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.

Contents

Summary of findings

Overall summary

The practice is located in Springwell Health Centre, Sunderland and provides primary medical care services to patients living in Springwell and surrounding areas of the City of Sunderland. The practice does not have any branch surgeries, so the inspection was focused on this location.

We held a listening event where members of the public could tell us about their experiences of GP services within Sunderland. We also asked patients prior to our visit to complete CQC comment cards about their experiences of the service they had received. We spoke with representatives from the Patient Participation Group (PPG) and patients attending for appointments during the inspection. We spoke with staff working in the practice on the day of the inspection.

Processes are in place to identify unsafe practices, and measures are put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence.

Care and treatment is being delivered in line with current published best practice. Patients' needs are being met and referrals to other services are made in a timely manner. The practice is regularly undertaking clinical audit.

All of the patients we spoke with said they are treated with respect and dignity by the practice staff at all times. Patients also reported they feel involved in decisions surrounding their care or treatment.

Patients said they are satisfied with the appointment systems operated by the practice. The practice has a policy for handling any concerns or complaints people raise.

There is an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and report feeling supported and valued by their peers.

The practice is in breach of the regulation that covers requirements relating to workers.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Processes were in place to identify unsafe practices and measures put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence. Staff were aware of safeguarding procedures and took appropriate action when concerns were identified. The practice must ensure staff involved with the chaperoning of patients have been the subject of Disclosure and Barring Service (DBS) checks. There was not a standard approach across the practice for the checking of medicines held within GP's bags.

Are services effective?

The practice is rated as good for effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audit, reviewing their processes and monitoring the performance of staff.

Are services caring?

The practice is rated as good for caring. All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Patients also reported they felt involved in decisions surrounding their care or treatment.

Are services responsive to people's needs?

The practice is rated as good for responsive. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients said they were satisfied with the appointment systems. The practice had a policy for handling any concerns or complaints people raised. The practice regularly surveyed their patients and worked with their Patient Participation Group (PPG) to resolve issues raised.

Are services well-led?

The practice is rated as good for well-led. Staff were aware of the need to get things right for patients and the care of patients was their priority. Feedback we received from patients showed they felt valued and well cared for by staff. There was an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and reported feeling supported and valued by their peers.

Summary of findings

The practice had a PPG and information relating to it was posted on the practice website.	

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice had a slightly higher proportion of patients over the age of 65 compared to other practices within the Sunderland CCG area. All patients over the age of 75 had a named accountable GP and had been informed by letter.

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. We spoke with a GP who told us Directed Enhanced Service (DES) for elderly care had been a help in developing local plans of care. Information was shared appropriately with other services, where there was a need to do so.

The practice was involved with a range of healthcare professionals for patients who required additional support. This included district and Macmillan nurses, health visitors and community matrons.

Older people received appropriate vaccinations, including pneumococcal vaccinations and an annual flu vaccination.

People with long-term conditions

The practice is rated as good for the population group of people with long term conditions. Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. We spoke with GPs and nurses who told us regular patient care reviews took place at six monthly or yearly intervals; for example for patients with chronic obstructive pulmonary disease (COPD) or asthmatic conditions. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing.

The practice was achieving nearly all of its Quality and Outcomes Framework (QOF) points (for the latest data available, 2012/13). It had achieved 99.6% of the available points for the 'clinical domain indicator groups'; a significant number of which related to the management of patients with long term conditions.

The practice ensured timely follow up of patients with long term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Summary of findings

Mothers, babies, children and young people

The practice is rated as good for the population group of mothers, babies, children and young people. The practice had a slightly lower proportion of patients under the age of 18 compared to other practices within the Sunderland CCG area.

We saw the practice had processes in place for the regular assessment of children's development. This included for the early identification of problems and the timely follow up of these. GPs, midwives health visitors and school nurses all had an important role with safeguarding children, which included the early identification of needs and the ability to offer help on a timely basis.

The practice had a programme of health and development reviews. The programme ran from an initial neo-natal examination through to vaccinations up to the age of 18 years. The practice ran a 'well baby immunisation clinic' on Tuesday afternoons. Post natal checks were also done by the practice nurses during these sessions.

Signposting to services and activities available locally to families was also provided. Lifestyle advice about healthy living, including on smoking cessation and alcohol consumption was given by the GPs, in addition to the midwives.

The working-age population and those recently retired

The practice is rated as good for the population group of the working-age population and those recently retired. The majority of the practice's patients could class themselves as patients who could be included within this population group.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service. The practice did not run any open access clinics, however it offered late opening until 8pm one night a week and were routinely open until 6pm.

We saw health promotional material was made easily accessible to people of working age through the practice's website. This including signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation.

Patients were given a choice in how the practice communicated with them. This included by telephone and letter. The practice previously communicated with patients, including those of working age, by text message. This included sending messages 48 hours in

Summary of findings

advance of appointments as a reminder. This was not currently available due to the recent conversion to a new computer system. The practice had raised the issue with the external service provider and was hoping to re-introduce the system soon.

