Monkwearmouth Health Centre

Quality Report

Drs Gellia and Balaraman
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Date of inspection visit: 3 September 2015
Date of publication: 10/12/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Gellia and Balaraman on 3 September 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, effective, responsive and well-led services. It was also good for providing services for the following population groups: People with long-term conditions; Families, children and young people; Working age people; People experiencing poor mental health (including people with dementia); people whose services may make them vulnerable. We found the practice required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients, staff and visitors to the practice were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles; however, not all staff had received infection control training.
- Not all staff who carried out chaperone duties had received appropriate training
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- The majority of patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available on the same day.
- The practice offered extended opening hours commencing at 7.30am and up to 7:00pm one day per week which improved access for patients who worked full time.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- In general, the practice did not have any process in place to monitor services supplied by the landlord such as maintenance of fire alarms and the dating of sharps boxes.

We saw several areas of outstanding practice:

- The development of a young people specific notice board and leaflets for young people including advice and guidance for young carers and on their rights regarding being seen alone during consultations with medical practitioners
- The development of the practice smoking cessation programme which was run by a member of the administrative team

However, there was also an area where the practice must make improvements:

- Review it's recruitment policy to ensure that appropriate pre-employment checks are carried out including references, photographic ID and confirmation of qualifications/registration with appropriate bodies when necessary.

There were also areas where the practice should make improvements:

- Ensure that only the practice staff who are appropriately trained carry out chaperone duties
- Ensure that cleaning and more regular infection control audits are completed and that all staff are appropriately trained on infection control
- Ensure that all newly appointed staff follow a comprehensive induction process and are given an opportunity for appraisal in a timely manner.
- Implement a process to monitor frequency and standard of tasks performed by the building landlord, including the maintenance of fire extinguishers and dating of sharps boxes.
- Work with practice staff to create a written business plan so that all staff are aware of vision, goals, objectives and pressures.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There were enough appropriately trained staff on duty at all times to keep patients safe. The practice appeared to be clean and hygienic but there was little evidence to confirm that cleaning and regular infection control audits were completed. Not all staff had received training on infection control. The practice had a chaperone policy in place. However, some staff who acted as a chaperone had not received the appropriate training. All staff had received a Disclosure and Barring Service (DBS) check. The practice recruitment policy needed revising and implementing as appropriate checks were not being carried out when appointing staff. In general the practice did not appear to monitor services provided by the landlord or building caretaker effectively, including the dating of sharps boxes. Effective arrangements were in place for the storage of all medicines kept on the premises, including those requiring refrigeration. Processes were in place for the safe management of prescriptions, including repeat prescription requests and the safe storage of blank prescriptions.

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were in line with other practices in the local Clinical Commissioning Group (CCG) and England. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice had systems in place for completing clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and all staff had

Summary of findings

received training appropriate to their roles and responsibilities. Staff received yearly appraisals which gave them the opportunity to formally discuss personal and performance issues and identify training and development needs.

A member of the administrative team had received training on delivering a smoking cessation programme and hosted weekly smoking cessation clinics. An area of the practice had been dedicated to providing a notice board for children and young people which gave information and guidance on a range of health related and other issues, including guidance on the right to be seen alone under the age of 16.

Are services caring?

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were generally better than the national average. Patients said they were treated well and were involved in making decisions about their care and treatment. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. We saw staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality. The practice had developed an effective working relationship with the local carers association. Carers' information/referral leaflets, including a young person specific leaflet were readily available.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were generally in line with or better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Demand for appointments was continuously monitored and extra sessions held when necessary. Patient feedback about the practice was good and most patients stated they found it was easy to make an appointment with a GP within an acceptable timescale. Systems were in place to ensure patients discharged from hospital were supported. The practice worked cohesively with multi-agency practitioners. Easy to understand information about how to complain was available and evidence showed the practice responded quickly and appropriately to issues raised. The practice and its patient participation group had engaged with local pharmacies to attach practice information leaflets to prescriptions improving communication and engagement with patients.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes; however, they did not have a written business plan in operation. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients, which they acted upon. The practice had an active patient participation group (PPG) which met regularly. The practice worked collaboratively with the PPG to identify problem areas and improve services. Comprehensive induction guidance was available for staff but newly appointed staff did not always receive a fully comprehensive induction. Regular staff meetings were held and staff received yearly appraisals.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 had a named GP and were routinely invited to attend an over 75 health check. Home visits were available.

The percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average and the practice was proactive in offering annual flu and one-off pneumococcal and shingles vaccinations.

The practice actively identified and flagged palliative care patients to ensure they were supported appropriately and multi-agency palliative care meetings were held on a quarterly basis.

