Drs Charlton, Russell, Stevens & Stone

Quality Report

Orchard Court Surgery
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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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Orchard Court Surgery (Drs Charlton, Russell, Stevens & Stone) on 2 March 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for safe, caring, responsive and for being well led. It was also outstanding for providing services for all the population groups. It was good for providing effective services.

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

- There were comprehensive systems in place to keep people safe, which took account of current best practice. The whole team was engaged in reviewing and improving safety. There was an open culture in which all safety concerns raised by staff and patients who used services were highly valued as integral to learning and improvement.
- The practice was proactive to anticipating and managing risks.
- The team was making use of clinical audit tools, intelligence monitoring tools, appraisals, clinical supervision and staff meetings to assess the performance of the practice and its staff.
- Staff recognised and respected the totality of patients' needs. They always took account of patients' personal, cultural, social and religious needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- Patients could access appointments and services in a way and at a time to suit them.
- The involvement of other organisations and the local community was integral to how services for patients were planned.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- There was a high level of staff satisfaction. Staff were proud of the practice they worked for and spoke highly of the culture.

The practice demonstrated, across all the population groups, elements of outstanding practice. This related to all the domains, primarily in those of safe, caring, responsive and well led. Some examples are detailed below:

- The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- The practice actively promoted diabetic patient education schemes and a locally procured CCG scheme and could demonstrate a high uptake from patients when compared to other practices in the CCG.
- 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
- The practice had comprehensive systems in place for managing medicines and audits showed this had had a resulting positive outcome for patients.
- We were provided with multiple examples which demonstrated the practice's commitment to work collaboratively with other partners to improve outcomes for people. Examples included the falls prevention team, Darlington Healthy Hub, and the Darlington rehabilitation stroke unit.
- Staff applied a holistic approach to managing patients. We were provided with multiple examples where staff had supported patients with other aspects of their lives, such as their social life to enhance their health and wellbeing. Staff had sourced activities for patients in their own time and shared this with patients. Patient feedback was aligned to this.
- The practice actively used local and national data to examine their performance and look for areas where they could improve. For example, the practice had carried out a review following a published national asthma deaths report in 2014 and had taken a number of actions in its local context in response to the themes from the national report.

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?

Outstanding ☆

The practice is rated as outstanding for providing safe services. This practice was safer than other similar practices and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. The whole team was engaged in reviewing and improving safety and safeguarding systems. There were enough staff to keep patients safe.

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. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff were qualified and had the skills they needed to carry out their roles effectively. They were supported to maintain and further develop their professional skills and experience. Staff worked with multidisciplinary teams and there was evidence 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 improved.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's lives were enhanced through the caring and supportive actions of staff. Patients' choices and preferences were valued and acted on.

Summary of findings

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding 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. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Staff recognised and respected the totality of patients' needs. They always took account of patients' personal, cultural, social and religious 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 was evident.

Are services well-led?

Outstanding

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

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. There were aspects of the practice which were outstanding.

Nationally reported data showed that 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 patients 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 patients, 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. This was encouraged by working closely with other services, for example the Council run 'Responsive Integrated Assessment Care Team' (Riact) which worked to provides 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. There were aspects of the practice which were outstanding.

The 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. Appointments were coordinated to help ensure the patient had a seamless pathway between the staff members on the same day, reducing the need for patients to attend on multiple occasions. The practice applied a holistic approach to the management of patients with long-term conditions. Staff encouraged patient self-management when deemed appropriate and patients were seen to have these plans in place for COPD and asthma when patients' symptoms were exacerbated. Staff supported patients to review inhaler techniques. The practice actively promoted diabetic patient education schemes and a locally procured CCG scheme and could demonstrate a high uptake from patients when compared to other practices in the CCG. The practice followed 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 community matron, district nurse, McMillan nurse and the hospice.

Summary of findings

Families, children and young people

Outstanding 

The practice is rated as outstanding for the care of families, children and young people. There were aspects of the practice which were outstanding.

The whole team was engaged in safeguarding systems. All staff had received training in safeguarding children and demonstrated an understanding and 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 safeguarding meetings every three months with a high level of attendance from staff within the practice, for example up to five GPs and two nurses. There was evidence of joint working with health visitors, district nurses, school nurses and midwives attending the safeguarding meetings. We saw areas such as 'looked after children', high number of A&E attendances and children who did not attend appointments were discussed and actions taken.

