Victoria Medical Practice

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.

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Summary of findings

Overall summary

The Victoria Medical Practice is situated in Washington and provides primary medical care services to patients living in and around the Washington area.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, treatment of disease, disorder and injury and family planning.

The patients we spoke with and those who completed the CQC comment cards were extremely complimentary about the care and treatment being provided and they felt safe. Clinical decisions are considered in line with best practice guidance.

There are effective systems in place to ensure the service is delivered to all patients in a way that meets their needs. There is collaborative working between the practice and other health and social care agencies which help to ensure patients receive the best outcomes from their treatment. There are appropriate governance and risk management measures in place.

Systems are in place for medicines management.

The staff were caring and ensured all treatments being provided followed best practice guidance.

The leadership team are reported to be approachable and visible.

The provider was in breach of regulations related to:

Cleanliness and Infection control.

Supporting staff.

We currently review six population groups at all inspections, the detail of which can be found after the summary in this report. The needs of these population groups are identified by the practice and systems are in place to improve their access to care.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Some aspects of the service were safe. Information from NHS England and the CCG indicated the practice had a good track record for maintaining patient safety. Each clinician was closely monitored to ensure that as far as possible patients who used the service were kept safe and protected from avoidable harm. We saw that people were not always protected against the risk of infection because there were short falls in the management of infection control.

Are services effective?

Some aspects of the service were effective. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner and appropriate timely referrals made. Healthcare professionals ensured that patient's consent to treatment was obtained appropriately at all times. No systems were in place to monitor and support staff performance within the practice.

Are services caring?

The service was caring. The 29 patients who completed CQC comment cards and 11 patients we spoke with during our inspection were complimentary about the service. The majority of patients found the staff to be extremely person-centred and felt they were treated with respect. Staff we spoke with were aware of the importance of providing patients with care and respect. Carers were identified in the practice and staff were aware of how to access local support for these patients.

Are services responsive to people's needs?

The service was accessible and responsive to patients' needs. The provider had a complaints policy with a nominated lead. Regular patient surveys were conducted in the practice. The provider participated actively in discussions with commissioners about how to improve services for patients in the area. There was a nominated lead in the practice to communicate with the CCG.

Are services well-led?

The service was well led. Governance and risk management structures were in place. Staff were committed to maintaining and improving standards of care. Key members of staff were committed to maintaining and improving standards of care and encouraged good working relationships amongst staff and other stakeholders.

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

The staff working in the practice were knowledgeable about the health needs and numbers of older people using the practice. They were able to identify high risk patients and those requiring further support. The staff actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. Medication and annual health reviews were completed with all patients over the age of 75. The staff kept an up to date register of patients' health conditions, carers' information and whether patients were housebound and required a home visit. They used this information to ensure patients received timely appropriate care to meet their needs and provide regular health checks.

We heard from patients in this age group that they had been able to see their named GP and that nurses encouraged them to contact them if they had any concerns. Patients were complimentary about the care and support they received from the staff. We found the practice worked well with other agencies and health providers and were aware of the range of local support and specialist services available within the local area.

People with long-term conditions

The clinical staff had a good understanding of the care and treatment needs of patients with a range of long-term conditions. The practice closely monitored the needs of this patient group and worked with patients to improve their quality of life. We saw the practice had developed named clinical leads for the different long term conditions. The staff had undergone further training and regular updates to develop their expertise in effectively managing long term conditions. We found staff had a programme in place to make sure no patient missed their regular reviews for conditions such as diabetes, respiratory and cardiovascular problems. We heard from these patients that staff invited them for routine checks and reminded them of appointments at the clinics.

Mothers, babies, children and young people

The practice provided services to meet the needs of this patient group. There were comprehensive screening and vaccination programmes which were managed effectively to support patients.

Summary of findings

Staff were knowledgeable about child protection and safeguarding. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

The staff were responsive to parents' concerns and ensured parents could access emergency appointments with open access for under-fives. We saw that the staff had a good knowledge of their patients and family groups and the management of childhood and adolescent illnesses.

The working-age population and those recently retired

The practice provided a range of services for patients to consult with GPs and nurses. The practice offered a range of appointments during the week with bookable appointments up to 8pm on a Monday. The practice offered patients the option of telephone consultation where they could speak directly to the GP or nurse if they would prefer.

The practice had developed a good information base which covered the needs of their entire patient group that would be used to support the management of patients. Staff had a programme in place to make sure no patient missed their regular reviews for conditions such as diabetes, respiratory and cardiovascular problems and were proactive in following these up. Staff were aware of the pressures working patients may have in accessing services and requesting prescriptions and tried to be flexible in their approach.

People in vulnerable circumstances who may have poor access to primary care

The practice size is small and we found the staff knew their patients well. The staff had a good knowledge of their patients; they were able to identify vulnerable patients and the care and support they required. The practice worked closely with other agencies when required; to provide a joint approach to the care management.

The practice had a named lead for learning disabilities that had a good knowledge of this patient group. They monitored care and worked with patients who had a learning disability and ensured they received fair access to care.