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

The practice is rated as good for the population group of 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 highlighted patients on the register for regular reviews. GPs we spoke with told us the practice had access to an expert learning disability team.

The practice communicated with other agencies, for example health visitors, to ensure vulnerable families and children were monitored to make sure they were safe. The practice received letters from services who treated patients for addictions. This helped them to monitor their recovery, including through the review of or changes to their medicines.

We saw there were areas where reception staff could speak with patients privately, should they express a wish to do so. Staff we spoke with demonstrated an awareness that people within this population group may benefit from a sensitive approach.

People experiencing poor mental health

The practice is rated as good for the population group of people experiencing poor mental health. We were told the GPs took the lead for the practice in the first instance with regards to patients experiencing poor mental health. Annual health checks were carried out for patients. These were completed by a GP or nurse.

Patients were supported to access emergency care and treatment when they experienced a mental health crisis. We were told the GPs were flexible with their appointments and patients were provided with contact details for the local crisis team.

We saw some patients were on weekly prescriptions due to assessed risks. We found systems were in place to identify if a patient was requesting too many or too few repeat prescriptions.

The practice worked in partnership with other local services to ensure patients experiencing poor mental health were supported. We were told a counsellor came into the practice on a regular basis and could be accessed by patients.

Summary of findings

What people who use the service say

All of the 17 patients we spoke with, which included two members of the practice's Patient Participation Group (PPG), were complimentary about the services they received at the practice. They told us the staff who worked there were very 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. A few patients said they had to wait longer for an appointment to see their own GP; however most people were happy with the appointments system.

We reviewed 43 CQC comment cards completed by patients prior to the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Two comments suggested these patients were disappointed with the length of time to obtain an appointment, however the majority feedback was again positive.

The latest GP Patients Survey completed in 2013 showed the large majority of patients were satisfied with the services the practice offered. The results were in line with or slightly better than other GP practices nationally. The results were:

- The proportion of patients who would recommend their GP surgery– 79.6%
- GP Patient Survey score for opening hours– 87.3%
- Percentage of patients rating their ability to get through on the phone as very easy or easy– 80%
- Percentage of patients rating their experience of making an appointment as good or very good– 81.1%
- Percentage of patients rating their practice as good or very good– 91.4%

The practice had also completed its own annual survey of 30 patients per GP in February 2014 and had achieved similar results. The results were also consistent with those achieved previously.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that staff involved with the provision of regulated activities, including chaperoning, have been the subject of Disclosure and Barring Service (DBS) checks. The practice should also assure itself that the nurses they employ remain registered with the relevant professional body.

Action the service SHOULD take to improve

The practice should take action to implement a system across the practice for the checking of medicines held within GP's bags. This should include checks to ensure any medicines held in GP's bags remain in date and safe to use.

Broadway Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a specialist advisor with experience of GP practice management and governance and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Broadway Medical Practice

The practice is located in Springwell Health Centre, Sunderland and provides primary medical care services to patients living Springwell and surrounding areas of the City of Sunderland. The practice provides services from only one address - Springwell Health Centre, Springwell Road, Sunderland, SR3 4HG. We visited this address as part of the inspection. The practice is based on the ground floor and shares the premises with another GP practice and other healthcare professionals. It also 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.

The practice has three GP partners, one salaried GP, two training doctors, two practice nurses, a practice manager, an assistant practice manager and five staff who carry out reception and administrative duties.

The service for patients requiring urgent medical attention out of hours is provided by Primecare.

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

Detailed findings

- People experiencing poor mental health

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG). We also held a listening event for the Sunderland area as a whole and spoke with two members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 01 September 2014. The inspection team spent eight and a half hours inspecting the service and visited the practice's surgery in Sunderland. We spoke with 17 patients and nine members of staff from the practice. We spoke with and interviewed the practice manager and their assistant, three GPs, a training doctor, a practice nurse and two staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 43 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Are services safe?

Our findings

Safe track record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how this practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

The practice had clearly defined systems, processes and standard operating procedures (SOP). We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. They told us the practice manager led on safety within the practice and there was an individual and collective responsibility to report and record matters of safety. Where concerns had arisen, they had been addressed in a timely manner. We saw outcomes and plans for improvement arising from complaints and incidents were discussed and recorded within staff meeting minutes.

There were formal mechanisms in place for obtaining patient feedback about safety. The practice had carried out an in-practice patient survey and had an active Patient Participation Group (PPG). The practice manager told us that any concerns raised would be used to inform action taken to improve patient safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events and our conversations with them confirmed their awareness of this. The practice manager told us staff were made aware of their roles and responsibilities with regards to incident reporting when they were recruited. The practice manager was the person who collated this information and staff we spoke with were aware of this. The practice manager also had responsibility for assessing whether any urgent or remedial action was required. They were also able to confirm which incidents were reportable to CQC.

We saw four significant or critical clinical events had been recorded during the last 12 months. We saw details of the event, learning outcomes and action points were noted. Staff meeting minutes showed these events were discussed within the practice, with actions taken to reduce the risk of them happening again.