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. Immunisation rates were relatively high for all standard childhood immunisations. Systems were also in place for managing the uptake of cervical smears and GPHLI data showed the practice uptake of cervical smears was higher than the national average.

The practice provided a range of contraceptive, pre-conceptual, maternity and child health services with some clinical staff holding specific qualifications in these areas. Systems were in place to check patients with IUS and implants and recall them to the practice. The practice had a designated area on their website for young people which detailed the services available to them at the practice and the Darlington area.

The practice offered combined appointments for mother and baby six week postnatal check with the eight week immunisation to reduce the number of appointments needed at the practice. They also allocated slots so mothers could visit the practice as close to collecting other children from school to again reduce their trips. The practice had systems in place for carrying out incomplete baby registration searches to ensure that babies who were registered at birth elsewhere were followed up for registration at the practice.

Summary of findings

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. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students). There were aspects of the practice which were outstanding.

The needs of patients in this population group had been identified. They 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 practice worked in partnership with the Pathways to Work (PAS) scheme. Patients benefited from an employment support advisor from the Job Centre being available at the practice one day a week. They provided advice on a full range of work related issues. PAS worked directly with Occupational Health Teams. They also accessed weight management advice, smoking cessation support and healthy lifestyle advice through Community Health Trainers. Close links were in place with the counselling services within the practice to build on support they offered. The practice offered NHS Health Checks to all its patients aged 40 to 75 years and patients were passed to the relevant member of staff if any concerns were identified. For example, ECGs and blood tests were carried out immediately at the practice. Practice data showed that 81% of patients in this age group had been checked opportunistically. We were told if any issues were identified at these checks that processes were in place to pass them onto a GP.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. There were aspects of the practice which were outstanding.

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 when they had their medicines reviewed. Appointments were arranged to suit the patients' needs. The staff were aware of their vulnerable patients. We were told of examples whereby patients in vulnerable circumstances had been identified and how

staff had intervened to provide help, chased appointments to secondary care and worked in close partnership with other health and social care professionals. This had led to an improved patient experience and outcome.

Data showed outcomes for patients who were deemed vulnerable were good. For example the percentage of patients in the influenza clinical at risk group that received the seasonal vaccination was above the national average

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. They 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.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). There were aspects of the practice which were outstanding.

Data from QOF showed the practice performed above the national average in a number of related areas. For example; the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 98% compared to the national average of 86%. GPHLI showed 98% of patients experiencing poor mental health had received a physical health check and 98% of patients had received an assessment for depression. The systems in place for recalls and medication reviews of patients in this group helped facilitate physical health checks for patients.

The practice had a primary mental health link worker and a counsellor who worked out of the practice at certain times. The practice worked in collaboration with the North East Council of Addiction (NECA). They offered facilities for staff from the NECA service to see patients with addictions at the practice if it was felt this would encourage engagement.

A specific health visitor external to the practice supported travellers in the area. We were provided with an example that demonstrated how staff had respected a patient's situation. They had been creative in overcoming barriers to help a patient receive care.

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 fifty completed CQC comment cards. We looked at the results of the 2013/2014 patient survey and the Friends and Family Test. We spoke with one member of the PPG. The feedback and results were all positive. Staff were described as excellent, efficient, friendly, helpful, kind and responsive. They said making and getting an appointment was easy and the practice was timely with any treatment.

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published on 8 January 2015 showed the practice scored 100% in 5 out of the 23 questions and above 95% in 13 out of the 23 questions. All but two were above 90%.

Patients said:

100% found it easy to get through to this surgery by phone

100% found the receptionists at this surgery helpful

100% said the last nurse they saw or spoke to was good at giving them enough time

100% said the last nurse they saw or spoke to was good at treating them with care and concern

100% had confidence and trust in the last nurse they saw or spoke to

100% described their overall experience of this surgery as good

The two areas in the 80% range were:

82% felt they didn't normally have to wait too long to be seen

80% with a preferred GP usually get to see or speak to that GP

There were 258 surveys sent out, 104 returned giving a completion rate of 40%. This equates to 1.3% of the registered patient list size.

Outstanding practice

Drs Charlton, Russell, Stevens & Stone

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 manager.

