Church View Medical Centre

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.

Contents

Overall summary

Church View Medical Centre is a GP practice located in the Silksworth area in the City of Sunderland. The provider of the service is City Hospitals Sunderland NHS Foundation Trust (the trust). It is housed in purpose built premises and has a list of approximately 6,000 patients.

During our inspection we spoke with GPs (two salaried and one locum), the practice manager and deputy practice manager, a nurse practitioner, practice nurse and reception and administration staff.

Summary of findings

We found further improvements were required for safety as some safety concerns were not dealt with quickly. There were not enough GPs to ensure continuity of care to patients.

There were systems in place to identify risks to patients and staff in terms of safeguarding, health and safety, fire and infection control.

Further improvements were needed for the practice to be effective as there were limited audits of patient outcomes to drive improvement. There were no formal arrangements to follow National Guidelines.

All of the patients we spoke with said they were treated with respect and dignity by the practice staff.

Further improvements were needed for the practice to be responsive to people's needs. Patients said they were satisfied with the appointment systems operated by the practice, however, continuity of care suffered because of only one salaried GP being employed there from January 2014. There was an accessible complaints system but the system for dealing with this or learning from complaints was unclear.

Further improvements were needed for the practice to be well-led. There was no clear leadership or lines of accountability. There was no clear vision or strategy for the practice to move forward. Policies and procedures were not specific to the practice.

The practice was in breach of the Regulation 10 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to assessing and monitoring the quality of service and in breach of Regulation 22 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to staffing.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found some aspects of the service were safe. Safeguarding vulnerable adults and children was seen as a priority and systems were in place. There were systems and processes in place to identify risks to patients and staff in terms of health and safety, fire and infection control. However, some safety concerns were not dealt with quickly, such as patient safety alerts. There was evidence that learning from significant events was limited and investigations not robust.

Are services effective?

We found some aspects of the service were effective. We were told that National Guidelines were considered, however, there was no formal method or practice approach to this being carried out. There were limited completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance for patient outcomes.

Are services caring?

The service was caring. Patients said staff were caring and responsive to their needs and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

We found some aspects of the service were responsive. Patients reported good access to the practice, with urgent appointments available the same day, however, continuity of care suffered because of only one salaried GP being employed there from January 2014. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system but the system for dealing with this or learning from complaints was unclear.

Are services well-led?

Some aspects of the service was well-led. The practice did not have a clear vision and strategy. There was no clear leadership structure or accountability and staff did not feel supported by the trust. The practice had a number of policies and procedures to govern activity; however these were produced by the trust and were not specific to the practice. The practice did not hold regular governance meetings

Summary of findings

and issues were discussed at ad-hoc meetings. There were not enough established GPs to provide continuity of care and recruitment had not been dealt with quickly. The practice had proactively sought feedback from patients.	

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
There were arrangements in place to identify vulnerable and frail older people at risk of abuse. The established GP was the named GP for those aged 75 and over. The practice told us that they recognised this group of people as important and they particularly cited their support to carers as a strong example of their approach to this group. The practice had strong links to the local carer's centre.

The practice held palliative care meetings which were attended by district nurses and community matrons.

People with long-term conditions
Patients with long term conditions were reviewed every twelve months with a co-ordinated approach to multiple long term conditions. The nurse practitioner and practice nurse were the care co-ordinators for this. There were arrangements in place for repeat prescriptions to help people manage their own long term conditions. Staff were alerted if a patient was overdue a medication review and asked to make an appointment with the GP.

Mothers, babies, children and young people
There were arrangements in place to safeguard children and young people. There were systems in place to monitor the uptake of childhood immunisations. Missed appointments were followed up by a letter after the second did not attend appointment. Expectant mothers and babies had medical support from midwives and health visitors, delivered in conjunction with the practice and there was a weekly ante natal clinic.

There was a confidential service provided for those under 16. Chlamydia screening was available for patients between 16-24 years of age.

The working-age population and those recently retired
The surgery opened at 8am and closed at 6pm five days a week. This increased the likelihood of patients who worked (and those recently retired) being able to see a clinician when they needed to do so. Patients told us they could access appointments easily which would assist working age patients. The practice felt they gave excellent access to patients.