Non-clinical incidents were recorded separately. The practice manager said any non-clinical incidents, for example relating to safeguarding, would be brought to the attention of the relevant practice lead in that area.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice electronically and were printed and passed on to clinicians and those who needed to see them. Any actions to be taken were agreed and the practice manager kept a record of alerts received and actions taken.

We found learning from safety incidents was communicated externally, as well as internally within the practice when required. For example, the practice had recorded and reported an incident to the local hospital where the patient hadn't attended, yet a summary of their consultation had been received. The practice had also recorded and reported an incident to the local district nursing team for investigation.

Reliable safety systems and processes including safeguarding

The practice had a range of policies, procedures and systems to help keep patients safe. These included policies for infection control, the protection of vulnerable adults and children and the recruitment of staff.

Staff we spoke with were aware of their responsibilities if they suspected someone was at risk of abuse. They knew who to contact if they had any concerns about patients' safety. Staff demonstrated an awareness of the escalation process. They were aware of the different types of abuse and could describe the signs patients might show if they were being abused or at risk of abuse.

The practice had a chaperoning policy. Staff we spoke with told us it would be the practice nurses who routinely acted as chaperones. The administrative and support staff we spoke with said they had acted as chaperones too. This was confirmed by the practice manager, who said practice's policy was for chaperones to stand inside the privacy

curtain with the patient and the clinician. We saw some staff had undergone chaperone training some time ago; however others who had performed the role had not been trained.

We asked the practice manager if non-clinical staff who acted as chaperones had been the subject of an enhanced Disclosure and Barring Service (DBS) check. The practice manager said they had not been the subject of DBS checks and risk assessments had not been completed.

A notice was displayed in the patient waiting area to inform patients of their right to request a chaperone. Staff we spoke with told us the patient's decision to accept or decline the use of a chaperone was always recorded.

The practice had a system in place to ensure that patient referrals were made in a timely manner. There was also a system in place to ensure the timely recall of patients, for example, for blood tests.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent. The practice did not run any 'open access' clinics; however we saw a patient who attended the practice on the day without an appointment was seen by a clinician after a short wait.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. This included GPs, a nurse, the practice manager and staff providing reception and administrative support. Staff we spoke with worked flexibly with regards to the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Staff had access to a defibrillator and oxygen within the shared medical centre premises 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 there were medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were kept stored securely, with access restricted to those that needed it. Records were kept whenever any medicines were used.

Medicines were regularly checked to ensure they were in date and remained safe to use. This included medicines kept by GPs in their emergency bags. We found the management of medicines within GPs emergency bags was not consistent throughout the practice. We checked the medicines within two GPs bags in partnership with the practice manager. We found the medicines in one bag were fully in date; however three medicines in the other bag were out of date. These medicines were removed immediately. We spoke with clinicians, including GPs and the nurse on duty, with regards to the agreed process and responsibilities for checking medicines in GPs bags. Some clinicians told us the practice nurses were responsible for checking the medicines were in date, while others told is it was the responsibility of the individual to check their medicines.

We saw fridge temperatures where medicines were stored were checked daily to ensure the medicines were stored in line with manufacturer's guidance. Records of these checks were maintained. We checked a sample of medicines stored in the fridge in the administrative office area and found they were all in date.

The practice had a process and audit trail for the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. We saw evidence to confirm this was put into practice. The practice also had processes in place for the management of information received from other services, including from out of hours services and hospital discharge letters.

The practice had appropriate arrangements for the receipt, recording and storage of blank prescription forms. Staff we spoke with told us boxes of blank prescription forms were kept in a locked cupboard within a locked room. This was confirmed by the practice manager. We saw the cupboard was not always locked during the hours the practice was open, although a staff presence was always seen to be maintained in this area. The staff with responsibilities for

Are services safe?

handling prescriptions agreed this presented a degree of risk. We were also told records were kept of the first and last serial number associated with each box of blank prescriptions. We saw records to confirm this.

Cleanliness and infection control

We saw the practice was visibly clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. The practice had a range of policies and procedures relating to infection control. These included guidance on hand hygiene, the use of personal protective equipment (PPE) and for handling specimens.

The practice had a nominated infection control lead. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. We spoke with the infection control lead who told us they felt well supported within the practice, however they reported access to external infection control nurses was not so readily available.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were also contracts in place for the collection of general and clinical waste. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

The practice manager explained the premises were owned by NHS Property Services and all fixtures and fittings were supplied and maintained by them. The cleaning of the premises, including the practice, was also provided by the owners. A cleaning schedule for the practice was on display on the walls and the practice manager told us any issues regarding the cleaning were escalated through NHS Property Services.

Staff reported there was always sufficient PPE available within the practice, should they need to use it. This included for the use of administrative staff when they received patients specimens. The staff explained and demonstrated how they avoided handling patients' specimen tubes directly to minimise the risk of infection transmission.