Background to Drs Charlton, Russell, Stevens & Stone

Orchard Court Surgery Orchard Court Surgery, Orchard Road, Darlington, County Durham, DL3 6HZ is situated in Darlington. The registered patient list size of the practice is 7, 716. The overall practice deprivation is on the fourth most deprived decile. The practice profile is 4.6% aged 0 to 4 years, 11.3% aged 5 to 14 years, 14.7% aged under 18 years, 21.3% aged 65+ years, 10.4% aged 75+ years and 3% aged 85+ years. Deprivation for children and adults is lower than the national average.

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

The practice had an arrangement with the CCG to open early four mornings a week under an extended hours access scheme. The practice opened on a Monday from 8.00am to 6.00pm and 7.30am to 6.00pm Tuesday to Friday. The practice closed every Tuesday between 12pm and 1pm for staff training. Arrangements were in place to cover the phone lines during this time.

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.

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

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- 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 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 2 March 2015. During our inspection we spoke formally with eight members of staff and informally with other members of staff. This included three GP partners, two nurses, health care assistant, practice manager and a member of the patient participation group (PPG). We also spoke to six patients who attended the service that day for treatment. We reviewed comments from fifty CQC comments cards which had been completed.

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

Outstanding ☆

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. For example, a member of staff told us how they had reported a significant event and how they had no concerns about doing this. The member of staff told us they were supported, the incident reviewed and changes to protocol put in place to mitigate a further similar incident. We reviewed safety records, incident reports and minutes of meetings, all of which demonstrated that risk and patient safety were 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, for example, medication, clinical assessment and consent, communication and confidentiality. All significant events including soft intelligence were submitted to North East Commissioning Support (NECS) as required. We looked at the 26 records of significant events that had occurred during the last 12 months. Significant events were reviewed on a regular basis with a dedicated meeting held to review them. Records showed the practice took the opportunity to learn from external safety incidents to help improve the patient experience. We saw that the majority of recorded significant events were related to secondary care. The practice had proactively sought feedback and had invited a representative from NECS to their next significant event meeting. This was to discuss how they could improve the feedback the practice received following events relating to secondary care. The practice had a small number of practice related specific significant events and records showed the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration and they felt encouraged to do so. We found all staff to be open and transparent and committed to reporting all types of incidents.

A system was in place for recording and reporting significant events. We looked at all the recorded events and saw records were completed in a timely and comprehensive manner. We saw evidence of action taken as a result. For example, enhanced checking systems were put in place when administering vaccines following a significant event. 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 number of people, dependent on the type of alert. This could be by the practice manager, GPs and the CCG. Minutes of staff meetings showed alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Staff we spoke with were able to give 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. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were aware of their responsibilities and knew how to share information. They recorded safeguarding concerns and knew how to contact the relevant agencies, in working hours and out of normal hours. Contact details were easily accessible.

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. The whole team was engaged in reviewing and improving safety and safeguarding systems. Records showed the practice held safeguarding meetings every three months with a high level of attendance from staff within the practice, for example up to five GPs and two nurses at each meeting.

Are services safe?

The practice demonstrated good liaison with partner agencies in relation to safeguarding and as such health visitors, district nurses, school nurses and midwives also attended these meetings. We saw areas such as 'looked after children', high number of A&E attendances and children who did not attend appointments were discussed and actions 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.

There was a chaperone policy which was visible in 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. If nursing staff were not available, then only if administration staff had been trained and had a criminal records check from the Disclosure and Barring Service (DBS) would they act as a chaperone. When they carried out this role they completed a record to show how the situation was managed and any areas of concern. We were told and we saw that staff did not always record when a chaperone was used in the patients' record.

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 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.

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.

One GP at the practice was the prescribing lead for the CCG. The practice had comprehensive systems in place for monitoring medicines in line with national guidance, for example the management of high risk medicines. Records showed the GP proactively sought and promoted improvement in medicines management for Orchard Court. Staff followed sets of protocols that had been introduced for the monitoring of certain medicines; data of which showed the change had been embedded by all staff and had resulted in improvements in the management of medicines at the practice. The protocol system alerted the reception staff or prescriber that a medicine review was required. The patient would then be booked an appointment and only when the medication review had been undertaken could the medicine be re-authorised.

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

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.

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.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. 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. Minutes of practice meetings showed the findings of the audits were discussed.

Are services safe?

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. There was also a policy for 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 (is a term for particular bacterium 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.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

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 clinical and administrative staff. We found appropriate pre-employment checks such as obtaining references and a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. The practice had arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies and that the required staff had medical indemnity insurance in place.