Summary of findings

Health checks were offered for the over 40s. Health promotional material was made easily accessible to people of working age through the practice's website and in the waiting area.	
People in vulnerable circumstances who may have poor access to primary care The practice had systems in place to identify patients, families and children who were at risk or vulnerable within this population group. The practice had a learning disabilities register which meant staff could plan or offer additional support as needed.	
People experiencing poor mental health Referrals to the mental health team were via a GP referral. Patients experiencing poor mental health were offered an annual health check. Newly diagnosed patients with poor mental health were given blood tests. There was a process for referral to counselling. There were arrangements in place to seek consent. Staff we spoke with understood the mental capacity act.	

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection. We also received feedback from two patients at a listening event we held where patients and members of the public shared their views and experiences of the service. We spoke with three members of the patient participation group (PPG). Overall patients found the staff friendly. They felt they could get an appointment to see a GP easily.

Three people specifically thought that the service had declined in recent years and they would not recommend the practice to friends. There were common themes in feedback from patients. There was a long wait to see a GP once you obtained an appointment, as appointments overrun, although the GPs always had time for patients in their appointment and patients didn't feel rushed. Four patients told us they found the music in the reception area was annoying. Three patients we spoke with said they did not feel they could always obtain an appointment with a female GP, if necessary; this was dependent upon which locum GPs were working. The most common theme from almost all patients was that they could not see the same GP as there was always a new or locum GP which meant they could not build up a trusting relationship with their doctor.

Areas for improvement

Action the service MUST take to improve

The practice must improve it's overall leadership structure. There were insufficient systems in place to monitor the quality of service given to patients and there was inadequate support given to staff from the trust.

The practice must review staffing levels to ensure continuity of care to patients.

The practice must improve its management and learning from significant events which occur in the practice.

The practice must review its complaints policy to make it in line with recognised guidance.

Action the service SHOULD take to improve

The practice should improve the secure handling and stock control of blank prescription pads. The practice had not implemented the processes documented in the security of prescriptions guidance, issued by NHS protect.

Church View Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP Specialist Advisor. The team included a CQC Pharmacist Inspector, a Practice Manager Specialist Advisor and an Expert by Experience.

Background to Church View Medical Centre

Church View Medical Centre located in the Silksworth area in the City of Sunderland. The provider of the service is City Hospitals Sunderland NHS Foundation Trust. It is housed in purpose built premises and has a list of approximately 6,000 patients. The practice provides services from only one address at Silksworth Terrace, Sunderland.

The practice offers on-site parking and disabled parking. The practice is open between 8am and 6pm each weekday and is registered for two regulated activities treatment of disease disorder or injury and family planning. There are two salaried GPs at the service, a practice and assistant practice manager, three practice nurses and one nurse practitioner, three healthcare assistants and reception staff.

The practice provides a range of services including a child health clinic, antenatal clinic, asthma, chronic obstructive pulmonary clinic, flu and pneumonia clinic, shingles, minor surgery, diabetic clinic, heart disease clinic, women's health service, sexual health services & contraception, travel vaccinations & advice and NHS health checks.

The service for patients requiring urgent medical attention out of hours is provided by NHS 111 telephone service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before the inspection we looked at a wide range of information we held about the service and information the practice sent to us. We asked other organisations such as the local Clinical Commissioning Group (CCG) to share with

Detailed findings

us what they knew about the practice. We held a listening event where members of the public could tell us about their experiences of GP services within Sunderland. We spoke with representatives from the PPG and patients attending for appointments during the inspection.

We carried out an announced visit on 16 September 2014.

During our visit we spoke with a range of staff including GPs, practice nurses, administration and reception staff and the practice manager. We spoke with seven patients who used the service. We also spoke with three members of the PPG before our inspection.

We observed how people were being cared for in communal areas and talked with carers and/or family members. We held a listening event where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

There were policies and protocols in place for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff.

The practice used a system called Datix for the reporting of serious incidents/events, which went to the provider, City Hospitals Sunderland NHS Foundation Trust (the trust) and also the practice manager.