The staff aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a good understanding of what services were available within their catchment area; such as supported living services, care homes and families with carer responsibilities.

Summary of findings

Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training.

People experiencing poor mental health

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to identify and offer patients an annual appointment for a health check and a medication review. The staff were aware of the range of issues that may affect up take of this service.

Clinicians routinely and appropriately referred patients to counselling and support services, as well as psychiatric provision within the locality.

The staff had a very good understanding of patients' social background, conditions and personal attitude towards their health. The staff used this information when communicating with patients. We saw the practice was able to identify patients in this group who required home visits.

The staff were proactive in identifying carers registered with the practice to ensure they were known to the practice and offered support and help to remain healthy. There was a named member of staff responsible for improving carer support in the practice.

Summary of findings

What people who use the service say

We received 29 completed CQC comment cards from patients and spoke with 11 patients who were using the service on the day of inspection. We spoke with a range of patients from different age groups and health needs. The patients were extremely complimentary about the service. The majority of patients told us they found the staff to be caring, person-centred, listening and treated them with respect.

We saw that a patient survey had been completed in the practice between February and March 2014; a total of 55 patients had responded. The majority of responses to the questionnaire were positive. When asked if it was easy to get an appointment, 67% agreed and 17% strongly agreed. Patients were asked if the opening hours were convenient, 72% agreed they were and 20% strongly agreed. The practice scored 100% when asked if patients agreed that the practice provided accurate and up to date information. Patients commented that they felt supported, listened to by staff and not rushed during their consultation time with the GP or nurse.

The practice had been unable to establish a patient participation group (PPG) and was looking at different ways in which they could continually gain patient feedback. The staff monitored how they responded to patient's needs and ways in which this could be improved. The staff told us they were hoping to increase patient triage and telephone consultations offered to patients in the future.

The practice was aware that waiting times in the waiting room for GP consultations were sometimes delayed. We saw in the practice meeting minutes that staff had been looking at systems to improve this however on the day of inspection the systems suggested to reduce waiting times was not in place. During the inspection the average waiting time for consultation was between 10 and 15 minutes and as long as 45 minutes for one patient. Patients were able to make bookings in advance with the GP of their choice and there were emergency appointments available on the morning and afternoon sessions. Patients told us they were satisfied with the availability of appointments and the ability to contact the practice.

Patients we spoke with told us they were fully involved in deciding the best course of treatment for them. They told us they would recommend this practice. During the inspection we spoke with a person registering their family with the practice. They told us their neighbours had recommended this practice as being a good practice. Another patient who was visiting the practice was feeling unwell and concerned about how they would take their prescription to the chemist when they were leaving. The reception staff took the prescription and arranged for it to go to the local chemist and be collected later by the patient's family. The patient was very pleased and grateful.

Areas for improvement

Action the service MUST take to improve

Systems were not in place to monitor and support staff performance within the practice. Staff did not receive regular supervision or annual appraisals.

Action the service SHOULD take to improve

No record of actions taken in response to safety alerts about equipment and drugs was available.

There was no training matrix in place which outlined what training each member of staff required, or were due to attend and when any refresher training was due.

There was a limited number of staff meetings held in the practice.

The practice did not have a process for monitoring concerns within the practice.

There was no system in place to ensure the practice involved patients in the development and improvement of the practice.

The practice business continuity plan did not contain up to date information.

There were no infection control audits and monitoring of infection control.

Victoria Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP, a practice manager and an expert by experience who is someone that has used health and social care services.

Background to Victoria Medical Practice

The practice provides GP services for patients living in the Washington and Springwell Village areas. The practice has two GP partners and two practice nurses.

The practice is open Monday to Friday from 8am to 6pm with a late night opening on Mondays between 6pm and 8pm. Patients can book appointments in person or via the telephone. The practice provides some access to a triage service so patients can discuss their condition with a GP who may provide advice or arrange a face to face appointment at the practice. The practice treats patients of all ages and provides a range of medical services.

The practice does not provide out of hours services for their patients and information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website. When the practice is closed patients access Northern Doctors Out of Hours Services.

The practice is part of Sunderland CCG and is responsible for providing primary care services to 3,051 patients. The number of patients over 65 years registered with the practice is well above the CCG and national average. The population of patients less than 18 years registered with the practice is well below the CCG and National average.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Detailed findings

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before and during the inspection. The information reviewed highlights some areas of concern across the five key question areas. We carried out an announced inspection on 02 September 2014 and spent eight hours at the practice.

We reviewed all areas of the practice including the administrative areas. We sought views from patients both face-to-face and via CQC comment cards. We spoke with the acting practice manager, two GPs, two nurses and four administrative staff. We spoke with patients who were using the service on the day of the inspection and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone.

We observed how staff handled patient information received from the out-of-hour's team and other organisations. We reviewed a variety of documents used by the staff to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Are services safe?

