Broadway 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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Broadway Medical Practice on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, caring, well-led, effective and responsive services. It was also good for providing services for the following population groups: 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).

At the previous inspection in September 2014 we issued a compliance action for a breach of Regulation 12 (Requirements relating to workers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As part of this inspection we checked to see if the provider had taken action to address this. We found the improvements required had been made.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were pro-actively supported to acquire new skills.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.
- 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.

We saw several areas of outstanding practice, including:

- Staff from the practice had played leading roles in the development and introduction of the Extended Access Scheme in operation within the West locality in Sunderland since November 2014. One of the GPs and the practice manager were part of the steering group, which had led and helped to implement record sharing agreements and mobilised shared access across 15 practices in the locality.
- All of the practice staff had completed dementia friends training in December 2014. They told us this had helped them to understand how they could help people living with this condition more effectively.
- Staff were consistent in supporting people to live healthier lives through a targeted and pro-active approach to health promotion and prevention of ill health, and every contact with patients was used to do so. For example, a GP we spoke with told us it had been identified that acute kidney injury admissions were rising. In response they had enacted the practice to produce leaflets to explain to patients how to minimise the risk of acute kidney injuries. The practice now issued this leaflet to all patients attending appointments for the management of chronic diseases and when patients started taking high risk medicines.
- The involvement of other organisations was integral to how services were planned and delivered and ensured that services met patients' needs. There were many examples of engagement, including with the CCG and other practices on the extended access scheme, with the CCG for the medicines optimisation local incentive scheme and with secondary care providers.
- Patients' individual needs and preferences were central to the planning and delivery of services. Longer appointments were available for patients on request and were routinely offered to patients who required them. For example, to older patients, those with chronic co-morbidity and also to patients who had difficulty accessing the surgery due to complicated domestic circumstances.

However there was one area of practice where the provider needs to make improvements.

Importantly the provider should:

- Review and improve the systems used to centrally record, monitor and review significant events and safety alerts within the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep people safe. Action had been taken in response to a breach of regulation we identified at the previous inspection in September 2014.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 99% of the points available. This was 4.1% higher than the local average and 5% higher than the national average. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers for the benefit of their patients. Staff worked with multidisciplinary teams which helped to provide effective care and treatment.

The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were pro-actively supported to acquire new skills. There was evidence of appraisals and personal development plans for staff. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

All staff from across the practice were actively engaged in the monitoring and improvement of outcomes for patients. Clinical audit activity was well established within the practice. A range of non-clinical audit activity was also embedded within the practice. The clinical audits completed by the practice measured whether agreed standards had been achieved and made recommendations and took action where standards were not being met.

Summary of findings

Staff were consistent in supporting people to live healthier lives through a targeted and pro-active approach to health promotion and prevention of ill health, and every contact with patients was used to do so. For example, a GP we spoke with told us it had been identified that acute kidney injury admissions were rising. In response they had enacted the practice to produce leaflets to explain to patients how to minimise the risk of acute kidney injuries. The practice now issued this leaflet to all patients attending appointments for the management of chronic diseases and when patients started taking high risk medicines.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with or above others for several aspects of care. For example, the National GP Patient Survey showed 82% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care. This result was higher than the local Clinical Commissioning Group (CCG) area (78%) and national (75%) averages. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Most patients said they found it easy to make an appointment with a GP, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The involvement of other organisations was integral to how services were planned and delivered and ensured that services met patients'

Summary of findings

needs. There were many examples of engagement, including with the CCG and other practices on the extended access scheme, with the CCG for the medicines optimisation local incentive scheme and with secondary care providers.

Patients' individual needs and preferences were central to the planning and delivery of services. Longer appointments were available for patients on request and were routinely offered to patients who required them. For example, to older patients, those with chronic co-morbidity and also to patients who had difficulty accessing the surgery due to complicated domestic circumstances.

All of the practice staff had completed dementia friends training in December 2014. They told us this had helped them to understand how they could help people living with this condition more effectively.

Are services well-led?

Good

The practice is rated as good for being well-led. They had clear objectives and aims. Staff were clear about their responsibilities in relation to these. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The practice had a small, active patient participation group (PPG) and was looking to expand this. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. They offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and had done so prior to it being a contractual requirement. Patients at high risk of hospital admission had care plans. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

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

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's administrative staff were responsible for this process and used index card systems to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked and was reflected by the practice's QOF performance. The practice had achieved 99% of the points available. This was 4.1% higher than the local average and 5% higher than the national average.

Appointments, including daily telephone appointments, were available each day to allow time for contact with other services to support patients who were vulnerable, had poor mental health or long term conditions should they need a more multidisciplinary team approach to their ongoing care.

Summary of findings

The practice maintained a list of patients who were receiving palliative care. A traffic light system was used to highlight those patients that required more intense input from the clinical team. The list was reviewed on a weekly basis and discussed at clinical meetings with the support of the Community Macmillan Nurse.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Childhood immunisation rates were in line with or slightly above averages for the local Clinical Commissioning Group (CCG). For example, MMR vaccination rates for two year old children were 98.3% compared to 96.6% across the CCG; and MMR dose 2 rates for five year old children were 96.2% compared to 94.5% across the CCG. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

We saw good examples of joint working with midwives and health visitors. Cervical screening rates for women aged 25-64 were similar to with national average at 80.1% (the national average was 81.9%).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflects the needs for this age group. GP appointments could be booked in advance online.