The practice had taken steps to ensure care plans were in place for its frail and elderly patients and for those resident in local nursing homes.

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions.

The practice had systems in place to ensure patients with long term conditions were recalled for review when required. Home visit reviews were available for housebound patients. The practice nurse was a nurse prescriber which meant that they were able to review and prescribe most medication following a long term condition review without GP intervention. This not only reduced the time patients waited for a prescription but also reduced pressure on the GPs.

The practice had supported and empowered one of its administrative staff to complete smoking cessation training. This member of staff now delivered a weekly in-house smoking cessation clinic. At the time of our inspection they had delivered the programme to 12 patients, four of whom had successfully completed the programme and stopped smoking entirely.

Chronic disease management clinics were held to cover a wide variety of diseases and the practice had ensured that self-held care plans were in place for a number of patients including those at risk of an unplanned admission to hospital.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example looked after children or children subject of a child protection plan. The practice had identified one of the GPs as safeguarding lead who was responsible for providing information to and attending multi-agency safeguarding meetings. The practice also held quarterly meetings with health visitors and school nurses to discuss safeguarding cases and concerns.

The practice had a recall system in place for childhood immunisations and rates were in line with or above local averages for all standard childhood immunisations. Appointments were available outside of school hours, starting at 7:30am and up to 7:00pm one day per week. Cervical screening rates for women aged 25-64 were above local and national averages.

An area of the practice had been dedicated to providing a young person specific notice board which contained a range of health information leaflets and contact information for services including sexual health, puberty, mental health, drugs and alcohol. The practice proactively identified and supported young carers and had produced a leaflet for young carers which was available in the practice. In conjunction with its patient participation group (PPG) the practice had also arranged for two local pharmacies to attach a copy of the leaflet to prescription orders for a period of time.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age patients (including those recently retired and students).

Nationally reported data showed that 52.3% of the practice population either worked or was in full time education (national average 60.2%). The practice was proactive in meeting the needs of these patients by offering online services such as being able to order repeat prescriptions, book appointments and view parts of their medical records. The practice was open from 8.00am to 6.00pm on a Monday, Tuesday and Friday; from 8.00am to 7.00pm on a Wednesday and from 7.30am to 1.00pm on a Thursday. One of the GPs remained 'on-call' on a Thursday afternoon to deal with requests for emergency appointments. Repeat prescriptions could be ordered at any time either online, in person or by telephone. The practice was also involved in the choose and book scheme which enabled patients referred to a hospital or clinic to choose the provider of their choice and at date and time which is convenient.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had a register of patients aged 18 or over with a learning disability and had a recall system in place to ensure these patients were offered an annual health check. The practice was working with the local clinical commissioning group (CCG) to improve services for patients with a learning disability and were planning to host the Sunderland People First Team (a self-advocacy group for the learning disabled population of Sunderland) in the near future. The aim of this was to review how the practice services, premises and staff accommodated and interacted with people with a learning disability. The Practice had also developed an effective working relationship with a local residential home for people with a learning disability and were flexible in their approach to requests for home visits from the residents.

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified a clinical lead for dealing with vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role.

The practice was proactive in identifying and responding to the needs of carers and had participated in the Carer's Incentive Scheme promoted by Sunderland Carer's Centre and the CCG. This scheme was aimed at proactively identifying carer's and offering support by way of a referral to the carer's association.

The practice ensured that a note of a patient's first spoken language was recorded on the records of their non-English speaking patients to ensure that an appropriate interpreter was booked for their appointment. These patients were automatically offered a longer appointment.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (92.3% compared to an England average of 86%) and for ensuring patients diagnosed with dementia had received a face-to-face review within the preceding 12 months (87.5% compared to an England average of 83.8%).

Summary of findings

Practice staff had undertaken dementia awareness training to ensure they had a greater understanding of the needs of patients with dementia. The practice had signed up to deliver an enhanced service to dementia patients and was committed to ensuring patients suffering from dementia were referred to the local memory clinic in a timely manner. The practice had developed an effective working relationship with a local care home where the majority of its patients suffered from dementia and were considering a ward round approach to reviewing and treating residents.

Practice clinicians were aware of their responsibilities under the Mental Capacity Act (2005) and in respect of gaining consent to care and treatment.

Summary of findings

What people who use the service say

During the inspection we spoke with one patient who was also a member of the patient participation group (PPG) and reviewed six Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated that patients were very happy with the care and treatment they received, felt they were treated with dignity and respect and received a service which met their needs.