Staffing and recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. For example, "New Employee Recruitment, Selection, Interview & Appointment Policy & Protocol" and "Professional Qualifications & Registration Policy for New & Existing Staff". The practice had a well established staff team, with the most recently recruited member of staff joining three years ago. We reviewed the records for this member of staff and found the appropriate checks had been completed.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)). For GPs they said the practice paid for their GMC registration by monthly direct debit, which assured them of their registration status. They said this arrangement was not in place for their nursing staff and no other routine checking of their registration status was done after the original pre-employment checking process. We checked the registration status of the nurses employed by the practice on the NMC website before the inspection and found they were registered as required.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. The practice manager said when a GP was on leave or unable to attend work, another GP from the practice provided cover. In addition, 'extra blocks of appointments' could be tagged on to the start or end of GP sessions to meet increases in demand.

We spent some time during the inspection observing how the staff dealt with patients who arrived to use the practice. We saw staff kept patients informed and confirmed who they would be seeing. This was well received by the patients.

Dealing with Emergencies

The practice had emergency response plans in place. The practice manager told us the practice had a business continuity plan; however they kept this at home so it was not available to view as part of the inspection. They told us the practice's 'major incident response' was to move across to the local church hall, for example in the event of flood or fire. The practice manager also explained they would be

Are services safe?

guided by their CCG, for example in readiness for expected epidemics. They told us how in the past the practice had worked closely with the neighbouring practice in the premises in preparation for swine flu. This included reciprocal working between staff groups to be able to understand each other's systems. This would have allowed staff to work across both sites in the event of the staff group being affected by the anticipated outbreak.

Equipment for dealing with medical emergencies was seen to be available within the practice, including emergency medicines. Staff we spoke with told us they had been trained to perform cardiopulmonary resuscitation (CPR) and we saw records to confirm this. We saw and were told 'panic buttons' were in situ in all of the consulting rooms to alert other staff in the event of an emergency.

Equipment

The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG) machines and fire extinguishers. We looked at a sample of medical and electrical equipment throughout the practice. We saw regular checks took place to ensure it was in working condition.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We found care and treatment was delivered in line with recognised practice standards, local and national guidelines. The practice manager told us they received guidance issued by the National Institute for Health and Care Excellence (NICE) electronically. They then circulated it to clinical staff and others, as required. All of the clinical staff we spoke with said they used information based around NICE guidance.

GPs and other clinical staff were able to perform appropriate skilled examinations with consideration for the patient. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

Staff we spoke with described how they carried out comprehensive assessments which covered patients health needs. They explained how care was planned to meet identified needs and how patients were reviewed at regular intervals to ensure their treatment remained effective. For example, the practice nurse explained that patients with long term conditions such as hypertension and those on hormone replacement therapy (HRT) were invited into the practice every six months to have their medication reviewed for effectiveness.

Patients we spoke with said they felt well supported by the GP and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who filled in CQC comment cards. A small minority of patients we spoke with said the GPs did not always explain their medication and potential side effects to them; however most patients said they felt well informed. The results of the practices own in-practice patient survey in February 2014 showed 92% of patients surveyed rated the question 'How thoroughly the doctor asked you about your symptoms and how you are feeling?' as good or very good.

Patients were referred appropriately to other services, where there was a need to do so. The GP recorded this in the patients' consultation notes.

We found processes were in place to seek and record patients' consent and decisions were made in line with relevant guidelines. Staff we spoke with were able to describe the consent process. For example, a GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing clinical audit cycles. Most of the clinical staff we spoke with were aware of and could describe audit activity across the practice. One GP we spoke with was unable to describe any practice based audit to us. One of the trainee doctors had only been with the practice a few weeks; however they told us they were already planning to undertake an audit on urinary tract infections (UTI's). Examples of 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. The clinical audits showed evidence of quality improvement processes that delivered improved patient care and outcomes through the review of care and implementation of change. In particular, the audit of PPI medicines had been through two complete audit cycles, with significant improvements in practice achieved.

As part of our pre-inspection analysis of information, we identified the practice was an outlier for higher than expected accident and emergency (A+E) attendances levels of its patients. We spoke with a GP about this and they were unaware the practice was an outlier in this area. They stated they would review this.

Effective staffing, equipment and facilities

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

Staff we spoke with told us about training and professional development available to them. This included being given time to maintain their current skills and opportunities to learn new ones. They confirmed they had received appraisals and had identified 'job lists' which set out their individual targets. For example, administrative staff were given a quota of patients to contact in relation to flu vaccinations. We saw individuals had deadlines to achieve

Are services effective?

(for example, treatment is effective)

their targets and progress was monitored by the practice manager. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills. The practice nurse we spoke with told us they regularly attended the local CCG's protected time learning events and also attended the locality based nurse forum, which provided information, training and shared learning. The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and updating of their skills.

Staff we spoke with said the CCG were not as well organised as the preceding primary care trust (PCT) for mandatory training, however this was improving. We saw records to confirm staff had completed training to the required levels for child protection and had also completed CPR training. There were some areas where staff required training or refresher training, including infection control, information governance and health and safety. The practice manager was aware of this and said since the CCG was introduced, they have had to source their own training for staff. The practice have now started to use e-learning packages for training such as safeguarding and health and safety. The staff we spoke with confirmed this and could show us evidence to support the completion of this training.