The practice offered extended opening hours on a Tuesday evening until 8pm. Patients could pre-book appointments to see a GP or nurse at these times. In addition, patients could pre-book appointments with a GP between 6pm and 8pm Monday to Friday and between 10am and 2pm at weekends due to the extended hour's scheme. This made it easier for people of working age to get access to the service.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. They had carried out annual health checks for people with a learning disability. The practice offered longer appointments for people with a learning disability, if required.

Appointments, including daily telephone appointments, were available with a GP each day to support patients who were vulnerable, had poor mental health or long term conditions.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They made vulnerable patients aware of 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.

Patients' individual needs and preferences were central to the planning and delivery of services. Longer appointments were available for patients on request and were routinely offered to patients who required them. For example, to patients who had difficulty accessing the surgery due to complicated domestic situations.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

Appointments, including daily telephone appointments, were available with a GP each day to support patients who were vulnerable, had poor mental health or long term conditions.

The practice had sign-posted patients experiencing poor mental health to various support groups and organisations. Information and leaflets about services were made available to patients within the practice.

Summary of findings

All of the practice staff had completed dementia friends training in December 2014. They told us this had helped them to understand how they could help people living with this condition more effectively.

For patients experiencing poor mental health, the practice made every effort to accommodate their needs. For example, patients with severe anxiety were seen out of usual surgery hours to facilitate them being seen. The practice also made proactive use of short review dates for patients prescribed antidepressants to ensure they were seen regularly.

Summary of findings

What people who use the service say

We spoke with 12 patients in total, including one member of the practice's patient participation group (PPG). They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

We reviewed 48 CQC comment cards completed by patients prior to the inspection. Of the 48 CQC comment cards completed, 34 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included caring, helpful, fantastic, great people, respectful, efficient, welcoming, polite and thoughtful. None of the CQC comment cards completed raised any concerns in this area. Four of the 48 patients who completed CQC comment cards were not as satisfied as others with the appointments system.

The latest National GP Patient Survey showed that the practice's results were mainly in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. Some of the results were:

- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 90% (CCG average 85%, national average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 88% (CCG 85%, national 82%);
- The proportion of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care – 82% (CCG 78%, national 75%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 92% (CCG 94%, national 92%);
- *The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 77% (CCG 83%, national 77%);
- *The proportion of respondents who said the last nurse they saw or spoke to was good at involving them in decisions about their care – 63% (CCG 75%, national 66%);
- *The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 78% (CCG 90%, national 86%).

These results were based on 115 surveys that were returned from a total of 295 sent out; a response rate of 39%.

*When we reviewed the results of the nurse-based questions, the patient satisfaction levels appeared to be well below the results for the same GP-based questions. Further investigation revealed at least 12% of the respondents answered 'doesn't apply' to each of the nurse-related questions, which should be taken into consideration when reading these results.

Areas for improvement

Action the service SHOULD take to improve
The provider should

- Review and improve the systems used to centrally record, monitor and review significant events and safety alerts within the practice.

Outstanding practice

- Staff from the practice had played leading roles in the development and introduction of the Extended Access Scheme in operation within the West locality in Sunderland since November 2014. One of the GPs and the practice manager were part of the steering group, which had led and helped to implement record sharing agreements and mobilised shared access across 15 practices in the locality.

Summary of findings

- All of the practice staff had completed dementia friends training in December 2014. They told us this had helped them to understand how they could help people living with this condition more effectively.
- Staff were consistent in supporting people to live healthier lives through a targeted and pro-active approach to health promotion and prevention of ill health, and every contact with patients was used to do so. For example, a GP we spoke with told us it had been identified that acute kidney injury admissions were rising. In response they had enacted the practice to produce leaflets to explain to patients how to minimise the risk of acute kidney injuries. The practice now issued this leaflet to all patients attending appointments for the management of chronic diseases and when patients started taking high risk medicines.
- The involvement of other organisations was integral to how services were planned and delivered and ensured that services met patients' needs. There were many examples of engagement, including with the CCG and other practices on the extended access scheme, with the CCG for the medicines optimisation local incentive scheme and with secondary care providers.
- Patients' individual needs and preferences were central to the planning and delivery of services. Longer appointments were available for patients on request and were routinely offered to patients who required them. For example, to older patients, those with chronic co-morbidity and also to patients who had difficulty accessing the surgery due to complicated domestic circumstances.

Broadway Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP specialist advisor and a specialist advisor with experience of practice management.

Background to Broadway Medical Practice

The practice is located in Springwell Health Centre, Sunderland and provides primary medical care services to patients living in Springwell and the surrounding areas of the City of Sunderland. The practice provides services from the following address and this is where we carried out the inspection:

Springwell Health Centre, Springwell Road, Sunderland, SR3 4HG.

The practice is based on the ground floor and shares the premises with another GP practice and other healthcare professionals. It offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access. The practice provides services to around 5,600 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has four GPs (three male, one female) in total; three GP partners and one salaried GP. The practice is a training practice, with one attached GP Registrar (a fully qualified doctor, allocated to the practice as part of their three year specialist training) and one F2 foundation doctor (a fully qualified doctor allocated to the practice as part of a two-year, general postgraduate medical training programme).There is also two practice nurses, a practice manager, an assistant practice manager and five staff who carry out reception and administrative duties.