Findings from the 2015 National GP Patient Survey published in July 2015 for the practice indicated most patients had a higher level of satisfaction with the care and treatment they received. For example:

- 91.1% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. Local CCG average 84.9% and national average 81.5%
- 92.4% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Local CCG average 87.5% and national average 85.1%
- 96.8% of respondents said the last nurse they saw was good at treating them with care and concern. Local CCG average 93.3% and national average 90.4%

These results were based on 91 surveys that were returned from a total of 252 that were sent out (a response rate of 36.1%)

Areas for improvement

Action the service MUST take to improve

The practice must review it's recruitment policy to ensure that appropriate pre-employment checks are carried out including references, photographic ID and confirmation of qualifications/registration with appropriate bodies when necessary

Action the service SHOULD take to improve

The practice should:

- Ensure that only the practice staff who are appropriately trained carry out chaperone duties
- Ensure that cleaning and more regular infection control audits are completed and that all staff are appropriately trained on infection control
- Ensure that all newly appointed staff follow a comprehensive induction process and are given an opportunity for appraisal in a timely manner.
- Implement a process to monitor frequency and standard of tasks performed by the building landlord, including the maintenance of fire extinguishers and dating of sharps boxes.
- Work with practice staff to create a written business plan so that all staff are aware of vision, goals, objectives and pressures.

Outstanding practice

- The development of a young people specific notice board and leaflets for young people including advice and guidance for young carers and on their rights regarding being seen alone during consultations with medical practitioners
- The development of the practice smoking cessation programme which was run by a member of the administrative team

Monkwearmouth Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) Inspector and a GP specialist advisor.

Background to Monkwearmouth Health Centre

The practice is located within Monkwearmouth Health Centre in a residential area of Sunderland north of the River Wear. The practice provides care and treatment to 2,084 patients from the Monkwearmouth and surrounding area of Sunderland. It is part of the NHS Sunderland Clinical Commissioning Group (CCG) and operates on a Personal Medical Services (PMS) contract.

The practice provides services from the following address, which we visited during this inspection:

Monkwearmouth Health Centre, Dundas street, Monkwearmouth, Sunderland, SR6 0AB.

The practice is located in a single storey purpose built building which it shares with other NHS health providers including a dental surgery, chiropodist and diabetic eye and foot clinic. All communal areas, waiting areas and consultation rooms are fully accessible for patients with mobility issues. Car parking facilities, including disabled car parking spaces and lockable bike storage are available on site. The practice is open between 8.00am to 6.00pm on a Monday, Tuesday and Friday; from 8.00am to 7.00pm on a Wednesday and from 7.30am to 1.00pm on a Thursday. One of the GPs remained 'on-call' on a Thursday afternoon to deal with requests for emergency appointments.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Northern Doctors.

Drs Gellia and Balaraman offer a range of services and clinic appointments including chronic disease management clinics, antenatal clinics, baby clinics, well women clinics, travel vaccinations and childhood immunisations. The practice consists of:

- Two GP partners (one male and one female)
- One practice nurse (female)
- One health care assistant who also acts as an administrator
- A practice manager
- An administrator
- Two medical receptionists

The practice is a teaching practice and provides training to third year medical students.

The area in which the practice is located is in the fourth (out of ten) most deprived decile. In general people living in more deprived areas tend to have greater need for health services.

The practice's age distribution profile showed a lower percentages of patients aged over 44 and under than the national average and a higher number of patients aged over 45. Average life expectancy for the male practice population was 77 (national average 79) and for the female population 83 (national average 83).

Detailed findings

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 September 2015. During our visit we spoke with a mix of clinical and non-clinical staff including GPs, the practice nurse, the practice manager, and administration staff. As the practice was closed on the afternoon of our visit and we were only able to speak with one patient who was also a member of the practice patient participation group (PPG). We observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection and reviewed six Care Quality Commission (CQC) comment cards that had been completed by patients. We also looked at the records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

As part of planning our inspection we looked at a range of information available about the practice including information from the latest National GP Survey results published in July 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report accidents and near misses.

We reviewed a sample of significant event audit records and serious incident reports, and minutes of meetings where these were discussed. This included an incident where a patient had been mistakenly prescribed an incorrect drug by a member of staff when issuing a repeat prescription. We saw evidence to confirm that the matter had been reported appropriately and that contact had been made with the patient and apologies issued demonstrating adherence to duty of candour responsibilities. In addition the practice had reviewed its process for dealing with non-routine repeat prescription requests and had carried out an audit of all repeat prescription requests. We were satisfied that the practice had managed significant events and serious incidents consistently over time and taken all necessary action to avoid possible recurrences. We also saw evidence to confirm that anonymised significant event information was shared with the patient participation group on a regular basis for analysis and discussion.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded nine significant events/incidents during the period 1 October 2014 to the date of our inspection. The practice was able to demonstrate the action taken to ensure these issues did not happen again and also how information regarding such incidents was disseminated to staff by way of minuted practice meetings. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

The practice nurse was responsible for cascading national patient safety alerts to the clinical staff and had a system in place to ensure these were acted upon. Clinical staff would then ensure appropriate action was taken which included medication reviews, contacting affected patients and amending their care plans.