Our findings

Some aspects of the service were safe. Information from NHS England and the CCG indicated the practice had a good track record for maintaining patient safety. Each clinician was closely monitored to ensure that as far as possible patients who used the service were kept safe and protected from avoidable harm. We saw that people were not always protected against the risk of infection because there were short falls in the management of infection control.

Safe patient care

The practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards (GPOS) showed it was rated as an achieving practice. GPs told us they completed incident reports and carried out significant event analysis as part of their on going professional development. We looked at the significant events analysis over the last year and saw that there were five events identified. There were no review dates identified for the analysis of these events.

The practice had some systems in place to monitor patient safety. There was an incident reporting policy in place which outlined why incidents should be reported, and how to report them. The acting practice manager, GPs and nurses discussed significant event analysis (SEA) and showed us documentation to confirm that incidents were reported. It was not always clear if and when actions identified would be reviewed or who would be responsible for these actions. We were unable to establish if all staff could readily identify all incidents that might have the potential to adversely impact upon patient care or if SEAs were discussed with all practice staff.

Staff had a good knowledge of how to identify concerns relating to the safeguarding of patients and used a flow chart which identified the steps they followed to ensure the relevant authorities were informed as quickly as possible.

The practice had developed a process to circulate any safety and medication alerts received to the staff. The staff we spoke with confirmed this however it was not clear who held responsibility for any actions identified or when these actions would be reviewed. From our discussions we found that GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Learning from incidents

The practice had some processes in place to review incidents occurring in the practice. We saw that there had been five SEAs reported in the last year and there had been no complaints recorded. The information was limited about when actions following SEA would be reviewed.

The practice had in place a process for complaints and a there was a named person responsible for monitoring this. There was information available for patients which informed them how and to whom they should address any complaints. We were unable to review the process for responding and learning from complaints as none had been received. Due to the size of the practice we were concerned that no complaints or concerns were recorded.

Safeguarding

The practice had up to date 'child protection' and 'vulnerable adult' policies and procedures in place. . These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers. Staff had access to contact details for both child protection and adult safeguarding teams at the local authority. Staff were knowledgeable about the actions they needed to take if they suspected abuse and described how they would report and discuss issues with the GPs in the practice.

The staff we spoke with had received safeguarding training in the last 12 months. They were knowledgeable about the types of abuse to look out for and how to raise concerns. The administrative staff told us about concerns they had raised and how these had been followed up immediately. The practice was able to identify were there were on-going safeguarding concerns relating to patients and which organisations were involved.

We saw there were effective systems in place to ensure the staff remained up to date with the latest developments. Clinical staff had access to developments and were engaged fully with the CCG where the latest best practice and new developments were shared.

Monitoring safety and responding to risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were allocated lead roles or areas of responsibility.

There were some procedures in place to assess and manage risks to patient and staff safety. We were told that

risks would be discussed at the clinical and practice meetings and discuss how to address these. We saw that there were long gaps between these meetings which did not provide a timely opportunity to engage staff. It was not clear what systems were in place to monitor infection control within the practice.

We found that there were some processes in place to monitor skill mix, demand and capacity within the practice. We found staff had received no annual appraisals which would allow the management to identify if there were sufficient staff with the right skills to meet patients need or if staff felt they had the right skills to do their job.

The temporary practice manager had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The temporary practice manager told us they were responsible for producing the rota, approving annual leave and for ensuring there were sufficient staff on duty each day.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were assigned lead role responsibility such as Chronic Obstructive Airways Disease (COPD), palliative care, depression and mental illness.

We saw that patients were monitored regularly to ensure patient reviews and reviews of medication were completed in a timely manner. Any changes in medication guidance were communicated to clinical staff which ensured staff were aware of any changes and patients received the best treatment for their condition. GPs reviewed their prescribing practices as and when medication alerts were received.

We found the practice had emergency equipment and medicines available to be used in an emergency and records showed that the equipment and medicines were checked regularly. The staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock.

Medicines management

We found that there were up to date medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were stored securely and only clinical staff had access.

There were processes in place to regularly review and monitor the prescribing of medication. The practice had the support of a pharmacy optimising manager attached to the practice with whom they worked closely to address concerns around prescribing and ensure patients received the correct medication. They also provided support to the clinical staff in keeping up to date with medication and prescribing trends. We saw a review of the prescribing work completed from 1 Sept 2013 to 30 June 2014. This demonstrated a review of the prescribing of certain medicines and the actions undertaken to improve prescribing within the practice in line with national best practice.

The GPs re-authorised medication for patients on an annual basis or more frequently if necessary. There were processes in place that staff followed when dealing with requests for repeat prescriptions. We saw patients could request repeat prescriptions either by telephone, in person or by post. Patients we spoke with were aware of how to order repeat prescriptions, however some patients commented that the time given for order prescriptions 2.00pm-5.00pm daily was difficult for people working. We discussed this with staff who told us that they were aware of this and tried to be accommodating. There were systems in place to alert patients when they required a review of their medication and advised patients to book an appointment.