Information taken from Public Health England placed the area in which the practice was located in the third more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile showed a slightly higher percentage of older patients than the national averages.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Nestor Primecare Services Limited t/a Primecare Primary Care – Sunderland (known locally as Primecare).

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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

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

Detailed findings

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

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

Before visiting, we reviewed a range of information that we hold about the practice. This did not highlight any areas for follow-up, other than the compliance action we set at our last inspection in September 2014. We checked to see if the provider had made the improvements required as part of this inspection. The provider had made the required improvements. We also asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 21 April 2015. We visited the practice's surgery in Springwell, Sunderland. We spoke with 12 patients and a range of staff from the practice. We spoke with the practice manager, assistant practice manager, three GPs, two practice nurses, the GP registrar and some of the practice's administrative and support staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 48 CQC comment cards where patients from the practice had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe Track Record

As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. For example, an incident had been recorded where a mistake had been made with a patient's repeat prescription. This was discussed with those directly involved and at a practice meeting. As a result it was agreed measures would be put in place to manage and minimise the risk of this incident occurring again.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed Care Quality Commission (CQC) comment cards reflected this.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records were kept of significant events that had occurred. The practice operated two separate systems; one for 'GP incidents' and one for 'other incidents', which included administrative and prescribing incidents.

Before the inspection, we asked the practice to provide us with a summary of their significant events from the last 12 months. We were provided with a summary of three events, which appeared to be fewer than expected for a practice of this size. We spoke with GPs and the practice manager about this and were told this was not a true representation of significant events within the practice. We were shown some additional records of significant events and minutes of meetings where these were routinely discussed. The practice were unable to provide an explanation of this discrepancy. We were unable to establish the total number of significant events (GP incidents and other incidents combined) during the last 12 months.

Significant events were discussed at practice and clinical sub-group meetings attended by GPs, nurses and others who were involved. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. If events required escalation externally, this was done. For example, we saw the practice informed the local Clinical Commissions Group (CCG) . Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events and said they felt encouraged to do so. The practice's GPs also met informally on a daily basis where significant events, matters of safety and other clinical matters were regularly discussed and escalated if there was a need to do so.

We saw incident forms were available to staff on the practice intranet and as blank hard copies. Once completed these were sent to the practice manager who managed and monitored them. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were received into the practice electronically by the practice manager. The alerts were reviewed and sent to the appropriate staff for their attention. Staff we spoke with were aware of these systems and were able to give examples of recent alerts relevant to the care they were responsible for. Staff said alerts were also discussed at meetings to ensure they were aware of any relevant to their area of work and where action needed to be taken. We were told that a central log of all alerts received in to the practice was not maintained, however we saw lots of evidence that alerts received had been acted upon.

Reliable safety systems and processes including safeguarding

The practice had systems in place to record, manage and review risks to vulnerable children and vulnerable adults. Staff we spoke with were aware of their roles and

responsibilities in relation to safeguarding vulnerable people and were able to tell us how they would respond to a potential safeguarding concern and how they would contact the relevant local authority safeguarding team.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children. Staff had completed safeguarding children training to a level appropriate to their role (level 3 for the GP's, level 2 for the practice nurses and practice manger and level 1 for all other staff). The staff training records we reviewed showed that only the practice manager and one of the practice nurses had attended safeguarding adult training.

A chaperone policy was in place and information about this was displayed in the reception area. The patients we spoke to told us that they knew they could request a chaperone if they needed to but had not chosen to use this service. At the previous inspection in September 2014 we found that non-clinical staff involved with the chaperoning of patients had not had been the subject of a Disclosure and Barring Service (DBS) check. This is a check to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. DBS checks had now been completed for these staff, as required.

Staff were aware of and easily able to access the practice's policies and procedures. This helped to ensure that, when required, all staff could access the guidance needed to help meet patients' needs and keep them safe from harm.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines Management

We found medicines management policies were in place and staff we spoke with were familiar with them and their responsibilities in relation to this. Medicines used by the practice were stored securely and access was restricted to relevant staff members.

Medicines were regularly checked to ensure they were in date and safe to use and this included medicines kept by the GPs in their emergency bags. At the previous inspection in September 2014 we had found the checking of medicines within the GPs bags was not consistent across the practice. An effective system had been implemented in response to ensure that GP bags were checked regularly by the practice manager.

Arrangements were in place to check the storage of medicines requiring refrigeration and records were kept to show that refrigerator temperatures and medicine expiry dates were checked regularly.

A system was also in place to record and check emergency medication held on site. We identified that the practice did not keep a stock of Atropine but were told that this was because there was an on-site pharmacy as well as the practices close proximity to the local hospital (Atropine is used in general practice as an emergency medicine to reverse the effects of some medicines and poisons).

A lead officer had been identified to manage patient safety alerts and had implemented an effective audit system to identify patients who could be affected. A note would be placed on the patients' record and the relevant clinician would be informed and take the necessary action. Evidence of this system working effectively was seen.