Reliable safety systems and processes including safeguarding

The practice had an effective policy and system in place to manage and review risks to vulnerable children, young people and adults. One of the GPs had been identified as the lead for safeguarding vulnerable children and adults and effective working relationships had been established with multi-agency practitioners. For example, quarterly multi-disciplinary meetings were held involving the GP, health visitor and school nurses. Staff we interviewed stated they would feel confident in making a safeguarding referral. A member of the administrative team was able to give a good example of when they had felt it necessary to raise concerns with the lead GP. Staff were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any relevant issues when they rang to make or attend appointments. The practice had produced a leaflet for patients entitled 'Stop Abuse – keeping adults safe from abuse and neglect'. This gave patients information on types of abuse, how to recognise the signs of such abuse in adults and what they could do about it.

A chaperone policy was in place and information about this was displayed in the practice waiting room. We were told that the practice nurse or health care assistant acted as a chaperone when required and had received training on their roles and responsibilities as a chaperone (a chaperone is a person who acts as a safeguard and witness

for a patient and health care professional during a medical examination or procedure). However, members of the non-clinical staff also told us that they had carried out chaperone duties but had not received any training to enable them to do this safely or effectively. All practice staff had received a Disclosure and Barring Service (DBS) check.

Patients' records were kept on an electronic system which stored all relevant medical information. As well as flagging vulnerable children and adults, the system also flagged patients with dementia, mental health issues, learning difficulties, carers and those receiving palliative care which helped ensure risks to patients were clearly identified and reviewed.

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

Medicines management

Effective arrangements were in place to ensure medicines requiring cold storage, such as vaccines, were stored appropriately. A policy was in place to ensure refrigerator temperatures were checked and recorded to confirm that medication stored in the refrigerators was safe to use. This policy had recently been reviewed and strengthened following an incident where the fridge door had been displaced and left ajar as it had not been locked. This had resulted in the fridge temperature rising and the vaccines having to be destroyed and replaced. The matter had been appropriately recorded as a significant event.

The practice maintained a register of emergency drugs held on the premises. These drugs were stored in a locked cabinet with restricted access. During our inspection we found that a process was in place to check these drugs on a monthly basis to ensure they were in date, destroyed appropriately and re-ordered when required.

Patients were able to re-order repeat prescriptions either on-line, in person or by phone. All staff were well aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect. The practice was in the process of reviewing the way in which it issued and recorded computer prescriptions to the GPs.

We saw evidence to confirm that the practice recorded medicines incidents and prescribing errors as significant events to ensure that similar errors did not recur.

The practice nurses used patient group directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Cleanliness and infection control

The premises were clean and hygienic throughout. The patient we spoke with and those that had completed CQC comment cards did not have any concerns regarding the level of cleanliness at the practice. Cleaning was carried out by the building landlord, NHS Prop Co. and a cleaning schedule was in place; however we could find no evidence to suggest that the practice carried out audits of cleaning standards.

An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. The practice nurse had been designated as the infection control lead and provided advice and guidance to colleagues when needed. The majority of staff had received infection control training; however we could not see any evidence to confirm that the health care assistant had received this training. The practice was able to demonstrate that it had carried out infection control audits but accepted that these needed repeating more regularly.

The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and replaced every three months.

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms but some of the bins we looked at had not been appropriately dated. The treatment rooms also contained hand washing sinks, hand soap and hand towel

dispensers to enable clinicians to follow good hand hygiene and infection control practice. The practice had a protocol for the management of clinical waste and a contract was in place for its disposal. All waste bins were visibly clean and in good working order.

Responsibility for the management, testing and investigation of legionella (a bacterium that can grow in water and can be potentially fatal) for the entire building was with with NHS Prop Co.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. We saw evidence to confirm the equipment was regularly inspected and serviced by either the practice or on their behalf by NHS Prop Co. This included the practice defibrillator, spirometer, oxygen equipment and portable electrical equipment. The practice used single use equipment. The equipment we check was in date and a process was in place for checking expiration dates on a regular basis.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff; however this did not include any requirement to obtain photographic identification, references or verification of qualifications/professional registrations (where relevant). The most recent members of staff appointed had not been subject to any formal reference checks. We checked the General Medical (GMC), Nursing and Midwifery Council's (NMC) records to confirm that all of the clinical staff were licensed to practice and received confirmation that all staff had received DBS checks.