Medicines stored in the practice were kept securely and could only be accessed by identified staff. We saw evidence that the GPs bags were regularly checked to ensure that the contents were intact and in date. There were processes in place to ensure the stocks of consumables and vaccines were readily available, in date and ready to use. There were clear records of any medicines stored in the practice and when they were used.

Prescription pads and repeat prescriptions were stored securely. There were processes in place to ensure the safe management of prescriptions which the reception staff closely monitored.

We saw that checks were in place to ensure medicines are stored at the correct temperature and the provider had systems in place to ensure the safe disposal of unwanted medicines. We looked at how vaccines were ordered and checked on receipt and stored. We saw that regular checks were in place to ensure vaccines were stored appropriately.

Are services safe?

Cleanliness and infection control

Patients we spoke with and those who had completed the CQC Comment cards told us they found the practice was clean and appeared hygienic. The cleaning services for the whole building was provided by NHS building and facilities who owned the building. We saw that the overall cleanliness of the building was good with cleaning schedules in place.

Infection prevention and control procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for infection prevention and control (IPC) however the lead told us that they were unaware of this responsibility. Not all staff were aware of who the IPC lead was. No IPC audits had been completed and the practice did not monitor the standards of cleaning provided by NHS Property Services, so any areas for improvement could not be identified and actioned.

We inspected all the treatment and clinical rooms. We saw that all areas of the practice were clean and the practice nurses had developed a cleaning check list for the clinical areas and equipment they used at the start and end of each day which they signed on completion.

We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms and in reception. Couches were washable and there were processes in place to regularly clean the curtains around them. Flooring in treatment areas were easy clean.

Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor.

Staff we spoke with told us that all equipment used for procedures such as smear tests and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean. It was unclear if there had been any infection control training provided to the non-clinical staff or practice nurses received regular updates specific to this role. This meant that staff were not kept updated or understood their roles or the importance of procedures such as hand washing.

We observed the reception staff handling specimens being brought into the practice by patients. The staff wore gloves when accepting the specimens however there were no hand wash available in the reception or waiting area. We spoke with the administration staff who told us they had not received IPC training and were not clear how they would deal with spillages of body fluids. This meant staff could not safely deal with all eventualities relating to infection control that may occur in the practice.

Legionella testing had been carried out at required intervals.

Staffing and recruitment

The practice had a recruitment policy in place which required updating to meet CQC regulation for the requirements relating to workers. We looked at a sample of recruitment files for administrative and nursing staff. All of the staff currently employed in the practice had been employed for some time and we saw that appropriate checks for employment had been undertaken.

The acting practice manager told us that as part of the quality assurance and clinical governance processes the provider checked the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year to make sure the GPs and nurses were still deemed fit to practice. We were told that the nursing and administration staff had not received an annual appraisal for more than three years. The staff were not provided with an opportunity to receive support, identify their development needs, concerns and any ideas they may have for practice development. The practice therefore did not have the information available to establish an annual training plan as they were unable to identify individual training needs.

We discussed staffing levels and skill-mix with the acting practice manager and they explained when the different staff worked each week. Patients we spoke with confirmed they could get an appointment to see a GP or nurse when they needed to. We found that the practice used the same GP to provide locum cover as much as possible when they were required. This meant that the locum would be familiar with the practice and its' procedures.

Dealing with Emergencies

Staff told us they received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR), anaphylactic shock (the treatment of severe allergic reaction) and other emergencies such as fire and floods.

Are services safe?

The practice had equipment in place to deal with a medical emergency in the practice; such as a defibrillator, medication, nebuliser, airway control and oxygen. We saw that there were processes in place to regularly check these. All staff were trained in basic life support and in dealing with emergencies. The clinicians had received further training in dealing with medical emergencies.

The practice had developed business continuity plan which detailed how to deal with a range of emergencies that might interrupt the smooth running of the service. We found that this plan had not been updated since 2008 and did not provide current up to date information and contact details.

Equipment

We saw that there were processes in place to regularly check and calibrate equipment used in clinical areas. We saw records showing that equipment had been serviced and maintained at required intervals by competent persons. These measures provided assurance that the risks from the use of equipment were being managed and people were protected from unsafe or unsuitable equipment.

During the inspection we heard patients being told that the ECG machine used by the whole building was out of order and patients were told they had to travel to another site to have this test undertaken. There was no explanation to patients of when this problem would be addressed.

Are services effective?

(for example, treatment is effective)

Our findings

Some aspects of the service were effective. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner and appropriate timely referrals made. Healthcare professionals ensured that patient's consent to treatment was obtained appropriately at all times. No systems were in place to monitor and support staff performance within the practice.

Promoting best practice

We saw there were systems in place to ensure that the practice demonstrated knowledge and understood about best practice. The clinical staff we spoke with were aware of best practice and guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required.

We discussed with the acting practice manager, GPs and nurses how National Institute of Health and Clinical Excellence (NICE) guidance was received into the practice. They told us that this was received electronically, disseminated to staff, reviewed for actions required and discussed at the clinical meetings. The Staff we spoke with all demonstrated knowledge of NICE guidance.

