation was responsible for reviewing their own results. The GP 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 out of hour's 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 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 members of the multidisciplinary team (MDT), for example community matrons. 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

Good

Are services effective?

(for example, treatment is effective)

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 to hospital and other services. Staff reported that this system was easy to use.

The practice had signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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 their medical history, medication and allergies.

Consent to care and treatment

We found that staff were aware 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

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 under16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's consent was obtained and then documented in the electronic patient record. The consent was used to record the relevant risks, benefits and complications of the procedure 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. 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.

Data 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 just below the national average at 80.28 % compared to the national average of 81%. 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.

The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 96.75% this was above the national average of 95.29%. 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.

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 local patient survey from 2014 to 2015. The survey was commissioned by the service following the results of the national patient survey. The practice commissioned a more in depth survey. The evidence from the survey showed 76% of patients rated the practice as good to excellent. They were also satisfied with how they were treated with compassion, dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 41completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting 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 said 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. The feedback we received was aligned with these views. Patients spoke of the high regard they had for the staff at the practice.

Staff told us they were able to access translation services for patients who did not have English as a first language. A number of staff in the practice spoke different languages which enabled them to provide some translation within the practice.

The practice had developed care plans for older people and those identified at risk; such as those with long term conditions. We were told that changes in these patients were continually reviewed and that community support teams were involved as required. The clinicians were able to discuss any concerns with other clinicians outside of the clinical meetings each day.

We saw that families, children and young people were treated in an age-appropriate way and recognised as individuals. However we saw that there were no toys or activities available to distract children waiting for appointments.

Patient/carer support to cope emotionally with care and treatment

The survey information and the comments we received showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with and the comment cards we received were also consistent with this information. For example, patients told us that all staff were professional and responded with kindness and compassion when they needed help and provided support when required.

Notices and information in the patient waiting room highlighted to patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer and support information was available for patients.

Staff told us if families had suffered bereavement, their GP contacted them. The practice sent families a personalised card designed by the practice offering their condolence and support.

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 and weekly ward rounds into the local care homes.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and the PPG. For example, we saw that following the satisfaction survey the practice produced posters which were displayed in patient areas to advertise on line services such as booking appointments and ordering repeat prescriptions. The practice had ordered additional telephone lines for both surgeries and was upgrading the telephone systems to enable them to handle the additional lines as well as providing text messaging as a way of communicating with patients. Our discussions with the PPG and the practice manager demonstrated the practice valued the responses from patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They recognised those with a learning disability, students, carers and the older population. The practice had access to translation services and all staff were aware of how to access this.

The practice provided equality and diversity training to staff. The staff we spoke with were very aware of the importance of equality and diversity. We saw staff had meetings or received information updates.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was situated on the first floor of the building. There was lift access to the first floor. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The branch surgery was also fully accessible to patients with disabilities. We noted that in the corridors of the main surgery there were rows of seats outside of the treatment rooms. These were not secured and there was a potential risk to patients using these.

Access to the service

The practice was open from 08:00 –18:00 on weekdays at the main surgery. The branch surgery was open from 08:00-12:30 and from 13:30 to 18:00 on weekdays and was closed between12.30 and 13.30. The practice did not provide extended opening hours. Patient's accessed appointments at the main surgery or branch surgery were they had registered. The exception to this being booked appointments with the nurse or HCA. Patients we spoke with and the PPG told us they would find it useful to be able to book non-urgent appointments with the GP of their choice at either practice site.

Comprehensive information was available to patients about appointments on the practice website and in the guide to services leaflet. This included how to arrange urgent appointments and home visits and how to book appointments via the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

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.

We saw information was available to help patients understand the complaints system; this was in the practice leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months. We found these were satisfactorily handled and were dealt

Good

Are services responsive to people's needs?

(for example, to feedback?)

with in a timely way. We found evidence of actions taken to prevent recurrence and improve service delivery. 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 clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's development plan from 2015 to 2018. The plan reviewed progress and achievement in 2014/15 and outlined the strategic development plans for the next three years. The practice mission statement, vision and values included being patient centred and providing high standards of care.

We spoke with fourteen members of staff and they all knew and understood the purpose of the practice, and knew what their responsibilities were.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at 14 of these policies and procedures. All 14 policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP and nurse for infection control, and another GP was the lead for safeguarding. All staff were clear about their own roles and responsibilities. We saw that staff were rotated across departments to expand their knowledge and experience. We saw evidence of staff development. The majority of staff told us they felt supported and all staff knew who to go to in the practice with any concerns.

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. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits and systems to identify where action should be taken. For example, we looked at two audits in detail and saw that repeat audit cycles had been completed and actions identified. We saw that following audit, the information was shared with clinicians and actions were developed which resulted in improvements in patient care and prescribing.

The practice held regular practice meetings and department meeting including governance meetings. We looked at the minutes from the meetings over the last year and found that quality, performance, audit, QOF and risks had been discussed.

Leadership, openness and transparency

We saw from minutes of practice meetings that a range of meetings were held regularly. Examples of these were GPs, nurses and gold standards meeting. This showed the practice continually reviewed their performance and ways of improving efficiency. The staff had access to the minutes of the meetings and in-between these times received email notifications of important information and practice changes. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. There were nominated department leads that were the first line of contact for staff to raise any issues and concerns with.

The practice manager and assistant manager were both responsible for human resource policies and procedures. We reviewed a number of policies. For example recruitment procedures, and induction policy. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. The practice had also introduced the Friends and Family Test.

The practice had an active virtual PPG. We met with two members of PPG who provided us with examples of how they had been involved in delivering change at the practice. For example, reviewing and commenting on practice developments and patient surveys. The PPG members we spoke with recognised the needs of the two different patient communities of Thornaby and Barwick. The group commented that they were unaware of how many virtual PPG members there and would welcome the opportunity to provide members who wished the opportunity to meet and discuss practice developments from time to time. The members we spoke with explained that for some this would not be possible.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they

Are services well-led?

Good

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

would discuss any concerns or issues with colleagues and their line managers. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. We saw that some staff had been supported to develop their roles. Examples of these were administration staff being supported to undertake nurse and health care assistant training. However some staff told us they would like further development and training to develop their administration roles.

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 and professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. Staff told us the practice was supportive of training and we saw evidence to confirm this.

The practice was a training practice with one qualified GP trainer and another partner currently undergoing trainer, training to support the GP registrars.There were currently one GP registrars and one foundation programme year doctor (FY2) working at the practice.

The practice had completed reviews of significant events. We saw evidence that these were discussed at governance meetings to ensure the practice learned from and improved outcomes for patients. We saw evidence of change being introduced following incidents.