Monitoring safety and responding to risk

The practice had comprehensive systems, processes and policies in place to manage and monitor risks to patients, staff and visitors 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. There was an identified member of staff who managed health and safety and we saw evidence to show they proactively managed this.

Multiple, effective systems were in place for managing and reducing risks to patients. For example, the way GPs managed blood that was taken by them and the management of abnormal test results. There was a proactive approach to anticipating and managing risks to patients, and all staff recognised and embedded this in their work. Identified risks were assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at practice meetings and or addressed with staff; this included records of significant events from other practices within Darlington that NECS circulated to practices.

The practice identified high risk patients through the use of a bespoke healthcare intelligence tool, 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 several detailed examples where their proactive intervention and perseverance working with other agencies to secure services for patients in a timely way had resulted in positive outcomes for patients and also significant cost savings for the CCG. Other examples of systems for managing and reducing risks to patients included medicines management and checking the work of other GPs. The practice had in place a system for checking on a daily basis to see whether any medication reviews were due which stimulated calls and recalls of patients to the practice for blood and medicine reviews. The GPs also checked another GPs letters on a weekly basis as a method of quality assuring the work of their colleagues. The practice accommodated those on polypharmacy with poor compliance with setting up and

the on-going use of the weekly dosage system. The GPs had in place a 'buddy system' so that if and when one of the pair was away from the practice the other GP took responsibility for their letters, results and queries, actioned them and made sure in real time that that was effective. They had arrangements in place to hand over key issues at the first opportunity.

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 at the required time. 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 provided us with an example where they had responded appropriately to an emergency at the practice which had resulted in a positive outcome for the patient. Whilst the incident had been dealt with in an appropriate way, the management reviewed the incident and increased the frequency of emergency first aid training for non-clinical staff.

Emergency medicines were available in various secure areas of the practice. These included those for the treatment of cardiac arrest, 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, which staff were aware of, 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, 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, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment. It included actions required to maintain fire safety. Records showed 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 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 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 each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines. These were reviewed when appropriate.

Clinical staff led and were trained in specialist areas such as diabetes, heart disease and asthma. The staff we spoke with were open about asking for and providing colleagues with advice and support. They told us they met regularly which enabled them to review and discuss new best practice guidelines. Minutes of staff meetings confirmed this.

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 showed at 99.7% that 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 (hospital). 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 where possible, 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. They were referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with all staff showed the culture in the practice was that patients were cared for and treated based on need. They 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. We were provided with multiple examples which demonstrated their commitment to work collaboratively with other partners to improve outcomes for people. Examples included the falls team, Darlington Healthy Hub, and the rehabilitation stroke unit. We heard how patients who had attended the practice for health issues had been asked about other aspects of their life, such as their social life. Where issues had been identified, staff had, with the agreement of the patient worked with other partners or carried out their own research to either involve other partners in the patients care or direct patients to other services. We were told by some patients that staff went over and above their roles to help them.

The practice had a system in place for completing clinical audit cycles. The practice showed us a range of clinical audits completed in the last 12 months. We looked specifically at two completed audit cycles where the practice was able to demonstrate the changes since the initial audit. The two audits we looked at related to the follow up of non-diabetic patients with previously high blood glucose or HbA1c readings and the second related to the monitoring of patients receiving certain commonly prescribed medicines. Other examples included an audit of hypertension and its management in type 2 diabetics and the other, an audit of investigation of haematuria. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the audit relating to the monitoring of patients receiving certain commonly prescribed medicines had resulted in the GP who was also the prescribing lead for the CCG in developing protocols for practice staff to use to improve medicines management. The initial results of the audit had identified areas of high compliance for monitoring for some medicines but not so for others. Following a repeat of the audit the practice had shown significant improvements,

particularly for those that had been previously identified as needing closer monitoring. The audit showed the protocols had been shared and adopted throughout the CCG to improve the management of some commonly prescribed medicines. The audit also showed the practice had improved more than other practices in the CCG following the audit.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. Where they continued to prescribe it they outlined their clinical decision in the patients' notes. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice 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. For example, the practice had carried out a review following a published national asthma deaths report in 2014 and had taken a number of actions in its local context in response to the themes from the national report. This included; checking that asthma patients had recovery medications and plan at home; children with asthma were followed up within 48 hours of A&E attendance or admission - phoned or appointment given.; inhaler use was monitored and shift to steroid based inhaler and a noted caution over putting salbutamol on repeat; safeguarding concerns raised if and where poor child asthma care or DNA at clinic appointments. This was supported by a structured care programme through nurse led clinics and recall systems. The practice had had no asthma deaths amongst its own patients

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, appraisals, clinical supervision by the CCG and by the practice, and staff meetings to assess the performance of the practice and its staff. The staff we spoke with discussed how, either within the practice or at external meetings 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 management of systems for bereaved patients and families and the systems for working with carers.