Patients were able to order repeat prescriptions in a variety of ways including via the pharmacy, by post or on-line. The practice web site provided patients with helpful advice about ordering repeat prescriptions. Staff knew the process they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what steps to take when the authorised number of repeat prescriptions was reached. The repeat prescription process was also used as an additional measure to ensure patients with long term conditions were invited into the practice for health checks. This was done by attaching a health check invite letter to the prescription form.

The practice had appropriate systems in place for the receipt, recording and storage of blank prescription forms. Staff were able to show us an inventory which recorded prescription serial numbers and usage as well as the locked room where they were stored.

We saw records that noted the actions taken in response to reviews of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and opiate prescribing within the practice. The practice were the third lowest

weighted prescribers of antibiotics in the locality and were generally rated in the top third in all areas of prescribing. Their prescribing patterns were broadly in line with current guidelines and local initiatives.

Cleanliness & Infection Control

The premises were clean and hygienic throughout and patients we spoke with told us that the practice was always clean and tidy. An infection control policy and various procedures were in place which included the safe disposal of sharps (needles and blades) and use of spillage kits (this is a specialist kit to clear spillages of blood or any other bodily fluid).

The practice had a designated infection control lead that was responsible for providing training and guidance to other practice staff on issues such as hand washing and dealing with patients' specimens. A sample of staff training records we looked at confirmed this. The infection control lead was also responsible for ensuring staff were offered Hepatitis B and Influenza vaccinations if required.

The clinical rooms we checked contained personal protective equipment such as latex gloves and there were privacy curtains and paper covers for the consultation couches. Arrangements were in place to ensure the curtains were regularly cleaned and replaced. Where sharps bins were contained within consultation rooms these where appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antibacterial gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Appropriate arrangements had been made to ensure the safe handling and disposal of clinical waste and clinical waste bins contained correctly coloured bin liners.

Up to date cleaning and calibration schedules for medical equipment such as the Spirometer (a device to measure the volume of air inhaled and expired by the lungs to diagnose lung conditions) were seen.

We were told by the practice manager that the premises were owned by NHS Property Services who retained responsibility for the supply, maintenance and cleaning of all fixtures and fittings. A cleaning schedule was displayed in the practice and evidence was seen that any problem with cleanliness was escalated appropriately to the landlord. Cleaning of the consultation couches was not the responsibility of the landlord; however we were informed by the practice manager that each clinician was responsible for cleaning the couch in their room. The practice manager showed us some examples of an 'infection control inspection checklist' that was completed on a regular basis for each of the consulting and treatment rooms.

NHS Property Services had responsibility for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We received assurances from them and the practice that they were carrying out regular checks in line with this to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and NHS Property Services had responsibility for ensuring this was completed in a timely manner. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. When equipment broke, the practice raised a request for an engineer to attend.

All portable electrical equipment had been tested, with the next set of testing booked to be completed on 25 April 2015. The practice manager said NHS Property Services completed the portable appliance testing (PAT).

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with an appropriate professional body and criminal record checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards they followed when recruiting staff. At the previous inspection in September 2014 we found no routine checking of the practice nurse's professional registration statuses was done after the original pre-employment checking process. We saw records to confirm this was now being completed.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for

members of staff to cover each other's annual leave. The practice had not used locum GPs for eight years, which had helped to provide greater continuity of care for their patients. When GPs took annual leave, their regular sessions were covered by other GPs from within the practice.

Staff told us there was enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was on display within the practice.

Identified risks had been recorded and each risk was assessed with mitigating actions noted to manage the risk. We saw where risks had been identified; action plans had been drawn up to reduce these risks. For example, each of the consultation and treatment rooms within the practice had been risk assessed for hazards, along with the reception and public waiting area.

Staff were able to identify and respond to changing risks to patients, including deteriorating health and medical emergencies. For example, staff who worked in the practice were trained in cardiopulmonary resuscitation (CPR) and basic life support skills.

GPs we spoke with said the practice was well-placed to be able to deal with sudden changes in demand for its services. GPs operated relatively short surgeries, which meant they had capacity to see patients at short notice. The practice operated a same day service and walk-in clinics for acutely unwell patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. The defibrillator was shared between the two GP practices and community based nursing staff based there and was kept in the central reception area of the building. NHS Property Services were responsible for the maintenance of the defibrillator and weekly checks of the oxygen were completed by the community based nursing staff. All the staff we asked knew the location of this equipment.

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

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure and loss of access to the building. It also included a detailed list of contacts, for example the GP partners and the owners of the premises. The practice manager kept a copy of the document off site and a hard copy was also kept in the admin office area.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, a GP we spoke with told us about action the practice had taken in response to a recent medicine alert. They said the practice had taken a proactive approach to reducing risks to their patients by discussing the matter with the local chemist on site. They agreed to co-ordinate their monitoring of the practice's prescribing level of a particular medicine with a view to reducing the amount dispensed. . We saw an audit on the practice's electronic systems which had been completed in response to the new guidelines. This showed that only 1% of patients who were indicated for this medicine were now being prescribed it.

GPs and nurses led in specialist clinical areas such as asthma and diabetes. GP leads had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. Nursing leads were jointly responsible with GPs for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. Each chronic disease or long term condition also had a dedicated administrative lead. They were responsible for the timely recall of patients to have their conditions reviewed.