The practice manager told us about the arrangements that were in place to ensure there were enough staff on duty at all times. A rota system was in place to make sure that only one member of the non-clinical staff team was allowed to be on annual leave at the same time. The practice nurse and health care assistant ensured they did not take leave at the same time. As the two GPs were married to each other they did tend to take the majority of their annual leave together. At such times the practice had no option but to rely on locum GPs but had ensured a comprehensive locum induction pack was in operation.

Staff and patients we spoke to on the day of our inspection told us they felt there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager and GPs told us that they constantly monitored demand and would increase the number of sessions the GPs delivered whenever necessary. An example of this was when the practice had taken on nearly 1000 patients from a neighbouring practice that had closed which had led to the GPs increasing the number of sessions they delivered per week. Additional sessions were also held following bank holidays and during times of additional/ seasonal demand.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included regular checks of medicines management, equipment and staffing. The practice had a health and safety policy and staff had received health and safety training. We checked the premises and found it to be safe and hazard free.

Staff told us of the process they would follow if there was a medical emergency on site. The member of staff informed about the incident would activate an alarm on the practice computer system which would alert any available clinician that their immediate attendance was required. Emergency bags and equipment were readily available. A CCTV camera system was in operation which covered all waiting rooms and communal areas within the building.

The practice had systems in place to monitor risks to patients, staff and visitors to the practice by way of risk assessments which also recorded what mitigating action had been taken to reduce identified risks. Health and safety information was displayed for staff to see. A code word system was in operation to enable staff to call for assistance to deal with potentially aggressive or intimidating situation.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records confirming that staff had received training in basic life support and cardio-pulmonary resuscitation (CPR).

Emergency equipment was available including a defibrillator and oxygen. Emergency medicines held on site

Requires improvement

Are services safe?

were in line with national guidelines, stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice.

Mitigating actions had been recorded to reduce and manage the risks. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The premises landlord (NHS Prop Co.) was responsible for carrying out fire risk assessments, fire alarms and fire drills. Staff had received training in fire safety. Fire extinguishers were supposedly subject to an annual check but on the day of our inspection we found that the extinguishers should have had their annual check in July 2015. The practice manager assured us they would raise this issue with the landlord immediately.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health Excellence (NICE) guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Practice staff were given regular protected time to carry out online training activities and attend training events. One of the GPs was a member of the CCG medication optimisation team.

The practice had reviewed and streamlined the system for their chronic disease management clinics to ensure that patients were recalled and seen in their birth month. This included a single review for patients with multiple long term conditions. The practice felt this had improved their Quality and Outcomes Framework (QOF) performance to the point where the practice had been identified as the best QOF achieving performance in Sunderland for 2013/2014 (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). Unfortunately its achievement rate had since been affected by taking on nearly 1000 patients from a neighbouring practice that had closed in September 2014 and it had experienced problems in being able to obtain patient summaries and medical history information for these patients. The practice had compiled a list of all of its patients taking disease modifying antirheumatic drugs (DMARDS) to ensure that patients being prescribed these drugs in secondary care were receiving regular reviews.

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

The GP partners monitored how well the practice performed against key clinical performance indicators such as those contained within the Quality and Outcomes Framework (QOF).

The practice was able to demonstrate that it undertook clinical audit cycles to help improve patient outcomes. We saw evidence of a number of clinical audits including a completed cycle audit of a respiratory care improvement scheme for asthmatic patients. The audit had led to the practice implementing a system to review patients requesting prescriptions for asthma bronchodilators (inhalers) more than once per month, ensuring asthma patients were correctly coded on the practice computer system and being reviewed annually and following up on patients who had attended A&E with asthma exacerbation.

The practice used the information collected from QOF and performance against national screening programmes to monitor outcomes for patients. For example 92.3% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record in the preceding 12 months which had been agreed with the patient and their family/carers. 86.6% of patients with diabetes had received a foot examination and risk classification within the preceding 12 months; 79.8% of patients with hypertension in whom the last blood pressure reading measured within the preceding 9 months was 150/90mmHg of less. The practice had scored in line with or above the England average in the majority of QOF indicators. We confirmed the practice had obtained the maximum number of points available to it for delivering a good standard of care to patients with a range of conditions including asthma, atrial fibrillation, chronic kidney disease, dementia, epilepsy, heart failure, hypothyroidism, and osteoporosis and to patients with a learning disability or mental health issue and those in need of palliative care.