The practice followed 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 community matron, district nurse, Macmillan nurse and staff from the local hospice.

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. GPs had additional diplomas in a range of areas; examples of which were Royal College of Obstetricians and Gynaecologists (DRCOG) Nursing staff also had a range of additional qualifications. Records showed staff were qualified and had the skills required to enable 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 had 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 their learning needs. The nursing team

Good

Are services effective?

(for example, treatment is effective)

and HCA had recently met with the CCG to reinstate the programme of clinical supervision. Staff told us they were supported to maintain and further develop their skills and experience. The practice closed for one hour once a week and this time was dedicated to staff development. Practice cover arrangements were in place during this time. We were told of a recent session where a visitor had come to talk about dementia care.

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. 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 where any results or discharge summaries were not followed up appropriately.

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 MIND) and the community matron. Staff felt this system worked well and remarked on the usefulness of established relationships with other partners which helped 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. For example, we were told that once a patient was recognised as being on the end of life pathway this was shared with the GP out-of hours provider. 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 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 software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also used an intelligence monitoring tool to help co-ordinate patient care. For example, the practice used the data from this tool to identify high risk patients.

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. 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. 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 an 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.

Health promotion and prevention

The data we looked at showed the practice performed well in the areas relating to health prevention. GPHLI showed the practices' performance in a range of health prevention areas was above the national average and did not present a risk. For example Flu Vaccination (at risk) rates, Diabetes Retinal and blood pressure monitoring, Flu Vaccination (Over 65s), cervical smears and health checks for mental illness.

Good

Are services effective?

(for example, treatment is effective)

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice data showed that 81% of patients in this age group took up the offer of the health check. The practice carried out the checks opportunistically. We were told if any issues were identified at these checks that processes were in place to pass them onto a GP.

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 mental ill health. Records showed the percentage of patients with mental ill health that had received a health check was higher than the national average. The practice provided us with examples where they had supported patients to stop smoking. Data showed the practice had recorded the smoking status in 96.3% of patients and of those patients that required it, 96.7% had a record of whether they had been offered smoking cessation advice. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Current data for the practice's performance for cervical smear uptake was 94.1% of the identified group. The practice was aware of the nine patients who had not had a smear in the last five years and was actively trying to encourage them to attend. For example they used the repeat prescription to put a note on to say to attend for a smear. The practice had a named nurse responsible for following up and managing patients who did not attend screening. The practice had similar mechanisms in place for other 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 in line with the CCG average. There was a clear policy for following up non-attenders by the named practice nurse.

Outstanding ☆

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 2013/2014 practice survey, national GP patient survey published on 8 January 2015, fifty CQC comment cards and the results of the friends and family test for January and February 2015. The evidence from all these sources showed an overwhelming satisfaction with the way patients were treated and that this was with compassion, dignity and respect. The national GP patient survey showed 100% of respondent patients described their overall experience of the surgery as good. The GP survey showed 97% of patients said the GP and 100% said the last nurse they saw or spoke to was good at giving them enough time. 97% said the GP and 100% said the last nurse they saw or spoke to was good at treating them with care and concern. 100% of patients said the reception staff were helpful.

Patients completed CQC comment cards to tell us what they thought about the practice. All the comments were positive about the service patients experienced. Staff were described as excellent, efficient, friendly, helpful, kind and responsive. The CQC comment cards and feedback from patients showed patients were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us 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 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 confidential information was kept private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected that 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 advertised the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Nationally reported data showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 93% of practice respondents said the GP and 97% said the nurse involved them in care decisions. 97% felt the GP and nurse was good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us 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 CQC 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.

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. A large proportion of the patients told us that staff went the extra mile to help support them. We observed person centred interactions between staff and patients on the day of our inspection. We were stopped by patients in the practice who wanted to share their positive experiences with us. The practice had recognised the needs of its patients when offering support. For example, diabetic Muslim patients were supported during Ramadan.