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who completed CQC comment cards.

Clinical staff we spoke with said they would not hesitate to ask for or provide colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

All staff from across the practice were actively engaged in the monitoring and improvement of outcomes for patients. These included data input, clinical review scheduling and medicines management. The information staff entered and collected was then used by the practice staff to support the practice to carry out clinical audits and other monitoring activity.

The practice was proactive in the management, monitoring and improving of outcomes for patients. For example, they used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice had achieved 99% of the points available in 2013/14, which included all of the points available for asthma and epilepsy.. The staff we spoke with were able to show us the robust systems they had in place to manage the recall of their patients effectively, which was reflected in the practice's QOF performance.

Clinical audits and audit activity was well established within the practice. They were able to show us some clinical audits that had been completed. We looked at two examples of clinical audits that had been completed recently. The audits included repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. For example, the practice had completed and audit on the prescribing of medicines for the treatment of patients living with type two diabetes. The aim of the audit was to ensure the practice was following NICE guidelines and to identify where any such prescribing could be improved. The first audit demonstrated that 77% of the patients identified met the stated criteria as per the guidance. The second cycle of the clinical audit demonstrated that 100% of the patients originally identified now met the stated criteria.

Good

Are services effective?

(for example, treatment is effective)

Examples of other clinical audits included the follow up of chest x-rays, a contraceptive implant audit and an audit on medicines known as Proton Pump Inhibitors (PPI's) and their prescribing in line with nationally recognised guidance. We saw an audit that was in progress, with one audit cycle completed and the second cycle planned for July 2015. The aim of this audit was to evaluate if urine dipsticks and / or cultures were being used appropriately in the diagnosis and treatment of uncomplicated urinary tract infections (UTI) in women under the age of 65. The initial audit had identified some areas for improvement and had been presented to the GPs by the GP Registrar leading the audit.

A range of non-clinical audit activity was also embedded within the practice. We were shown a number of examples, including one on a type of needle as a result of new guidance received, one on MMR vaccination catch-up's and one on the number of did not attend (DNA) appointments within the practice. We saw each of these audits had been through at least two completed cycles in order to identify the improvements achieved since the original audits.

The practice had a number of improvement plans in place. For example, the practice participated in the medicines optimisation local incentive scheme. We saw a range of comprehensive medicines optimisation audits had been completed with the input of the attached practice pharmacist. Areas of prescribing reviewed included antibiotic usage, opiates management and the prescribing of laxatives. We saw records to show that all of the practice's patients who had been prescribed simvastatin had been switched to atorvastatin. Statins are a group of medicines that can help lower the level of cholesterol in the blood, with current guidance suggesting atorvastatin to be the statin of choice. The practice were generally rated in the top third in all areas of prescribing within the locality.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records with the practice manager. We found comprehensive records of training completed by staff were maintained. All staff were up to date with attending mandatory courses such as cardiopulmonary resuscitation (CPR), fire safety and information governance. 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 NHS England can the GP continue to practise and remain on the performers list.)

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw records in staff files of appraisals completed within the last 12 months. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were pro-actively supported to acquire new skills. Staff we spoke with said the practice was supportive in providing training and funding for relevant courses. For example, nurses were encouraged to attend training events and GPs were allocated time for continuing professional development (CPD) as part of their timetable. One of the practice nurses we spoke with said the practice had supported and funded them to complete a diploma in the clinical field of Chronic Obstructive Pulmonary Disease (COPD).

Nursing staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, they were trained to administer vaccines and immunisations and carry out reviews of patients with long-term conditions such as asthma and diabetes.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex health conditions. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received 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 promptly and efficiently. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Good

Are services effective?

(for example, treatment is effective)

GPs and nurses told us they worked well together as a team. For example, on the management of patients with chronic diseases and long term conditions, as well as on the sharing of daily administrative tasks such as the reviewing of test results by the GP on call that day.

The practice held multidisciplinary team (MDT) meetings on a weekly basis to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by a range of healthcare professionals, including district nurses, community matrons and Macmillan nurses. Decisions about care planning were recorded. The practice's GPs attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information. A 'traffic light system' was used for palliative care patients to indicate those that required more intense input from the clinical team. These patients were reviewed and discussed at the MDT meetings.

Staff from the practice had played leading roles in the development and introduction of the Extended Access Scheme in operation within the West locality in Sunderland since November 2014. One of the GPs and the practice manager were part of the steering group, which had led and helped to implement record sharing agreements and mobilised shared access across 15 practices in the locality. The GP had canvassed practices within the locality to support the scheme, demonstrating clinical leadership and encouragement to the practices. The scheme had enabled patients to be booked directly into Grindon Lane Primary Care Centre to be seen by a local GP who had access to their records in a timely and efficient manner. Patients from the participating practices could book appointments to see a GP from 6pm to 8pm Monday to Friday and at weekends between the hours of 10am and 2pm. The scheme had been resourced by the Clinical Commissioning Group (CCG), initially as part of a winter pressures initiative, but it was now funded throughout the year.