We were told by the practice manager that it was the individual staff member's responsibility to report serious incidents to her, staff we spoke with confirmed this.

Learning and improvement from safety incidents

The practice's approach to reporting, recording and monitoring significant events was unclear. There was a policy for the recording of serious events which was the trust's and it was not practice specific. Significant events were reported to the trust via a system called Datix but we were told there was no feedback from the trust to the practice in relation to the reported incidents. There was no individual staff member who was responsible for the process of learning and improvement from safety incidents at the practice and no policy to set out how lessons were learned from them.

We were told that significant events were discussed within the practice at team meetings and annually where there was a review of the whole year's events. We looked at the significant event file and confirmed recorded significant events had been reported and only reviewed at an annual meeting. The last team meeting was documented as April 2014 (date of the visit was 16 September 2014). Learning from significant event was therefore not shared regularly with the practice team.

We saw some serious incidents, which had been reported, were on a piece of paper with rough notes and the reporting person's name on it, a proforma was attached but uncompleted. The practice manager told us these had not yet been dealt with or discussed, these incidents were a few months old. There was a risk of significant events not being dealt with in a timely manner.

We found the practice had inappropriate systems in place to manage patient safety alerts. We looked at five alerts and saw the practice could not demonstrate they had been actioned. The alerts had been circulated to staff but staff had not indicated the alert had been seen. The salaried GP appeared to be the only GP who indicated that they were receiving these alerts There were no records of circulation to locum staff.

We saw one example of where a safety alert was handled effectively. The practice pharmacist had identified patients receiving medication which needed to be reviewed following a safety alert. The patients were called in for review and treatment stopped and the reasons recorded.

Reliable safety systems and processes including safeguarding

We spoke with staff and they could demonstrate their understanding in terms of safeguarding vulnerable patients. New staff received safeguarding training as part of their induction which then became part of their annual mandatory training. This was confirmed when we looked at training records. One of the salaried GPs was the safeguarding lead for the practice who was level three trained in both safeguarding adults and children. We were told staff attended local safeguarding meetings as needed and alerts were placed on patients electronic records to inform staff of any safeguarding issues for patients who attended the practice.

There was a notice in the waiting room which advised patients they could request a chaperone if needed.

Monitoring Safety & Responding to Risk

The practice manager and assistant practice manager explained that they maintained the appointment system and ensured there were enough appointments and staff available to offer the correct number of appointments needed. For example, reception staff regularly updated them on demand and additional appointments added after bank holidays when the surgery was busier. The practice nurse and practice manager met regularly to review nursing appointments

We found that the practice ensured that the clinical staff received annual cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis shock. Staff trained to use the defibrillator received regular update training to ensure they remained competent in its use.

Are services safe?

Staff had access to a defibrillator for use in a medical emergency. All of the staff we spoke with knew how to react in urgent or emergency situations. We also found the practice had a supply of medicines for use in the event of an emergency.

Medicines Management

We found that there were appropriate arrangements in place to manage medicines.

The practice had in place a system for managing national alerts about medicines such as safety issues. We checked on one medicine alert received in May 2014 and saw that prompt action had been taken to review all the patients receiving this medicine to make sure that it was safe and appropriate to continue treatment. However, there was not a clear audit trail documenting action that had been taken and by whom for each alert received.

Arrangements were in place to manage repeat prescribing safely. Reception staff described a process whereby staff alerted the patient to an overdue medication review and asked them to make an appointment with the GP. Regular review makes sure that prescribing of medicines remains up to date, relevant and safe.

We looked at the prescribing of some high risk medicines and saw that scheduled blood monitoring tests were carried out before further prescriptions for these medicines were issued. There was a robust system in place to manage any medicine changes for patients discharged from hospital, or seen by external healthcare professionals.

Medicines were kept safely and well managed. Medicines and oxygen for emergency use were readily accessible and were checked regularly to make sure they remained safe to use. Checks were in place to make sure that refrigerated medicines such as vaccines were stored at the correct temperature. There were arrangements in place to maintain the cold chain when vaccines were taken to care homes as part of the flu vaccination programme.