There was a protocol for repeat prescribing which was in line with national guidance. Staff were aware of the action to take when a patient had reached the authorised number of repeat prescriptions or when a prescription had not been collected.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of palliative care patients and their families.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of two GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, fire safety, information governance, safeguarding and appropriate clinical based training for clinical staff. Not all staff had received infection control training.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurse reported they were supported in seeking and attending continual professional development and training courses. The practice also provided medical students with opportunities to complete their GP training.

All staff undertook annual appraisals; however, the practice nurse who had commenced with the practice in November 2014 had not been appraised nor had any opportunity for a formal discussion at the time of our inspection. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

We looked at staff cover arrangements and identified that there were sufficient GPs on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. The administrative staff covered for each other and the practice nurse and health care assistant were not allowed to take leave together. When the GPs were on annual leave together the practice relied on the use of locum GPs but a comprehensive locum induction pack was in place.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held quarterly multidisciplinary team meetings to discuss palliative care patients and vulnerable children. Meetings were minuted appropriately.

The practice had a system in place to ensure that hospital discharge letters were reviewed and patients contacted, if appropriate to review their medication and ensure the patients' needs were being met.

We found appropriate end-of-life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider.

Emergency hospital admission rates for the practice were lower than the national average at 10.6% (national average 14.4%).

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the e-Referral service which gave patients the ability to choose their own appointment dates and times.

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

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 91 patients who participated in the National GP Patient Survey published in July 2015, 91.1% reported the last GP they visited had been good at involving them in decisions about their care. This compares

Good

Are services effective?

(for example, treatment is effective)

to a national average of 81.5% and local CCG average of 84.9%. The same survey revealed that 96.8% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 90.4% and local CCG average of 93.3%.

Staff told us that they asked patients for their consent before undertaking any care or treatment and acted in accordance with their wishes. Staff told us that they ensured they obtained patients' written, verbal or implied consent to treatments.

GPs 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. The practice had developed a leaflet aimed at the under 16 age group entitled 'Did you know you can be seen alone?' which gave young people information on their rights in respect of consultations with medical practitioners.

Patients with a learning disability and those with dementia were supported to make decisions. Clinicians we spoke with were able to demonstrate an understanding of the Mental Capacity Act (MCA) 2005 and their responsibilities in relation to this.

Health promotion and prevention

There was a range of information on display within the practice reception area which included a number of health promotion and prevention leaflets, for example on mental health, dementia, support available for carers, emergency contraception and cervical cancer. There was also a separate information board for young people which contained relevant health information concerning issues such as sexual health, bullying, contraception, healthy eating, drugs and alcohol. The practice website also included links to a range of patient information including family health, long-term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review which was generally in the month of their birth. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was 89.9% which was above the national average of 81.9%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was in line with or slightly above averages for the CCG. For example, Dtap/IPV/Hib (a 5-in-1 vaccination to prevent diphtheria, tetanus, pertussis, polio and haemophilus influenza type b) vaccination rates for 12 month old children were 95.8% compared to 98% locally. The meningitis c vaccination rate for two year old children was 100% compared to 98.2%; and for five year old children 94.4% as compared to 98.7% locally. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 77.9% (national average 52.3%) and the percentage of patients aged 65 or older who have received a seasonal flu vaccination was 84.9% compared to a national average of 73.2%.

The practice also offered NHS health checks for patients between the age of 40 and 74, new patient health checks and over 75 annual reviews.

A weekly smoking cessation clinic was held and patients were proactively signposted to this service. The notes of 99.2% of the practices patients with physical and/or mental health conditions recorded a smoking status in the previous 12 months compared with a national average of 95.3%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The patient we spoke with said they were treated with respect and dignity by the practice staff. Comments made by patients on Care Quality Commission (CQC) comment cards reflected this. All of the six CQC comment cards completed 41 were positive. Words used to describe the practice and staff included excellent, polite, friendly, professional, caring and clean.

Data from the National Patient Survey, published in July 2015, showed the practice was rated as above average for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors. For example:

- 93.7% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91% and national average of 88.6%.
- 95.5% said the GP gave them enough time compared to the CCG average of 89.4% and national average of 86.8%.
- 97.1% said they had confidence and trust in the last GP they saw compared to the CCG average of 95.7% and national average of 95.3%

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times. National GP Patient Survey results showed that 97.6% of respondents found the receptionists at the practice helpful compared with the CCG average of 89.9% and national average of 86.9%.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A separate room was available if a patient wished to speak to a receptionist in private.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

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

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients response was higher than average in relation to questions about their involvement in planning and making decisions about their care and treatment. For example, the survey showed 91.1% of the 91 patients who responded to the survey said the last GP they saw or spoke to involved them in decisions about their care. 92.4% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the local CCG and national averages.