The practice were also part of the recently established Vanguard site set up within Sunderland, one of 29 across the country. Each vanguard site will take a lead on the development of new care models. This would mean, for example, that elderly patients would be encouraged to recover in their own homes, as opposed to staying in hospital. The intention was that patients would receive person-centred, co-ordinated care, and would have more input into the care that they received.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, for example, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

Systems to manage and share the information that was needed to deliver effective care were co-ordinated across services and supported integrated care. For example, the practise of gaining consent from patients who attended the extended access service had been considered and acted upon. Information sharing agreements between the 15 practices involved were in place and an assumed consent policy in line with direct care was in place. However in addition to this, prompts had been built into the extended access service's electronic systems to ensure that consent was still sought from the patient to view their records at their appointment.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Good

Are services effective?

(for example, treatment is effective)

All of the practice staff had completed dementia friends training in December 2014. They told us this had helped them to understand how they could help people living with this condition more effectively.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. GPs we spoke with gave examples of how some patient's best interests had been taken into account when they had not had the capacity to make a decision.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. These were completed by the GP and nursing staff employed by the practice. All new patients were asked to complete a practice questionnaire and to have an appointment with a GP and a practice nurse. The GP completed the 'new patient interview' and the practice nurse completed the 'new patient health check', including for the management of long term conditions. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, patients with long term conditions would be added to the appropriate registers.

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 (2013/14) for immunisations was in line with or slightly above averages for the local Clinical Commissioning Group (CCG). For example, MMR vaccination rates for two year old children were 98.3% compared to 96.6% across the CCG; and MMR dose 2 rates for five year old children were 96.2% compared to 94.5% across the CCG.

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's administrative staff were responsible for this process and used index card systems to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked and was reflected by the practice's QOF performance. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was similar to with national average at 80.1% (the national average was 81.9%).

Staff were consistent in supporting people to live healthier lives through a targeted and pro-active approach to health promotion and prevention of ill health, and every contact with patients was used to do so. The practice took a pro-active approach to providing their patients with information about medicines they had been prescribed. For example, the practice had produced an information leaflet for patients to explain that their medicine was now classed as a 'controlled drug' (medicines that require extra checks and special storage arrangements because of their potential for misuse). All patients who took this medicine had been provided with this leaflet to help them understand how this change affected them.

A GP we spoke with told us it had been identified that acute kidney injury admissions were rising. In response they had enacted the practice to produce leaflets to explain to patients how to minimise the risk of acute kidney injuries. The practice now issued this leaflet to all patients attending appointments for the management of chronic diseases and when patients started taking high risk medicines. This initiative had been introduced within the last three weeks and was still being piloted.

There was a range of information on display within the practice reception and waiting area. This included a number of health promotion and prevention leaflets, for example on cancer, self-care, alcohol awareness and mental health support services. The practice's website included links to a range of patient information, including for smoking cessation, weight management and sexual health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards mostly reflected this. Of the 48 CQC comment cards completed, 34 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included caring, helpful, fantastic, great people, respectful, efficient, welcoming, polite and thoughtful. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

The reception area fronted directly onto the patient waiting area. We saw staff who worked in these areas made efforts to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients and other healthcare professionals were taken by administrative staff in an area where confidentiality could be maintained.

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. Staff we spoke with said a spare room or private area was made available for patients to use if they wanted to speak about matters in private. This reduced the risk of personal conversations being overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Staff had completed information governance training.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 82% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care. This was higher than the local Clinical Commissioning Group (CCG) area (78%) and national (75%) averages. 63% said the last nurse they saw or spoke to involved them in decisions about their care. This was lower than the local CCG (75%) and national (66%) averages. When we reviewed the results of the nurse-based questions, the patient satisfaction levels appeared to be well below the results for the same GP-based questions. Further investigation revealed at least 12% of the respondents answered 'doesn't apply' to each of the nurse-related questions, which should be taken into consideration when reading these results.

The majority of the most recently published National GP Patient Survey results for the practice were a little above the local CCG area and national averages. For example, 89% of respondents said the last GP they saw or spoke to was good at listening to them and 77% of respondents reported the same for the last nurse they saw or spoke to. The CCG averages were 89% and 85%, with the national averages being 87% and 79% respectively. The practice had also scored well in terms of patients feeling they had confidence and trust in the last GP (92% of respondents) or nurse (78%) they saw or spoke to. This compared to the CCG averages of 94% and 90%, with the national averages being 92% and 86% respectively.

Feedback from patients we spoke with reflected the results from the latest National GP Patient Survey. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff and felt they had sufficient time during

Good

Are services caring?

consultations to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

The practice had identified its most at risk and vulnerable patients. They had signed up to the enhanced service for 'Avoiding Unplanned Hospital Admissions' and were completing the work associated with this service. Enhanced Services are services which require an enhanced level of service provision beyond their contractual obligations, for which they receive additional payments. A number of patients had been identified as being at high risk of hospital admission. The practice had contacted these patients and with their involvement and agreement, had put agreed plans of care in place. For example, plans that had been put into place for a number of at risk patients were described to us by the GPs we spoke with. The practice manager said 90 patients were currently part of this enhanced service.