We were told new staff were supported with an induction programme. This was referred to in the staff handbook and covered the practice's policies and procedures, including health and safety. The practice was designated as a training practice for GP Registrars and one of the GP's was the designated trainer for the practice. We spoke with the current GP Registrar at the practice who told us they received good clinical support in a supportive environment. The patients we spoke with told us they were confident staff knew what they doing and were trained to provide the care required.

The practice had processes in place for managing the performance of staff. These were covered within the staff handbook and were referred to as 'capability procedures', 'disciplinary procedures' and 'grievance procedures'.

The facilities and equipment in use within the practice were appropriate for the services provided. The CCG had provided medical equipment such as an ambulatory blood pressure machine and an ECG, along with training on how to use these.

Working with other services

We saw evidence and the practice staff told us they worked with other services and professionals. The GPs we spoke with all made reference to regular meetings with other healthcare professionals. These included with district nurses, community matrons, health visitors, school nurses and midwives. We were told that although it was felt meeting arrangements were good, there were no clearly defined ways of working and relationships were often 'impersonal'. Relationships with social services were also reported to have weakened from previous levels. One GP we spoke with reported having good personal relationships with some hospital specialists and met with some informally on a monthly basis. They said another of the GPs in the practice belonged to a similar group.

The practice had systems are in place for recording information from other health care providers. This included from out of hours services and secondary care providers, such as hospitals. We saw there was effective communication and information sharing about patients between services. For example, details of patients contact with out of hours GP services were received by fax and added to the on-call GPs job list for review. Special patient notes were added to the practice system and these were shared with the ambulance and out of hours GP services. Special notes included references to palliative (end of life) care management plans, hospital admission avoidance plans and other information to protect patients.

Health, promotion and 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'. The practice manager said to improve patient uptake, both appointments were held on the same day to

Are services effective?

(for example, treatment is effective)

remove the need for the patient to attend on more than one occasion. Information taken from patients included a full medical history and any current medicines they were taking.

We found patients with long term conditions were recalled at regular intervals, to check on their health and review their medications for effectiveness. Processes were also in place to ensure the regular screening of patients was completed, for example cervical screening.

Some of the patients we spoke with told us they were on regular medicines. They confirmed they were asked to attend the practice regularly to review their conditions and the effectiveness of their medicines.

There was a range of information on display within the practice reception area. This included upcoming flu clinic dates and times, a display of information for carers and support groups for these patients and a range of health promotion and prevention leaflets. The practice's website provided some further information and links for patients on health promotion and prevention. This included information on weight management, sexual health and smoking cessation.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on CQC comment cards reflected this. Of the 43 CQC comment cards completed, 33 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included caring, respectful, considerate, polite, empathetic and obliging. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in reception and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. The reception desk fronted directly onto the patient waiting area. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients were taken by administrative staff in an area where confidentiality could be maintained.

People's 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. We saw information about the chaperone service offered was clearly displayed in the patient waiting area. We saw some staff had completed chaperone training. A private room or area was also made available when people wanted to talk in confidence with the reception staff.

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.

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.

The practice provided services for people who cared for others (carers). This included working with local organisations and maintaining a practice register of carers.

Support was provided to patients during times of bereavement. GPs and the practice manager told us a sympathy card was sent to the family once the practice had been notified. The practice also offered 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.

Involvement in decisions and consent

Patient's we spoke with reported they felt involved in decisions surrounding their care or treatment. They went on to say an explanation was given to them by their clinician about their treatment or medication and they were given options to consider. Information provided by patients who filled in CQC comment cards reflected this. A small number of patients said they were not sure the possible side effects of medicines were fully explained to them at all times. The staff we spoke with said consent to treatment was always sought and documented within the patients' records.

The results of the practices own in-practice patient survey in February 2014 showed 87% of patients surveyed rated the question 'How much did the doctor involve you in decisions about your care' as good or very good.

Clinical staff we spoke with were clear about the principles behind decision making with regards to patients who may lack the capacity to make decisions for themselves. The practice nurse said if they had queries around a patient's mental capacity they would refer the patient to a GP. GPs we spoke with said they were confident in assessing patients capacity, but the practice also had access to an expert learning disability team who also assessed family best interest issues.

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice had very few patients whose first language wasn't English. They said when a patient requested the use of an interpreter, a referral form was filled in and the interpreter would physically attend the appointment with the patient.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice from Public Health England, published in 2013. The practice had a slightly lower percentage of patients under the age of 18 than the CCG average and a slightly higher percentage of patients aged 65+ than both the CCG and England averages. The majority of the practice's population were of working age.

We found the practice, including the consulting rooms were accessible to patients with mobility difficulties. There was also a toilet that was accessible for disabled patients. There was a large waiting room with plenty of seating; the consulting rooms were all close by and could be accessed directly from the waiting area.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home. Patients could also make appointments with the GP or nurse of their choice. An interpreter service was available for those patients whose first language was not English and the practice had an induction loop system to assist those with hearing difficulties.

Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required. We saw two repeat prescription request boxes were fixed to the wall in the practice; one in the entrance foyer and one with the patient waiting area near the reception desk.

Patients received support from the practice following discharge from hospitals or following the return of test results. This included through the timely provision of post-operative medicines and follow-up appointments with a GP or nurse as required. Some of the patients who filled in CQC comment cards mentioned how pleased they were with the support provided following discharges from hospital in particular.

The practice had a patient participation group (PPG). We spoke with two members of the PPG before the inspection. They both told us the practice took notice and responded to requests and concerns the group fed back to them.

Access to the service

Patients we spoke with and those who filled out CQC comment cards all said they were satisfied with the appointment systems operated by the practice. This was reflected in the results of the most recent GP Survey (2013/14). This showed 81.1% of respondents were satisfied with booking an appointment and 87.3% were satisfied with the practice's opening hours. These results were 'in the middle range' and 'among the best' respectively for GP practices nationally. The practice had completed its own survey of 30 patients per GP in February 2014. Results from those who responded were similarly positive about the practices opening hours, with 91% rating this good or very good.

Patients could make appointments in a number of ways. They could call into the practice in person, request an appointment over the telephone or book an appointment online (once they had registered for this service). The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice, on the practice's website and in the practice booklet. Out of hours enquiries were redirected to the practice's contracted out of hour's provider, Primecare. The practice offered a late surgery until 8pm every Tuesday evening, in addition to being open until 6pm on other weekdays. Appointments were also available from 8.30am every weekday. This allowed people who worked during the day or were unable to get to the practice a choice of when they wanted to see a clinician.

Consultations were provided face to face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time.

Meeting people's needs

The practice worked with other health organisations to make sure that patients' needs were met. The practice used the 'Choose and Book' system to access hospital appointments for their patients. The NHS Choose and Book is a government initiative that allows patients to choose the time, date and hospital for their treatment. Patients were supported to choose other services in line with their preferences.

Are services responsive to people's needs?

(for example, to feedback?)

We saw the practice had systems in place to ensure the timely referral of patients. We were shown the computerised system which was used. Staff with responsibility for referral letters routinely checked it to ensure referrals were made when required. There were also systems in place to ensure patients returned to the practice for follow-up appointments. The practice had a system whereby patients were contacted up to three times to request they attended the practice. After three invitations, patients who didn't attend were deemed to have declined by informed dissent and their record was updated accordingly.

Patients we spoke with who had been discharged from hospital previously told us they had received support from the practice at that time. We were also told by the practice they routinely followed up test results for patients with secondary care services, for example hospitals.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. The procedure did not signpost patients to the ombudsman, independent advocacy services or CQC.

We saw the practice had received three formal complaints within the last 12 months. We reviewed these and found the complaints had been recorded and investigated fully. As a result of the complaints, some changes had been made relating to future care planned for the individuals concerned. Where a complaint was not upheld, an explanation of the reasoning behind this was provided.

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. We saw the practice had a 'comments box' in place for patients to use. We saw information relating to comments, complaints and suggestions was included on the practice's website and within the practice booklet for patients to refer to.

None of the 15 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 43 CQC comment cards completed by patients indicated they had felt the need to complain.

Are services well-led?

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

Our findings

Leadership and culture

There was an established management structure within the practice. The practice manager, GPs, practice nurse and administrative staff we spoke with were clear on their roles and responsibilities. All of them demonstrated an understanding of their areas of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. We found staff had been allocated lead roles for key areas, for example infection control and safeguarding. Staff described their aim was to provide patients with a high quality service. It was evident there was a strong team-working ethic among the practice staff. Several of the staff told us about how they 'mucked in' and helped colleagues during busy periods or when the need arose. Staff reported feeling supported and valued by their peers.

All the staff we spoke with felt they had a voice and the practice was interested in creating a supportive working environment. We saw there was input from stakeholders, patients and staff which ensured the practice regularly reviewed the aims of the practice to ensure they were being met.

Staff told us there was an open culture in the practice and they could report any incidents or concerns. Challenges to poor practice were encouraged; this ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported, investigated and actions identified to prevent a recurrence.

We saw all practice staff met regularly and mechanisms were in place to support staff and promote their positive wellbeing. Minutes of team meetings were available and were circulated to staff, including those who had been unable to attend. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team. Feedback received from members of the PPG on the staff employed by the practice was very positive and reflected this.

The values and ethos of the practice were stated on the practice website and within the practice booklet for patients. Staff we spoke with said their primary focus was to contribute to providing good patient care and this reflected the practice's stated aim.

Governance arrangements

Staff were aware of what they could and couldn't make decisions on. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions. We also found clinical staff had defined lead roles within the practice, for example, for the management of long term conditions.

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. For example, we were told and saw the practice had identified patients who presented risks with taking their medicines. The practice worked with these patients to ensure they were only given prescriptions for a week's supply of their medicines at a time.