Blank prescription forms were stored securely by the practice. Clear and unambiguous records documenting the receipt of prescription forms and the distribution of forms to authorised prescribers was not maintained. For example the name of the person issuing the stock and the serial numbers of the prescription pads were not documented in line with security of prescriptions guidance.

Cleanliness & Infection Control

The policies in place for infection control were trust policies which included hand washing, wound care, safe disposal of sharps and spillages. The practice had a named infection control lead who attended monthly meetings at the trust to discuss changes in policy, updates and review of equipment. Information was then passed on to the staff at the practice at clinical staff meetings. Staff received infection control training on induction and the reception staff received training in hand hygiene.

Infection control audits were carried out every three months. Domestic and clinical waste was collected by a contractor and documentation regarding this was seen. We saw specific spillage kits were available.

Patients we spoke with all thought the surgery was clean. We looked at the general surgery areas, treatment and consultation rooms and found them to be clean and tidy. The material curtains in the treatment rooms were cleaned on a regular basis and there was a schedule available to confirm this.

There were records kept of staff immunisation and hepatitis B status. This helped to identify potential risks and reduce the spread of infections.

Staffing & Recruitment

The practice adhered to the trust's recruitment policy which we were told by staff was robust. However staff told us there was an issue with the time taken in being able to recruit staff quickly when they were needed. We were also told induction dates had to suit the trust rather than the practice.

Recruitment records were held centrally by the trust but we were able to see examples of staff files. Each member of staff had received a Criminal Records Bureau /Disclosure and Barring (CRB/DBS) check, references had been sought and identity checks made. This ensured the person was able to carry out the duties required of their role.

We saw that on each person's staff file, where appropriate, clinical qualifications were recorded and locally checked on an annual basis or on renewal of their professional registration.

Are services safe?

Staff received annual appraisals. Staff told us the process was supportive and they felt very supported by the practice manager and long standing salaried GP. Several members of staff told us they did not feel supported by the provider, City Hospitals Sunderland NHS Foundation Trust.

Dealing with Emergencies

The practice had a continuity plan in place in case of emergencies such as staff shortage or illness, failure of electricity or telephone systems. The protocol set out what needed to be done and who needed to be contacted.

The deputy practice manager was the fire warden. The last fire drill was two weeks prior to our visit and staff all received fire training as part of their basic training. There was a fire risk assessment for the building and maintenance of the fire equipment was carried out by a contactor and records of this were available. There was also a health and safety risk assessment for the premises.

All staff received cardiopulmonary resuscitation (CPR) training and were trained to deal with any medical emergencies. Staff were trained to use the defibrillator and received regular training updates to ensure they remained competent in its use. Emergency drugs were in date and safe to use.

Equipment

All equipment was checked, portable appliance testing (PAT) and calibrated annually. The trust had systems in place to ensure this was carried out.

It was the responsibility of the trust to ensure that maintenance of the building was carried out. Staff felt that this was something which worked well and requests for maintenance were carried out in a timely and effective way.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We were told by the salaried GPs that the National Institute for Clinical Excellence (NICE) guidelines were implemented along with other guidance received but there was no formal method or practice approach to this being carried out. Staff told us they felt there were issues with establishing standards of care and treatment due to the high levels and turnover of locum GPs and there only being one salaried GP in recent months.

The practice manager told us that training in the mental capacity act was due to be delivered to staff. GPs told us informed consent was given by patients and recorded. GPs we spoke with were aware of the mental capacity act and best interest decisions.

We reviewed the most recent Quality and Outcomes Framework (QOF) scores for the practice. Practices are rewarded for the provision of quality care. The practice's overall score for the clinical indicators was higher than the national average.

Management, monitoring and improving outcomes for people

The trust had a protocol for clinical audit. However, we were told there was not a local system in place for completing clinical audit cycles. There was evidence of only one audit which had been carried out and this was instigated by the salaried GP as it was needed for his appraisal purposes. The audit was of patients in atrial fibrillation. There were two completed audit cycles and the audit showed improved outcomes for patients. There was no evidence of any medication audits carried out by the practice pharmacist. There was no programme in place to improve patient outcomes or systems for learning.