Staff told us that translation services were available for patients who did not have English as a first language. We also saw that support was available for patients with hearing difficulties.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring and supportive.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice website included information to support its patients. For example, information was provided for patients who had caring responsibilities or those who were cared for by a family member or friend. The practice maintained a carer's register and had established good links with voluntary organisations. They had recently invited the carer's association into the practice to deliver a talk to staff about caring for carers. Patients who registered with the practice were asked if they had any caring responsibilities. The practice had also established links with local alcohol support charity services, in addition to its commissioned services for alcohol management.

Support was provided to patients during times of bereavement. The practice offered patients and their family's details of bereavement services upon request, with information displayed on notice boards in the patient waiting area. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times. Support was tailored to the needs of individuals, with consideration given to their preference at all times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

The involvement of other organisations was integral to how services were planned and delivered and ensured that services met patients' needs. The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. There were many examples of engagement, including with the CCG and other practices on the extended access scheme, with the CCG for the medicines optimisation local incentive scheme and with secondary care providers.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff we spoke with said patients were encouraged to see the same GP which enabled good continuity of care. This included patients who had been seen by one of the doctors placed at the practice as part of their training.

Patients could access appointments face-to-face in the practice, receive a telephone consultation or be visited at home. Patients' individual needs and preferences were central to the planning and delivery of services. Longer appointments were available for patients on request and were routinely offered to patients who required them. For example, to older patients, those with chronic co-morbidity and also to patients who had difficulty accessing the surgery due to complicated domestic circumstances. For patients experiencing poor mental health, the practice made every effort to accommodate their needs. For example, patients with severe anxiety were seen out of usual surgery hours to facilitate them being seen. The practice also made proactive use of short review dates for patients prescribed antidepressants to ensure they were seen regularly.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had an active patient participation group (PPG) and met with them on a bi-monthly basis. We spoke with one member of the group ahead of the inspection. They said the group was quite small, however they were actively looking to expands its membership beyond the current level of five patients. They said feedback from the group was well received by the practice and a number of changes had been made which they had been involved with and consulted on. For example, input had been sought from the PPG on the extended access scheme now in operation and they were currently engaged in discussions with the practice about the provision of an electronic announcement screen. The request for a screen had come from the patient group after feedback from some of the practice's patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide early evening appointments one day a week at the practice with a GP or nurse. The practice was also part of the local extended access scheme which meant patients could book an evening or weekend appointment to see a GP at Grindon Lane Primary Care Centre. This helped to improve access for those patients who worked full time. The practice also had access to translation services if required, for those patients whose first language was not English. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground floor and all services for patients were provided from there. The main entrance doors had been automated to improve access and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. The reception desk had an area where the counter had been lowered to enable patients who used wheelchairs to speak face to face with the reception staff. We saw that the waiting area had space to accommodate

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. The patient toilets could be accessed by patients with disabilities. Dedicated car parking was provided for patients with disabilities in the car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

Access to the service

Most of the patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they were satisfied with the appointment systems operated by the practice. Comments included if you tell them your problem you get an appointment straight away; appointments are at suitable times; I can get an appointment when it suits me as I am working, and you can get an appointment usually when you require. A small number of the patients (four out of 48) who filled in CQC comment cards were not as satisfied. They made comments such as quite hard to get an appointment for two weeks in advance as the computers don't go past two weeks, and sometimes issues with getting an appointment quickly. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent, including some on the day we inspected.

The latest results from the National GP Patient Survey published in January 2015 were positive in terms of patient's feedback regarding appointments. 90% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. This was above both the local Clinical Commissioning Group (85%) and national (85%) averages. The practice had also achieved better than local and national average results from patients on their ease of getting through on the phone and satisfaction with the practice's opening hours. 83% of respondents said they found it easy to get through on the phone (compared to the CCG average 79%, national average 72%) and 84% said they were satisfied with the practice's opening hours (compared to the CCG average 81%, national average 76%).

We looked at the practice's appointments system in real-time at 11.50am on the day of the inspection. At that time, appointments were still available to be booked with a GP or nurse that day. Routine appointments to see a GP were available to be booked the next day. From 12 noon onwards, the practice was also able to offer patients the facility to book an appointment with a GP between 6pm and 8pm that day as part of the enhanced access scheme. Later in the day we saw patients had made use of this service.

Patients could access appointments and services in a way and at a time that suited them. The practice was open from 8.30am to 6.00pm Monday to Friday and stayed open later until 8pm on a Tuesday. The practice's extended opening hours on Tuesday's were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who normally worked during the week. In addition, patients could pre-book appointments with a GP between 6pm and 8pm Monday to Friday and between 10am and 2pm at weekends due to the extended hour's scheme. From the start of the service in November 2014 until the day before this inspection, the practice had made appointments for 163 of its patients at the extended hour's scheme. This had helped to enable patients who worked during normal surgery hours to have same day access to a GP.

Longer appointments were available for patients who needed them. This included appointments with a GP or nurse. Home visits were made to those patients who were unable to attend the practice.

Information was available to patients about appointments on the practice website. The practice offered the facility for patients to book appointments with GPs online, once patients had registered for this service. Information on how to arrange home visits was provided for patients on the website.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The service for patients requiring urgent medical attention out-of-hours was provided through the 111 service and Nestor Primecare Services Limited t/a Primecare Primary Care – Sunderland (referred to locally as Primecare).

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in

Good

Are services responsive to people's needs?

(for example, to feedback?)