We spoke with one nurse who was able to demonstrate how they had changed and improved the treatment and management of a particular patient group. The nurse undertook a clinical audit to demonstrate the effectiveness of changing a particular medicine in the management of this group. This resulted in the GPs changing their prescribing for this condition in line with best practice and improving patient care.

Staff had a good understanding of the Mental Capacity Act 2005 and ensured the requirements were adhered to. The clinical staff were able to identify patients who may need to be supported to make decisions and identify were a decision may need to be made in a person's 'best interest'. The staff were fully aware of the Gillick competency assessments that may be required in treating children and young people. The Gillick competency is a rule for judging legal capacity in children under the age of 16 years were such children are deemed to be capable of giving valid consent to health-care treatment.

We saw there were prompt referrals to on-going services by the clinicians. The practice monitored referrals of all patients to other services to check that referrals had been received or if patients had failed to attend these appointments. We saw that the administrative staff were very supportive of patients during this process. The practice had an excellent cancer detection rate. This ensured that best practice was followed by ensuring timely access to on going services.

Management, monitoring and improving outcomes for people

The practice had systems in place for completing clinical audit cycles. Examples of clinical audits included referrals to secondary care, monitoring of baby clinics, urine tract infections and prescribing audits for a range of medicines. These audits had led to improved service delivery and effective safe prescribing. This ensured staff continually reviewed their practice and service delivery in line with current best practice.

We looked at how the practice monitored the Quality and Outcome Framework (QOF) diagnosis and prevalence. The practice used the information they collected for the QOF and their performance to monitor patient outcomes. The QOF report from 2012-2013 showed the practice was supporting patients well with conditions such as, chronic obstructive airways disease, diabetes and heart failure. The QOF is a system used to identify and reward general practices for providing good quality care to their patients, and to help fund work to further improve the quality of the health care delivered. We saw the practice closely monitored their performance against other practices in the Sunderland and nationally. The practice fully engaged with the local CCG and attended regular meetings and training which allowed the practice to receive support from other practices, learn from bench marking and adopt local and national initiatives to ensure best care was provided

Are services effective?

(for example, treatment is effective)

Staffing

We saw that the practice employed a Human Resource (HR) company to develop a staff handbook inclusive of an induction programme and policies. We were shown a draft of this document which was comprehensive and included key documents and guidance required by staff.

The staff files we reviewed showed nursing and non-clinical staff had not received an annual appraisal for several years and in some instances this was up to four years. Staff told us they felt supported but confirmed they did not receive formal supervision and did not have the opportunity to discuss their individual training needs. The acting practice manager told us if they had concerns about a staff member's performance they would speak with them in private. The staff told us they had access to a range of policies and procedures to support them in their work.

We looked at staff training and access to training in the practice. We saw that staff had attended a range of courses and currently they had access to 'Time-in Time Out '(TITO) training sessions organised by the CCG. The staff told us these were very good; however they had concerns that they may not always be able to attend these as the practice workforce was small.

It was unclear, as there had been no appraisals, what the training needs of the practice and staff were. We could find no annual training plan however we saw that staff had been provided with some training. For example, practice nurses had received condition specific training which helped them to support patients with long term conditions. The practice nurses told us they also attended well-led practice nurse forum within the local area which they found supportive.

The GPs received an external professional appraisal as part of their appraisal and revalidation with the General Medical Council (GMC). Revalidation is the process by which licensed GPs are required to demonstrate on a regular basis that they were up to date with clinical practice and are fit to practice.

Working with other services

The practice demonstrated that they worked closely with a range of other services and disciplines to provide good patient care. We saw that regular meetings and contact had been established to meet with other agencies to enable good communication and effective care planning for the different patient groups. Examples of those groups were palliative care and older people.

The practice were aware of the care homes for older people within their locality and provided regular visits to assess patients.

We were told that the practice staff had formed strong links with the community nursing services, health visitors and community matrons. The staff told us they regularly discussed complex patients and referred patients onto the community teams to improve support for patients.

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. This ensured that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

The practice had guidance for dealing with abnormal test results. The staff were aware of how to deal with these results and ensure they were reviewed by the GPs. Patients who had abnormal test results were followed up appropriately

There were systems in place to deal with information, coming into the practice such as discharge letters, was sent to the GP for review and action. The information was recorded appropriately from other health care providers in the patient records and available to the clinicians.

We saw how information was shared with and by the GP Out of Hours service in the local area. Staff told us that patient information received from the out of hours service was of good quality and received on time each morning and was passed onto the GP for review.

Health, promotion and prevention

The staff supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, cervical smears, long term condition reviews and provided health promotion information to patients. 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.

Are services effective?

(for example, treatment is effective)

The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services and how to access them.

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. We saw that this was promoted in the practice information leaflet and on the web site. The needs of new patients were assessed and a plan of the person's on going needs to stay healthy was developed.

There was information available to support patients who planned to travel abroad and to help them plan the healthcare they would need to keep them safe, such as travel vaccinations.

Are services caring?