Effective Staffing, equipment and facilities

There was no one single person with overall responsibility for the practice or clear lines of responsibility given to staff who worked within it. For example, there were no GP leads for palliative care, clinical governance or those with learning disabilities.

The administrative staff and the nurses received annual appraisals with the most appropriate person to appraise them. Staff said they felt supported by the practice manager and established salaried GP, who they felt both worked tirelessly. However they also told us they did not feel supported as employees of the trust. They said they felt they were viewed as a department within the trust rather than a GP practice.

Staff received an induction which was provided by the trust. There was a staff training matrix which showed that staff had received basic training including fire, health and safety, safeguarding and life support.

One GP was due to have his revalidation in the next few weeks following our visit and the other GP was revalidated in their previous practice in May 2014. Revalidation is the process where GPs demonstrate they are up to date and fit to practice.

Staff told us they felt there were inadequate staffing levels at the practice. Reception staff told us they were working extra hours and taking on additional tasks to provide cover for reception although they acknowledged that some recruitment was underway.

Patients and staff told us that the high number of locum GPs used by the practice meant the practice was unable to provide adequate continuity of care to patients. Staff thought they needed three or four salaried GPs to be effective and currently they could only provide a basic service to patients with the staff they had. There were two salaried GPs working in the practice at the time of our inspection. One of them had joined the practice the week before our inspection. The other salaried GP had been the only salaried and permanent GP in the practice since January 2014.

A nurse practitioner had been employed by the practice four weeks before our inspection. Staff told us they were hopeful that due to the new recruitments that there would be far more options available to them in the future.

Working with other services

The practice held palliative care meetings which were attended by district nurses and community matrons. There were arrangements in place to manage the information sent by the out of hours service and 111 service.

The system in place for monitoring blood results was robust as the practice had direct access to the system which holds them. The established GP goes through all of the results daily and any urgent results are passed to the duty GP to action.

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

There were numerous health information leaflets available in the waiting room, for example, smoking cessation, dementia and contraceptive services.

There was information for carers in the waiting room and a board which promoted the local carer's centre. There was also information on the practice website regarding this and carers were offered an annual health check.

New patients were given a health check. There were clinics available for asthma, chronic obstructive pulmonary disease, shingles, diabetes, heart disease, sexual health and contraception, smoking cessation, travel vaccines, flu and pneumonia vaccinations and a woman's health service. Chlamydia screening was available for patients between 16 – 24 years of age.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff were familiar with steps they needed to take to protect people's dignity. Consultations took place in consultation rooms which gave patients privacy and separate examination rooms promoted patients dignity. There were signs explaining that patients could ask for a chaperone during examinations if they wanted one.

Patients said they felt they were treated with respect and dignity. They said they had enough time with the GP and nurse during consultation and felt they could ask questions about their treatment. Three patients and a member of staff thought that the reception area was not private enough to speak to the receptionist. There was a notice advising patients they could ask to speak with receptionists in a private room if they required this. There was music playing in the reception area, however four patients said they found the type of music playing was annoying, especially if they had a long wait to see the doctor.

We observed the reception staff and the nurses attending to patients. We saw they were friendly and interacted in a caring manner with patients. We heard conversations on the telephone with patients requesting further prescriptions. Staff treated the callers with respect and resolved their queries in a timely and professional way.

The salaried GP had won an award for support given to carers a "Caring for carers" award in 2013 from the local carer's centre.

Involvement in decisions and consent

Patients we spoke with felt they had been involved in decisions about their care and treatment. They thought their treatment was fully explained and they understood the information. Patients confirmed consent was always sought before any examinations were conducted. Patients commented on the useful information which was available to them in the waiting room

We found that clinical staff were able to confirm how to make "best interest" decisions for patients who lacked capacity and how to seek appropriate approval for treatments such as vaccinations from children's legal guardians. Staff understood the purpose of the Mental Capacity Act (2005). They told us how they would consult with carers and other health care professionals who knew the person well.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice was accessible to patients with mobility difficulties with a large waiting area with space for wheelchair users. The consulting rooms were all located on the ground floor. There was also an adapted toilet. There was an induction loop for those hard of hearing.