The practice had comprehensive systems in place for supporting patients and their family who were bereaved which was managed by a member of the administration team. When a patient died a named GP was identified, who made initial contact with the family via the telephone and a condolence card sent. The practice also contacted all clinics the patient had been attending. An appointment

Outstanding ☆

Are services caring?

was then diarised for the practice to call the family three months later to offer any help or support. If deemed appropriate, patients were referred to services for support, for example St Theresa's Hospice.

Data from the national GP survey showed 97% said the last GP and 100% said the last nurse they saw or spoke to was good at treating them with care and concern. 99% also said the GP and nurse was good at listening to them which was above the national average.

We were provided with at least five specific examples that demonstrated staff were aware of patients emotional and social needs and recognised they were as important as patients physical needs. Staff told us they always asked about patients social lives and how they were feeling. A member of staff told us how they had looked for specific recreational activities for patients in their own time. They had then shared this with the patient with an aim to enhance their social life. This was aligned with feedback on CQC comment cards. We heard how staff had worked with a family, a patient and other professionals to improve the outcome for a patient who was isolated at home. They worked with the health visitor team and consultants and made arrangements for the patient to visit the practice when it was quiet. The examples clearly demonstrated staff had taken into account patients cultural, social and religious needs.

Outstanding ☆

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 it delivered services in response to feedback from the PPG. For example, introducing text messaging to remind patients about booked appointments.

Tackling inequity and promoting equality

Staff at the practice completed training in equality and diversity. Discussions with staff demonstrated a clear understanding of the demographic at the practice. The practice had recognised the needs of different groups of patients when planning its services and supporting patients. For example, staff described how they had a large Muslim population. They told us how diabetic Muslims were supported during Ramadan and how the practice avoided offering patients appointments on a Friday afternoon as they may be attending prayer.

The practice worked in partnership with the Pathways to Work (PAS) scheme. Patients benefited from an employment support advisor from the Job Centre being available at the practice one day a week to provide advice on a full range of work related issues. This was part of an initiative in practices in the Darlington area. The practice booked patients into this service. Data provided to us on the day of the inspection showed that this service had had a positive impact on patients. For example, 30 patients had started full time work, 19 patients had started voluntary work and 31 participated in training and the cost benefit this had had for the practice.

Staff could access a translation service that was funded by the CCG. Staff told us that leaflets in different languages would be made available although we did not see any available in the patient waiting area. The practice was situated on the ground floor. Consulting rooms and corridors were accessible to all patients which made movement around the practice easy 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. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Parking was available for patients and one disabled parking space was available.

Access to the service

The practice had an arrangement with the CCG to open early four mornings a week under an extended hours access scheme. The practice opened on a Monday from 8.00am to 6.00pm and 7.30am to 6.00pm Tuesday to Friday. The practice closed every Tuesday between 12pm and 1pm for staff training. Practice cover arrangements were in place during this time. The GP national survey data showed 95% of respondents were satisfied with the practice's opening hours.

The data we reviewed and the feedback from patients about the appointment system showed a high level of satisfaction with the appointment system and access to the service. 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 or by 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. The national GP survey results showed 99% of respondents said the last appointment they got was convenient. 100% of respondents found it easy to get through to the surgery by phone. 98% described their experience of making an appointment as good; which was significantly higher than the national and CCG average.

Appointments were open to patients to book four to six months in advance. We were told by staff that no patient was ever turned away from the practice and the practice staff were flexible and proactive in managing appointments and would add extra surgeries if needed. The practice did

not have a set limit of extra or urgent appointments per day. This was aligned with the feedback from patients. 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 then they could have their blood taken by a GP or they could be passed over to other staff, such as the nursing team for an ECG. We were told equality and diversity was considered when sending patients routine appointments. For example, families with children at school. We were told of an example where a patient had been brought to the practice when it was quiet to reduce their anxiety. The practice was actively involved in CCG initiatives such as weekend appointments and next day appointment booking by Out of Hours services.

The practice had a policy in place for managing longer appointments. Longer appointments were automatically arranged for a number of patients. For example, a person newly diagnosed by the GP with COPD was automatically offered a 30 minute appointment with the nurse. Longer appointments were also available for more complex reasons. 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 showed us their annual review of complaints. They had received eight complaints, four written and four verbal/telephone. The records showed the outcome of the complaint investigation had been recorded. None were referred to; The Health Service Commissioner to consider under the 1993 Act; or The Local Commissioner to consider under the Local Government Act 1974. All complaints were resolved with written acknowledgement followed up by written explanation after investigation. Individual records we looked at confirmed the information in the annual report and showed the complaints had been dealt with in a timely way and were 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?