Our findings

The service was caring. The 29 patients who completed CQC comment cards and 11 patients we spoke with during our inspection were complimentary about the service. The majority of patients found the staff to be extremely person-centred and felt they were treated with respect. Staff we spoke with were aware of the importance of providing patients with care and respect. Carers were identified in the practice and staff were aware of how to access local support for these patients.

Respect, dignity, compassion and empathy

We observed patient's arrive into the reception area of the practice and saw that the staff interacted well with patients. They were polite, welcoming, professional and sensitive to the different needs of patients. We also observed staff dealing with patients on the telephone and saw them respond in an equally calm professional manner. Staff we spoke with were aware of the importance of providing patients with privacy they told us they could access a room off the reception area if patients wished to discuss something with them in private. Due to the layout of the reception when the area was quiet it became difficult for the staff to ensure patient information could not be overheard.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. The consultation room doors were routinely locked when patients were being seen, which meant patient dignity was maintained. We observed staff were discreet and respectful to patients.

Information about accessing a chaperone was on display in the waiting and consulting areas.

We observed patients being offered a chaperone at the time of booking an appointment. Staff told us they recorded when a chaperone was provided or refused however the person providing this role did not confirm this by entering it into the patient notes. Patients we spoke with told us they were aware of the process for requesting a chaperone.

Staff we spoke with understood the role and duties of being a chaperone and had received some training. We spoke with the non-clinical staff about providing this role. Not all staff were comfortable with providing this role but had not shared this with their manager. Patients told us they felt the staff and GPs effectively maintained their privacy and dignity.

On the whole patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and found clinicians were extremely empathetic and compassionate. Patients did comment that the waiting time in reception was sometimes long and there no notification or explanation provided to advise patient of the delays.

The practice had systems in place to communicate with people whose first language was not English. There were also systems in place for those patients who had a sensory loss or disability that required help in communication with staff. Overall patients told us that the staff were always friendly and sensitive to their needs, put them at ease, asked their permission to examine them and explained what they were doing and the plans for on going care

Involvement in decisions and consent

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. The clinicians explained how they asked for and recorded consent in the patient notes. One of the practice nurses we spoke with explained that they always asked the parents of a baby or child having immunisation to sign for this procedure in the child's health book. The nurse also explained that if a family member other than the parent arrived with the child for immunisation they always contact the parent or legal guardian for approval and consent. The patients we spoke with reported being involved in decision making and being supported to make decisions.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions

Are services caring?

about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity.

Patients told us they felt involved in their care, that the GPs and nurses listened to them, gave them time and provided explanations about their treatment. We saw that there were a range of support services available to patients in the practice.

The practice had an 'access to records' consent policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information was available for patients in the waiting areas of the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was accessible and responsive to patients' needs. The provider had a complaints policy with a nominated lead. Regular patient surveys were conducted in the practice. The provider participated actively in discussions with commissioners about how to improve services for patients in the area. There was a nominated lead in the practice to communicate with the CCG.

Responding to and meeting people's needs

We found that the practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties and there was also a toilet for disabled patients. We spoke with the staff about patients with disabilities and they had a good knowledge of which patients required assistance. We observed staff assisting patients during the inspection. There was a large waiting area with plenty of space for wheelchair users.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice had a good understanding of their patients and when they may need support in accessing these services. An example of this was the practice had processes in place to ensure that the housebound such as the elderly or patients with mental health problems could access a full range of services.

Staff were knowledgeable about how to book interpreter services for patients where English was their second language. There was guidance about using interpreter services and the contact details available for staff to use. The reception staff told us that they were familiar with patients who may require any assistance they were able to give us example of how they met the needs of patients who were visually impaired, people with learning disabilities and patients with long term conditions.

The practice does not have a PPG and we were told that they have been unable to recruit any patients to this role. The staff discussed a range of initiatives they were hoping to put in place to assist them in consulting with patients to change and improve service delivery.

Access to the service

We found that patients could make their appointments in different ways, either by telephone and face to face. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. Patients we spoke with told us that they were able to get appointments without problems.

We saw that it was not always possible to see the particular GP of your choice on the same day but that the GPs were responsive to ensuring all patients were seen. We saw that there was open access to services for the under 5s and very elderly patients.

On the whole patients were satisfied with the practice. Several patients mentioned that it was difficult for people who were working to request prescription between the hours identified; although staff told us they always tried to be flexible and accommodate people.

The practice was using a degree of triage when assessing patients. The GP offered patients a telephone consultation were the GP may provide advice, support or a face to face appointment. We were told that the practice is looking to develop this service further in the future to respond to patient's needs.

The opening hours were Monday to Friday between 08.30 and 18.00 each day with extended opening up to 19.30 on Tuesdays. We saw that the practice leaflet had recently been updated and provided good information for patients using the services however the practice website was not up to date.

Concerns and complaints

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

We saw the complaints procedure and information on display in the practice. The practice web site also had a comment form that people could complete. The patients we spoke with were aware of the process to follow should they wish to make a complaint.