The practice had a system in place for monitoring of the service. The practice manager told us staff always looked to continuously improve the service being offered.

Systems to monitor and improve quality & improvement (leadership)

The practice had systems in place to monitor and improve quality. We saw evidence of audit activity within the practice during the last 12 months. Full clinical audits had been undertaken in a number of areas, including prescribing. The audit and re-audit of prescribing patterns had resulted in improvements in the quality of prescribing within the practice for various medicines groups. For example, and audit on the prescribing of proton pump inhibitors (PPI's) with non-steroidal anti-inflammatory drugs (NSAID's) in line with The National Institute for Health and Care Excellence (NICE) guidance had been through two complete audit cycles. We saw significant improvements had been achieved.

Audits had also been completed in other areas, including the follow up of chest x-rays and contraceptive implants. Each audit showed evidence of the results having been analysed and records of improvements made or actions required.

Patient experience and involvement

The practice had a patient participation group (PPG). We spoke with two current members of the group. They told us the group met every three months and they discussed a variety of issues that related to the practice. These included changes within the NHS, patient questionnaires and any updates or changes to the operation of the practice.

Are services well-led?

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

Minutes of meetings were produced and members of the group told us they were provided with a copy of these, even if they had been unable to attend. We saw information generated by the group, including minutes of meetings and survey results, were posted on the practice's website.

From the minutes of the PPG and the patient surveys which the practice undertook regularly there was evidence that feedback from patients was acted on. For example, a patient who completed the practice patient questionnaire had asked for a separate telephone number to be made available to cancel appointments. We were told in response, the practice had made the office line available for this purpose.

We saw the practice had a suggestion box mounted on the wall within the practice to encourage patients to give feedback on the services provided.

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

The practice carried out an annual patient survey and reviewed it findings in partnership with its PPG. The results were also compared with the previous year's results to identify any improvements or areas for improvement. The practice posted the results of the survey on their website. We saw results from the most recent survey in February 2014 were consistent with previous results achieved. Patients reported they were generally very happy with the services provided.

Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. We saw copies of minutes taken to confirm this. 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.

Management lead through learning & improvement

We saw practice staff met on a regular basis. Practice meetings were attended by clinical staff and the practice manager, while staff meetings were attended by the practice manager and the administrative support team. Minutes from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement.

Staff we spoke with discussed how action and learning plans were shared with all relevant staff and meeting minutes we reviewed confirmed that this occurred. Staff could describe how they had improved the service following learning from incidents and reflection on their practice. Staff from the practice also attended the Clinical Commissioning Group (CCG) protected time education initiative. This provided GP practice staff with protected time for learning and development.

Identification and management of risk

The practice had an up-to-date employee handbook which had been produced in conjunction with the practice's HR provider. The handbook included information on health, safety welfare and hygiene for staff to refer to. Staff also had access to a range of other policies which set out the responsibilities of the provider and their employees.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents.

We spoke with the practice manager and GPs about how the practice planned for the future. They told us a practice risk register was not routinely maintained, although risk management was on-going within the practice on a daily basis. We found the practice was not pro-active in the identification of risk in order to ensure the future sustainability of high quality care.

Older people

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

Our findings

The practice had a slightly higher proportion of patients over the age of 65 compared to other practices within the Sunderland CCG area. All patients over the age of 75 had a named accountable GP and had been informed by letter. We saw an example of a letter that had been sent out. Patient checks for those aged 75 and over were completed at least annually by the nurses.

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. Patient's individual circumstance, such as domestic arrangements and input from carers of patients was considered. We spoke with a GP who told us Directed Enhanced Service (DES) for elderly care had been a help in developing local plans of care. Information was shared appropriately with other services, where there was a need to do so. For example, patient's 'special notes' were shared with the practices out of hours GP and ambulance services. These notes included references to palliative (end of life) care management plans and hospital admission avoidance plans.

The practice manager told us the practice was involved with a range of healthcare professionals for patients who required additional support. This included district and Macmillan nurses, health visitors and community matrons. Meetings were held fortnightly with district nurses and every two months with health visitors and community matrons to discuss patient issues.

The practice contributed to ensure patients received appropriate co-ordinated care, including in the event of returning home after a hospital admission. Patients we spoke with from this population group confirmed this. The assistant practice manager told us medication reviews on discharge from hospital were completed as soon as the discharge information was received; usually within 48 hours of discharge.

Older people received appropriate vaccinations, including pneumococcal vaccinations and an annual flu vaccination.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service.

People with long term conditions

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

Our findings

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. We spoke with GPs and nurses who told us regular patient care reviews took place at six monthly or yearly intervals; for example for patients with chronic obstructive pulmonary disease (COPD) or asthmatic conditions. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. The practice nurses had a leading role in this area and told us templates had been provided to the practice by the CCG. Carer's were involved in these reviews at the patients' request. The practice also had the facility to refer patients onto specialist services.