Outstanding ☆

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

Our findings

Vision and strategy

The practice defined its philosophy in their practice leaflet and on their website. It was also included in the statement of purpose aims and objective. This was; Orchard Court aims to provide accessible, high-quality health care to all patients in a friendly, open, non-judgemental and professional atmosphere.

We spoke with six patients, reviewed 50 completed CQC comment cards. The feedback was aligned to Orchard Court delivering its vision and strategy. We spoke with eight members of staff formally and others informally. They all demonstrated a clear understanding of the practice vision and could provide clear examples of how this had been achieved.

Governance arrangements

The practice had a range of policies and procedures in place to govern activities 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 governance meetings where matters such as performance, quality and risks were discussed. A range of other meetings were held on a regular basis. These included safeguarding, palliative care, Multi-disciplinary, GP and nurse meetings, whole staff meetings, QOF and avoiding unplanned admissions. Many of these meetings included multi-disciplinary attendance and in some instances 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 intelligence monitoring tools, QOF, staff supervision, peer review (internal and external) to the practice and effective systems and processes for recalls and medicine management. The practice carried out clinical and non-clinical audits which demonstrated outcomes for patients had improved. The findings of one particular audit had been shared with the CCG 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 99.7%. 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 also saw an audit had been shared with the CCG as it related to the performance rates for monitoring the management of certain medicines in all practices in Darlington.

We saw evidence that succession planning was regularly discussed. Recent changes in staffing at the practice had been planned to mitigate any impact on patients. Change was communicated to patients in advance of it being implemented. Records showed changes for primary medical services were discussed with staff. Decisions around how the practice would manage these challenges whilst continuing to meet the practices vision and values were recorded.

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, nursing staff attended safeguarding meetings, nursing leads attended QOF and unplanned admissions meetings, and there was a full staff meeting. Staff told us there was an open culture 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

Are services well-led?

Outstanding ☆

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

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. The results of the last patient survey which run from December 2013 to January 2014 were reviewed and an action plan put in place. We saw evidence that the action plan had been acted on. For example, we saw from the PPG records the practice had reviewed the last survey report, listened to feedback and put measures in place. For example the survey had shown that only 42% of patients were using the website for ordering prescriptions and so the practice had increased the promotion of the website facility. More recently the practice had put in place the Friends and Family Test. We looked at the results for January and February 2015 and saw the practice had reviewed the feedback and reported it to staff. There was no action for the practice to take as all the feedback was positive.

The practice had an active patient participation group (PPG) and actively tried to recruit new members. The profile of the group represented the breadth of the population .We met with one member of the group and they were extremely complimentary about how the PPG was run and the overall experience of being a patient at the practice. Records confirmed the PPG met on a quarterly basis. The PPG had been involved in reviewing the last results of the patient survey and had put in place an agreed action plan. We saw evidence that these actions had been put in place, for example, the use of text messaging to remind patients of their appointments in an attempt to reduce patients who did not attend. The PPG information was available on the practice website.

There were high levels of constructive staff engagement and all staff were actively encouraged to raise concerns. The practice had gathered feedback from staff through staff away days and generally through staff meetings, protected learning time appraisals and discussions. Staff told us they gave feedback and discussed any concerns or issues with colleagues and management. Our discussions with staff demonstrated a high level of staff satisfaction and a confidence that their views were listened to.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. Staff told us that the practice was supportive of training. The practice closed every Tuesday for one hour for dedicated staff training time. Recent training had included a visit from Dementia Friends. 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, one member of staff had started at the practice as a HCA and was now the practice nurse. One member of staff told us how they had undertaken specific training on asthma and how they had brought their learning back to the practice and introduced changes to further improve the management of asthma at the practice. All the GPs we spoke with spoke about the drive for continuous improvement.

The practice had comprehensive systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice demonstrated a strong collaboration and support across all staff and 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 administrative systems, support for staff, engagement with other professionals, engagement with patients and quality monitoring systems.

The cohesiveness shown amongst the whole team was remarkable. Everyone we met was committed to high standard professional practice and to working with one another to make effective use of every resource for delivering organised and co-ordinated services to meet current patients' needs. They took every opportunity for learning from current experience and used it towards developing better care provision for the future.