We reviewed the complaints records and saw that there had been no complaints or comments recorded that related directly to the practice. We found this unusual and

Are services responsive to people's needs?

(for example, to feedback?)

we expressed concerns that the practice may not be capturing all concerns raised. We received a CQC comment cards where a patient had commented they were unhappy with aspects of the service however it was unclear if this person had passed on their concerns to the temporary practice manager. The practice had a process in place to analyse any complaints they may receive.

Are services well-led?

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

Our findings

The service was well led. Governance and risk management structures were in place. Staff were committed to maintaining and improving standards of care. Key members of staff were committed to maintaining and improving standards of care and encouraged good working relationships amongst staff and other stakeholders.

Leadership and culture

We saw that the practice had developed named leads where staff held responsibility and leadership for a range of areas. Examples of these were safety alerts, complaints and a full range of Long term conditions.

All the discussions and evidence we reviewed confirmed that the management team had a clear vision and purpose. The GPs we spoke with demonstrated understanding of their area of responsibility. We saw that both GPs and the acting practice manager were fully engaged with the CCG to monitor performance and implement new methods of working to meet the needs of local people. An example of this was the access to training for staff at the TITO sessions and a process for improving carer's access. All the staff we spoke with told us they felt they were valued and their views listened to.

We saw that the schedule for practice and clinical meetings were not regular and there had been a limited number held over the past year. There had been only two clinical meetings in 2014 and one practice meeting. The staff we spoke with told us that they were often briefed on news and developments on an informal basis or one to one. No records of these informal meetings were recorded therefore it was difficult to establish what actions had been agreed or if areas of responsibility had been allocated. Staff we spoke with told us they would like more meetings as this helped them keep up to date with new developments and concerns. Staff told us they were committed to providing a good service for patients.

The practice had identified that the staff job descriptions and contracts required updating. In response to this the practice had employed a Human Resource company (HR) to develop new staff contracts and a staff handbook. We looked at this handbook which provided staff with detailed comprehensive information such as policies and procedures they would require to undertake their role and what the practice expected from them.

Governance arrangements

The practice had identified leads for key areas such as safeguarding, medicine optimising and infection prevention and control. There were systems in place for the practice to work with the local CCG to monitor their performance and bench mark with other practices in the area.

From our discussions with staff we found that they looked to continuously improve the service being offered. We saw evidence that they used data from incidents and audit to identify areas where improvements could be made for example in areas such as the monitoring and prescribing of medicines.

The staff told us there was an open culture in the practice and they could report any incidents or concerns about practice with the management team.

Systems to monitor and improve quality and improvement

The practice used information they collected for the QOF and national programmes such as vaccination and screening to monitor patient quality outcomes. GPs told us they worked with the medicines optimising manager to identify any areas were the practice could improve upon. We saw that there had been a number medication and clinical audits undertaken by the practice that resulted in improvement for patients. Staff told us they had not received annual appraisals for a number of years. The practice was unable to use the process to identify staff performance and development needs or support individual staff.

The GPs, nurses and temporary practice manager all contributed to risk management, clinical audits and significant event analysis. We saw that there had been 5 SEAs undertaken during 2013/14.

The practice worked with the CCG to share information and implement new methods of working. For example the practice had undertaken an audit of care homes in their area and was implementing the 'named GP' initiative for patients over 75.

Are services well-led?

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

Patient experience and involvement

We received 29 completed CQC patient comment cards and spoke with 11 people on the day of our visit. We spoke with people from different age groups, including parents and children and those who had different levels of contact with the practice. All these patients were very complimentary about the clinical staff and the overall friendliness and behaviour of staff.

Patients commented that the waiting time in the practice waiting room was long. In the patient survey 44% of patients commented that they waited in the waiting room between 15 - 30 minutes and 17% said that they waited more than 30 minutes. We saw from the minutes of the practice meeting in March 2014 that an initiative had been introduced to assist in reducing waiting times however on the day of inspection this initiative was not in place. We could not establish if the initiative had been successful as we could find no review. Over 90% of the patients felt the GPs and nurses were competent and knowledgeable about their treatment needs.

Staff engagement and involvement

The practice had been unable to engage a patient participation group (PPG) within the practice. A PPG is made up of a group of volunteer staff and patients who meet or communicate regularly to discuss the services on offer and how improvements can be made for the benefit of the local patient population and the practice. The practice had not introduced any other system to engage patients other than the annual satisfaction survey undertaken in February /March of 2014. We looked at the responses to the survey and were unclear if actions had been undertaken by the practice to share this with patients or to improve areas of the service following the survey.

Learning and improvement

The practice understood the need for staff to have access to learning and improvement opportunities. We saw that staff had attended a range of training opportunities; however there were no annual practice or individual training plans in place. Staff told us they were able to access training particularly the TITO training developed by the CCG.