England and there was a designated responsible person who handled all complaints in the practice. Information about services and how to complain was available and easy to understand.

We saw the practice had received three complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

None of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 48 CQC comment cards completed by patients indicated they had raised a complaint with the practice.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice's aims and objectives were to provide its patients with the excellent, high quality care and to provide this safely. This was reflected in the practice's statement of purpose, along with a number of other aims including to treat patients as individuals and with respect and dignity to work with other NHS organisations and colleges to provide the best care for their patients. One of the GP partners said an emphasis was being placed on implementing integrated care hubs within the locality in order to help facilitate seamless care.

We spoke with a variety of practice staff including the practice manager, GPs, practice nurses and some of the practice's administrative and support staff. They all knew and shared the practice's aims and objectives and knew what their responsibilities were in relation to these. Staff we spoke with talked about working towards the same aim – making sure patients got the best care possible at all times.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Hard copies were also kept for staff to refer to. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies (for example the practice's recruitment procedures) which were in place to support staff. All of the policies and procedures we looked at had been reviewed regularly and were up to date. Our discussions with staff demonstrated they had read and understood these and staff told us they had all been involved with the creation of the staff handbook. Staff knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, reminders were routinely sent to patients if they failed to respond to requests to attend the practice for reviews of their long-term conditions.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The clinical audits completed measured whether agreed standards had been achieved and made recommendations and took action where standards were not being met. GPs we spoke with said the results of completed audits were presented to and discussed with their colleagues at meetings.

Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a range of potential issues. We saw that risks were regularly discussed at practice meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place. For example, each of the consultation and treatment rooms within the practice had been risk assessed for hazards. The practice monitored risks on an on-going basis to identify any areas that needed addressing.

The practice held regular meetings for clinical staff, management and the administrative team. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. Each chronic disease or long term condition also had a dedicated administrative lead that was responsible for the timely recall of patients to have their conditions reviewed. We spoke with a range of staff and

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they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We found there were good levels of staff satisfaction. Staff we spoke with were proud of the organisation as a place to work and spoke of the open and honest culture. There were good levels of staff engagement. We saw from minutes that team meetings were held regularly. Staff told us they had the opportunity and were happy to raise issues at team meetings.

The practice carried out proactive succession planning. GPs and the practice manager spoke about the potential retirement of one of the GPs in the near future. The practice had already advertised the position and had had some informal expressions of interest. This showed the practice were thinking ahead in order to maintain the levels of services they would be able to provide in the future.

The practice was a training practice and during the inspection we spoke with the GP Registrar placed there as part of their training. They told us they felt their training experience at the practice was brilliant and added they felt very privileged to have been placed there. They had been allocated a GP as their clinical supervisor who provided them with tutorials, debriefs after surgeries and was their first port of call for any queries they had. During our interview with their GP clinical supervisor, the GP Registrar came to see them with a query. We saw their GP clinical supervisor was very supportive and provided appropriate clinical leadership. This was clearly appreciated by the GP Registrar and was indicative of the leadership, openness and transparency we saw within the practice.

Practice seeks and acts on feedback from users, public and staff

At the previous inspection in September 2014 we issued a compliance action for a breach of regulation. As part of this inspection we checked to see if the provider had taken action to address this. We found the improvements required had been made. In addition to this we identified an area where the provider could improve. We found they had taken action on this matter too, which showed they welcomed constructive challenge from stakeholders and took action in response to improve the services provided.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings, including within their own work areas and wider practice meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved in the practice to improve outcomes for both staff and patients.

The staff we spoke with, including the practice manager and GPs told us forward planning was discussed. We saw plans were in place to develop and improve the services provided. For example, the practice were engaged with the CCG on how their Vanguard site status could help to deliver improvements to the services their patients received locally. Staff said they felt listened to and their opinions were valued and contributed to shaping and improving the service.

The practice had an active patient participation group (PPG). The PPG had a small number of members; however they were looking to increase the size of the group. The PPG met bi-monthly and representatives from the practice always attended to support the group. We spoke with one member of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. For example, the practice were looking into the possibility of installing an electronic message board in the patient waiting area. Patient feedback and survey results were also routinely reviewed at group meetings, including any actions taken by the practice in response.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had. Staff said significant events were handled consistently, which helped to create a culture of dealing positively with circumstances when things went wrong.

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Management lead through learning & improvement

Staff said that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and development opportunities. GPs and the practices nurses we spoke with all said without exception that clinicians at the practice were strongly encouraged to develop their clinical skills. For example one of the practice nurses said the practice had funded them for numerous professional development courses, including diplomas in the clinical areas of COPD and heart failure. This allowed the nurses to provide a wide scope of care for patients with one or more of a number of conditions.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and Clinical Commissioning Group (CCG) meetings. They attended learning events and shared information from these with the GPs and nurses in the practice. One example given was a change in practice for patients with chronic kidney disease that was disseminated to the practice nurses by a GP. Nursing staff we spoke with said they had attended practice nurse forums which provided them with further education and support.

Information and learning was shared verbally between staff and the practice also used their intranet system to store and share information. Learning needs were identified through the appraisal process and staff were supported with their development. For example, one of the administrative team had asked for some formal training relevant to their position and the practice had supported and provided them with that.