The practice was achieving nearly all of its Quality and Outcomes Framework (QOF) points (for the latest data available, 2012/13). It had achieved 99.6% of the available points for the 'clinical domain indicator groups'; a significant number of which related to the management of patients with long term conditions.

The assistant practice manager told us medication reviews on discharge from hospital were completed as soon as the discharge information was received; usually within 48 hours of discharge. The practice ensured timely follow up of patients with long term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service. This had not yet been extended to appointments to see the practice nurses.

Mothers, babies, children and young people

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

Our findings

The practice had a slightly lower proportion of patients under the age of 18 compared to other practices within the Sunderland CCG area.

We saw the practice had processes in place for the regular assessment of children's development. This included for the early identification of problems and the timely follow up of these. GPs, midwives health visitors and school nurses all had an important role with safeguarding children, which included the early identification of needs and the ability to offer help on a timely basis.

The practice had policies and processes that covered child health and family support. This included a programme of health and development reviews. These were to allow them to assess growth and development of young children, identify risk factors and opportunities for improving health. It also gave parents the opportunity to routinely discuss any concerns they had with their children. The programme ran from an initial neo-natal examination within the first 72 hours of birth through to vaccinations up to the age of 18 years. The practice ran a 'well baby immunisation clinic' on Tuesday afternoons. Post natal checks were also carried out by the practice nurses during these sessions.

Signposting to services and activities available locally to families was also provided. Lifestyle advice about healthy living, including on smoking cessation and alcohol consumption was given by the GPs, in addition to the midwives.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service. This had not yet been extended to appointments to see the practice nurses.

Working age people (and those recently retired)

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

Our findings

The majority of the practice's patients could class themselves as patients who could be included within this population group.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service. The practice did not run any open access clinics, however it offered late opening until 8pm one night a week and were routinely open until 6pm. 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 we spoke with from this population group said they were satisfied with their ability to access appointments at the practice. This was reflected in patient satisfaction levels in the practice's own patient survey completed in February 2014.

We saw health promotional material was made easily accessible to people of working age through the practice's website. This including signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation. The smoking status of patients was captured by practice staff during patients' appointments. The practice was able to direct patients to pharmacies open at the same time. This included the pharmacy located in the same building and one based in a local supermarket.

Patients were given a choice in how the practice communicated with them. This included by telephone and letter. The practice previously communicated with patients, including those of working age, by text message. This included sending messages 48 hours in advance of appointments as a reminder. The assistant practice manager told us this was not currently available due to the recent conversion to a new computer system. The practice had raised the issue with the external service provider and was hoping to re-introduce the system soon.

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

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

Our findings

The practice had systems in place to identify patients, families and children who were at risk or vulnerable within this population group. For example, the practice maintained a register of patients with learning disabilities. The practice highlighted patients on the register for regular reviews. GPs we spoke with told us the practice had access to an expert learning disability team.

The practice communicated with other agencies, for example health visitors, to ensure vulnerable families and children were monitored to make sure they were safe. The practice received letters from services who treated patients for addictions. This helped them to monitor their recovery, including through the review of or changes to their medicines.

We saw there were areas where reception staff could speak with patients privately, should they express a wish to do so. Staff we spoke with demonstrated an awareness that people within this population group may benefit from a sensitive approach.

The assistant practice manager told us about adjustments the practice had made in response to patients identified vulnerabilities. For example, a patient who had been identified as being agoraphobic (fear and anxiety of being in places where it is hard to escape) was now supported with clinical consultations on the telephone.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service.

People experiencing poor mental health

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

Our findings

We were told the GPs took the lead for the practice in the first instance with regards to patients experiencing poor mental health.

Patients were supported to access emergency care and treatment when they experienced a mental health crisis. We were told the GPs were flexible with their appointments and patients were provided with contact details for the local crisis team. Crisis teams provide services to patients who are in need of urgent help due to a severe mental health problem.

Annual health checks were carried out for patients experiencing poor mental health. These were completed by a GP or nurse. We were told these checks could be more frequent when a patient had been diagnosed with depression.

Patients experiencing poor mental health had their medicines reviewed in the same way as other patients. The assistant practice manager told us some patients were on weekly prescriptions due to assessed risks. This was confirmed by staff who oversaw the issue of repeat prescriptions. We found systems were in place to identify if a patient was requesting too many or too few repeat prescriptions.

The practice worked in partnership with other local services to ensure patients experiencing poor mental health were supported. We were told a counsellor came into the practice on a regular basis and could be accessed by patients.

Patients experiencing poor mental health were not routinely offered a named GP; however the practice encouraged them to see the same GP to promote continuity of care. We spoke with a practice nurse who told us patients assessed as having complex mental health needs would be referred to a GP for a thorough assessment.

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service.

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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person had not ensured that information specified in Schedule 3 was available for all people employed for the purposes of carrying on the regulated activities. Specifically, not all staff involved with chaperoning patients had been the subject of Disclosure and Barring Service (DBS) checks. The registered person had also failed to check that people, specifically nurses employed by the practice, continued to be registered with the relevant professional body. Regulation 21(b) and (c)