The majority of the survey results for the practice were higher than the national averages. For example, 95.3% of respondents described their overall experience at the GP surgery as good compared to the local CCG average of 88% and national average of 85.2%. The percentage of patients who stated they would recommend the surgery to someone new to the area was 90.2% (local CCG average 80.5%, national average 78%).

We saw that a translation and interpretation service was available for patients who did not have English as their first language and a hearing loop was available for patients with a hearing impairment. Providing this type of service helps to promote patients' involvement in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The patient we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were excellent, polite, friendly, professional and caring.

Good

Are services caring?

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice was proactive in identifying and responding to the needs of carers, including young carers and had forged effective working relationships with the local carers association to which patients could be referred. Carers were routinely offered a longer appointment, carer's assessment, annual health check and flu immunisation.

The practice held quarterly multi-agency palliative care meetings. The practice regularly sent sympathy cards to patients experiencing bereavement and would also contact bereaved patients directly to offer support.

The National GP Patient Survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 92.4% said the last GP they spoke to was good at treating them with care and concern compared to the local CCG average of 87.5% and national average of 85.1%.
- 96.8% said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 93.3% and national average of 90.4%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had considered the needs of its patient population in planning its services. This included:

- Constant monitoring of demand for appointments which often led to additional sessions being delivered.
- Reviewing the way in which chronic disease management and long term condition review appointments were held to ensure reviews took place in birth months.
- Ensuring that patients with multiple long term conditions were offered one comprehensive review.
- Creating bookable telephone consultation appointment slots.

The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment. For example, the practice had a palliative care register and held quarterly multidisciplinary meetings to discuss patients and their families' care and support needs. Practice staff were also able to demonstrate that they worked closely with other health care professionals such as school nurses and health visitors.

The practice held a register of those patients with a learning disability or mental health condition. These patients were offered an annual health check and flu vaccination. An alert was placed on the practice computer system for all vulnerable patients which enabled staff to identify them and ensure their needs were met when requesting appointments or during consultations. The practice had taken steps to ensure patients with dementia were identified and received appropriate treatment and services.

The practice had a higher than England average number of patients over the age of 75 (15.2% compared to the national average of 7.6%) but ensured that all of these patients had a named GP and were offered a health check. The practice was proactive in identifying and responding to the needs of carers.

The practice could demonstrate that it had considered suggestions for improvement and changes to the way services were delivered as a consequence of feedback from patients. The results of a patient survey the practice had carried out in September 2014 had been analysed by the patient participation group. The patient participation group (PPG) consisted of approximately 10 members who met formally on a quarterly basis and more regularly informally. The PPG were actively trying to recruit more members and were targeting in particular the 36 – 45 year old age group as this was an area where they felt they lacked representation. They were also trying to get local pharmacists involved in the group. We spoke to a member of the PPG who told us that they had successfully managed to engage two local pharmacies to attach information leaflets/flyers to prescriptions to aid practice communication. This had included a leaflet offering support for young carers.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of people in the planning of its services. The practice had access to a telephone translation service if required for those patients for whom English was not their first language. The practice also maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all patients had equal opportunities to access the care, treatment and support they needed.

The premises were situated on the ground floor of the building which met the needs of people with disabilities. The reception area, treatment and consultation rooms were all accessible by those with mobility difficulties and there was step free and wheelchair access to the building. The practice had a car park with dedicated disabled parking spaces and on-street parking was readily available free of charge nearby. Lockable bike storage units were also available.

The practice had male and a female GP, which gave patients the ability to choose to see a doctor of a particular sex if preferred.

Patients were easily able to register with the practice and patients who were not registered, such as temporary visitors to the area or those of no fixed abode were able to access appointments as temporary residents. The practice had temporary residents of a local bail hostel and homeless unit on its patient list.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open from 8.00am to 6.00pm on a Monday, Tuesday and Friday; from 8.00am to 7.00pm on a Wednesday and from 7.30am to 1.00pm on a Thursday. One of the GPs remained 'on call' on a Thursday afternoon to deal with requests for emergency appointments.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered early opening from 7.30am one day per week and extended opening hours up to 7.00pm one night per week. Pre-bookable telephone consultations were also available to ensure the needs of people who worked and students could be accommodated.

The patient we spoke with and those who completed Care Quality Commission (CQC) comment cards said they were satisfied with the appointment system operated by the practice. Of the patients who participated in the 2015 National GP Patient Survey published in July 2015, 98.3% said they could easily get through to someone at the practice on the telephone (local CCG average 79.3%; national average 74.4%) and 90.1% stated they were satisfied with the practice opening hours (local CCG average 81.2%; national average 75.7%).