Reception staff explained to us how they had a system which alerted the GP that they had a visually impaired patient in the waiting room and they knew to call them in by going to the reception area for them.

Staff said they had access to interpreter or translation services for patients who required it and there was guidance to follow about using interpreter services.

Three patients we spoke with said they did not feel they could always obtain an appointment with a female GP, this was dependent upon which locum GPs were working.

We were told there were routine health checks for patients. These included yearly checks for patients with chronic health problems and patients who experienced poor mental health. There were also health checks for the over 40s, new patients and smoking cessation clinics. These were carried out by the practice nurse. The practice newsletter highlighted to patients that open flu vaccine clinics were running from September to October.

The practice had an active PPG to help it to engage with a cross-section of the practice population and obtain patient views. We spoke with representatives of the PPG who explained their role and how they worked with the practice. There was evidence of meetings with the PPG quarterly throughout the year and the practice had implemented suggestions for improvements.

Access to the service

While access to the practice appeared to be good, continuity of care suffered because of only one salaried GP being employed there from January 2014, until a further salaried GP was recruited the week before our inspection. Complaints we saw during our visit and feedback from patients highlighted the issue of continuity of care being a problem. Patients and staff told us the service had relied on a number of locum GPs.

The surgery was open 8am to 6pm Monday to Friday, with a view to enhance the service further following the commencement of new staff members.

Patients told us they could access appointments easily, particularly emergency appointments. The next available routine GP appointment was within the next four working days. Alternative appointments were held back and then only released on the day for the GP on call. They operated a series of open access surgeries with the nurses, together with specific chronic disease clinics. A triage system was in place. The practice felt they gave excellent access to patients. There were plans for the new nurse practitioner to have her own clinics. Double appointments were given to patients at the GP request only. The nurses gave 15 minute appointments for everything apart from travel vaccinations were patients were given 30 minute slots.

A patient information leaflet set out what clinics and appointments were available and this information was also available on the practice website. The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

Patients could access repeat prescriptions within 48 hours of their request. Staff were able to access laboratory/ hospital reports which helped reduce delays in issuing a prescription if the GP needed to check before a prescription was issued.

There were arrangements in place to ensure patients could access urgent medical assistance when the practice was closed. This was provided by an out-of hour's service.

Concerns & Complaints

The practice's complaints policy was the trusts' generic complaint policy and it was not in line with recognised guidance and contractual obligations for GPs in England. The chief executive of the trust was deemed as responsible person overall for all complaints in the practice. However we were told the practice manager was responsible for managing complaints but this was not in the policy.

Information was provided to help patients understand the complaints system. There was a notice in the waiting room

Are services responsive to people's needs?

(for example, to feedback?)

advising patients how to complain and a leaflet for patients. There was also information on the practice website which referred patients to the trust to make a complaint.

We were told that not all verbal complaints were documented. We looked at four recent complaints, one of which was still on going. Some had been responded to by a GP at the surgery and others had been referred to the trust and responded to by them. Three of the complaints related to patients being unable to see the same GP. The process for handling complaints at the practice was not clearly documented.

There was no analysis of complaints available to detect themes or trends from the complaints.

Are services well-led?

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

Our findings

Leadership & Culture

We found that the practice was not well led; there was no clear overall leadership or leadership to unify clinical practice. Staff we spoke with felt they had good team working between the staff who worked in the practice. They said they supported each other and had support from the practice manager and long standing salaried GP but there was no support from the trust. The practice team were doing their best in difficult circumstances.

The provider for this service was City Hospitals Sunderland NHS Foundation Trust. There was no requirement for a registered manager of the service under CQC registration regulations.

We were given a statement of purpose for the trust which staff said was also for the practice which set out the regulated activities with CQC for all of the hospital departments and the practice. The document contained a statement dated January 2013 regarding the practice which set out the number of patients it had and the type of contract it had with the CCG but had no specific objectives for the practice. Audits were carried out to fulfil statutory purposes. There was no organisational document showing roles of staff and accountability. Any policies and procedures were specific to the trust rather than the practice.