We saw that the practice had identified the need for a staff handbook and induction and we saw evidence these were being developed

The GPs and clinical staff had held two clinical meetings in 2014 where they discussed changes and developments within the practice. The practice had plans in place to ensure this was increased and all staff were aware of this. The staff we spoke with told us that they would like more meetings; however as the team was small, there were processes in place to share information informally.

Identification and management of risk

The practice had some systems in place to identify, assess and manage risks related to the practice. We saw policies in place which provided clear guidance to staff. There were processes in place to share safety and risk information with the staff; however records were not detailed to identify who was responsible for any actions identified.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at the practice meetings or informal meetings to raise awareness and prevent reoccurrence however it was unclear who was responsible or when it would be reviewed to establish its effectiveness.

The staff carried out audits and checks to monitor the quality of services provided. For example the GPs used prescribing information provided by the CCG medicines optimising manager and were able to produce a list of reviews and actions that were undertaken in the practice over the last year.

Staff told us they felt confident about raising any issues and concerns with the management team and that they would be listened to.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Older people had regular reviews which included medication and any long term conditions they may have. We found that staff were aware of their older population and their on going needs. Care provided had been tailored to meet individual needs and circumstances, including a person's expectations, values and choices. We saw that the practice had identified patients who were housebound or in need of extra support and responded appropriately. An example of this was that house bound patients were assessed at home annually and more frequently as required.

The practice was engaged in a pilot to ensure all carers and their needs were identified. This ensured that all aspects of the patients care were addresses. A named GP was accountable for the care of each patient over the age of 75 years.

Clinician's ensured patients and carers have access to appropriate coordinated, multi-disciplinary care (including for those people who move into a care home or those returning home after hospital admission). We saw that the GP and practice nurses were aware of what local support services were available that patients could be referred appropriately.

Unplanned admissions and readmissions for this patient group were reviewed and action was taken to make any necessary improvements. Access to services, including flexible appointment times and same day telephone consultations where appropriate. We saw that there was open access to appointments for the very elderly and frail in the practice. The practice was aware of care homes in their catchment area and regularly visited these to assess patient's on-going needs.

The staff had the knowledge, skills and competence to respond to the needs of this population group including training in appropriate communication skills. We also saw that the non-clinical staff were also aware of extra support older people may require for example in arranging an appointment with the hospital and provided the patients with this support.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

All staff had a very good understanding of the care and treatment needs of people with long-term conditions. The practice closely monitored the needs of this patient group and advised patients how they could maintain and improve their quality of life. We saw that patients were invited for routine checks and when required they were reminded they needed to book a review appointment. The staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems.

The staff we spoke with were skilled and had undergone regularly updates in specialist areas which helped them ensure best practice guidance was always being followed. We found that staff could clearly identify the number of patients suffering from different long term conditions and their needs.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The staff provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively to support patients and families. Staff were knowledgeable about child protection, the process for identifying concerns and referrals. The practice monitored any non-attendance of babies and children at vaccination clinics and follow up any concerns. We saw that the named nurse dealing with babies had recently reviewed the process which resulted in improved information recording and providing parents with good access to services.

All of the staff were very responsive to parents' concerns and ensured parents could readily bring children into the practice to be seen who appeared unwell. The practice provides open access for under-fives and children who may arrive home from school unwell.

Midwifery services were not provided at the practice but any female patient who became pregnant would be referred to book in with the midwife who was located in the same health centre.

The clinical staff had a good knowledge of symptoms for childhood and adolescent illnesses and used this to direct parents to the most appropriate healthcare resource. We saw that a range of clinics were held in the practice examples of these are the Baby Clinic (with Practice Nurse) Childhood Immunisations and Postnatal Clinic (with GP).

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice provided a range of services for patients to consult with GPs and nurses. Patients had access to a range of information and support in the practice to support people with concerns about their health and well- being.

The staff had developed an information base which covered the needs of their entire patient group. There were systems in place to make sure no patient missed their regular reviews for their condition such as diabetes, respiratory and cardiovascular problems. Appointments were available 8.30am – 6.00pm with an extended surgery one day a week. Patients could also request a telephone consultation with the GP or request to speak with the nurse.

The practice had specific time slots and telephone numbers were patients could request services for example prescriptions, test results, insurance and medical reports.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Some of the staff had completed specific training around working with people who had a learning disability and ensured this group got a fair access to care. The practice made adjustments to how they provided care in order to meet patients' needs offering longer appointment times. This helped to ensure patients were given time to be fully involved in making decisions about their health.

The staff were aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a very good understanding of what services were available within their catchment area such as supported living services, care homes and families with carer responsibilities.

Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in the last 12 months.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice staff could clearly identify which patients would require home visits or extra support.

The GPs proactively ensured they were up to date with the latest developments for people with mental health needs. Clinicians routinely and appropriately referred patients to counselling and psychiatric provision.

All of the staff had a good understanding of patients' social background, conditions and personal attitude towards their health. They used this information this information in communicating effectively and supporting this patient group.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23. (1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by— (a) receiving appropriate training, professional development, supervision and appraisal; and (b) being enabled, from time to time, to obtain further qualifications appropriate to the work they perform.