Appointments could be booked in the surgery, by telephone or online. We looked at the practice's appointment system during our inspection and found that a routine appointment was available with a GP two working days later. Urgent appointments were available the same day and telephone consultations were available by appointment. The practice was flexible in its approach to request for home visits.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed there was an answerphone message advising the called to ring the NHS 111 service for further advice and guidance. The exception to this was on a Thursday afternoon when phone calls would be answered by the on-call GP.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was designated to handle all complaints and would investigate complaints in conjunction with the GP partners.

We saw that information detailing how to make a complaint was included in the practice information leaflet, on a poster displayed in the waiting room and on the practice website.

The practice recorded five complaints for the period 1 April 2014 to 31 March 2015 and had received no further complaints from 1 April 2015 to the date of our inspection. From the complaints we looked at we found that they had been dealt with appropriately and apologies issued where a complaint was felt to be justified. The practice manager told us that lessons learned and matters arising from complaints wold be disseminated to practice staff via team meetings with the aim of trying to identify trends and themes.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was clearly outlined in their statement of purpose which stated:

'Our purpose is to provide people registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. We aim to achieve this by developing and maintaining a happy sound practice which is responsive to people's needs and expectations and which reflects whenever possible the latest advances in primary health care'.

The staff we spoke to told us they understood and were committed to their roles and responsibilities in relation to this.

The practice did not have a written business plan although they did have an annual business planning meeting and staff were clear about what the long term vision and objectives of the practice were. This included trying to secure additional accommodation space within the building, developing the practice further as a training practice, and working with the local GP alliance to ensure seven day access was available to its patients.

Governance Arrangements

There was a clear leadership structure with named members of staff in lead roles. For example one of the GPs was the lead for safeguarding and the other for QOF. Each member of the administrative team were responsible for an area of QOF and for ensuring patients were invited to attend reviews. Members of staff we spoke with told us they were clear about their own roles and responsibilities as well of the roles of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures which were up to date.

The practice held regular informal and quarterly formal whole staff meetings. The formal meetings were minuted and addressed issues such as performance, quality, risks, learning and issues outstanding from previous meetings.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. A staff handbook was available and policies and procedures were easily accessible both electronically and in paper format. All new staff went through an induction process and an induction pack was available.

We found there were good levels of staff satisfaction which had resulted in a stable workforce and good staff retention rates. Staff we spoke with were proud of the practice and felt it was well led and a good place to work. They told us there was an open and honest culture within the practice and they were happy to raise issues both informally and during team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had an active patient participation group (PPG) who met on a quarterly basis and carried out annual patient surveys. The priorities identified from the survey carried out in September 2014 were:

1. The availability of appointments
2. The process for dealing with repeat prescription requests
3. The care of patients with cancer, mental illness and depression

There were 13 patient reviews of the practice on the NHS Choices website resulting in a rating of four (out of five) stars. Of the 13 reviews, 9 were very positive. The other four reviews were negative and the two most recent posted in January and March 2015. These raised concerns over a lack of consultation regarding a change in medication and the patient only being given a very short consultation time. The practice had responded appropriately to the majority of reviews.

The practice gathered feedback from staff through staff meetings and on a more informal day to day basis. Staff we spoke with told us they regularly attended staff meetings

Are services well-led?

Good

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

and felt these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice which they said helped to improve outcomes for both staff and patients.

A whistle blowing policy was in place which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop. The practice nurse told us they had opportunities for continuous learning to enable her to retain her professional registration and develop the skills and competencies required for chronic disease management. Regular staff appraisals were taking place for the non-clinical staff. However, the practice nurse who had been appointed in November 2014 had not yet had the opportunity of an appraisal and had not been through a formal induction process since joining the practice.

The practice had regularly reviewed significant events and other incidents with a view to identifying any trends or themes and determine learning opportunities. These events were shared with relevant staff as and when appropriate through team meetings.

Innovation

We saw several areas of innovation during our inspection, including:

- The use of local pharmacies to attach practice information leaflets to prescriptions aiding practice communication and engagement.
- A young people specific notice board and development of leaflets for young people including advice and guidance for young carer's and on their rights regarding being seen alone during consultations.
- The development of the practice smoking cessation programme which was run by a member of the administrative team

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The practice recruitment policy did not include the need to seek references, verification of qualifications/ registration with appropriate bodies, DBS checks or photographic ID. Recently appointed staff had not been subject to formal reference checks**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.