Governance Arrangements

There were some governance arrangements in place for identification of risk, for example, good infection control arrangements and the training and recruitment of staff. However there was no link between audits, incidents and learning to improve the quality of service.

We found while the practice had policies they were generic and not adapted for practice use. Responsibility for delivery of care ultimately sat with the chief executive of the trust and there were lines of management accountability. The salaried GPs were accountable to the chief operating officer at the trust and the practice manager was accountable to the head of performance and improvement at the trust. However there was no evidence of effective management through these lines.

The practice manager provided leadership and the salaried GP provided clinical support to staff within the practice. Staff felt they were not receiving adequate support from the trust and we did not see sufficient evidence of any support from the trust for staff, for example, there was no monitoring of the service from the trust, visits or evidence they assured themselves that the practice was operating effectively.

Systems to monitor and improve quality & improvement (leadership)

There was no documented vision statement or strategy plan for the future of the practice. There was a practice development plan dated April 2014 which gave a list of practice aims, identification of need and a list of how these were to be met. However there was no monitoring of this or dates for review.

We asked staff if there was a quality assurance report or visit from the trust, as provider of the service, and we were told there was not. There was no monitoring in place of the practice by the provider.

Patient Experience & Involvement

We saw that the practice had a newsletter. The most recent one being September 2014 giving details of new staff in the practice and new health checks.

The practice carried out a survey of patients between October and December 2013. The results of this were available on the practice website. 56 people had responded to the survey. The analysis of the survey showed patients were mostly satisfied regarding the telephone system, booking appointments and with opening times. There were some comments regarding staff attitudes which the survey said would be addressed. There was an action plan attached to the analysis setting out what the practice were doing to improve as a result of the survey, such as, recruitment of more salaried GPs. However there were no dates set as to when these actions were to be achieved.

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

There was a suggestion box in reception with comment cards for patients to complete.

The practice had a PPG which had been established for many years. The group met every month and there were minutes of the meetings and the meetings included guest speakers. We spoke with three members of the PPG who said they felt that the practice listened to their ideas and feedback. They provided an example where their feedback had resulted in a change to the practice.

Are services well-led?

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

Feedback left by patients on the website "NHS choices" where members of the public can post their views on the practice had not been responded to. There had been 26 reviews left in total for the practice giving a one star rating overall out of five. We looked at the latest seven reviews which had been left since the beginning of 2014. They were all negative and the most common theme was lack of continuity of care due to there being only one permanent GP and the attitude of staff. The practice had not responded to any of the concerns. Staff we spoke with believed some of the comments to be valid but some to be malicious.

There was evidence of some staff meetings taking place. Minutes were available for some staff meetings and not others. There was no organised approach to staff meetings.

Management lead through learning & improvement

We found there were no arrangements in place to actively encourage learning and improvement. There was no clear strategy to support quality improvement. There were no objectives for staff to focus on the improvement of the service at the surgery. There was some evidence that patients were listened to from the PPG group and by way of the patient survey.

There was not a structured approach to staff meetings. The reception staff did not have meetings. We were told that information was passed onto them by the reception manager and any information to be shared between them was via messages which were not documented. We asked to see minutes of any other staff meetings. We were shown minutes of a practice meeting which were dated 23 April 2014, we were told there had been another meeting since but there were no minutes of this meeting.

There was no evidence of learning as a team from significant events, clinical audit cycles or complaints made to the practice.

Identification & Management of Risk

We saw evidence that risk assessments such as fire and health and safety identified risks to the service.

Staff told us they did not feel supported by the trust. It was not clear how the trust supported the practice with the identification of management of risk. Whilst information was shared with the trust there was no evidence of this information being routinely reviewed with the practice by the trust.

Policies and procedures were too broad and not specific enough to manage risk in the actual practice itself. There were no clear lines of responsibility for the improvement of quality patient care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Family planning services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: Patients were not protected against the risks of inappropriate or unsafe care and treatment by way of effective operations of systems designed to regularly assess and monitor the quality of service and there were insufficient systems in place to identify assess and manage risks relating to health, welfare and safety of service users.

Regulated activity	Regulation
Family planning services Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.