Dr Shetty and Partners

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.

Summary of findings

Contents

Summary of findings

Overall summary

The practice is located in Pallion Health Centre, Sunderland and provides primary medical care services to patients living in the City of Sunderland.

Processes are in place to identify unsafe practices, and measures are put in place to prevent avoidable harm to people. However there is no written evidence available to show any learning from incidents or action that had been taken 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 has recently started undertaking clinical audits.

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.

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 the time of the inspection that time.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Some aspects of the service were safe. The practice investigated incidents when they had occurred but there was no written evidence available to show any learning from incidents or of any action taken to prevent a recurrence. Staff were aware of safeguarding procedures for children and adults but had not received training for adult safeguarding

Are services effective?

The service was effective. Care and treatment was being considered 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 was undertaking some clinical audits, reviewing their processes and monitoring the performance of staff.

Are services caring?

The service was effective. Care and treatment was being considered 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 was undertaking some clinical audits, reviewing their processes and monitoring the performance of staff.

Are services responsive to people's needs?

The service was responsive to people's needs. 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 service was well led. The practice delivered person centred quality care to the patients. The practice had a clear vision and set of values which were understood by staff and evident on the practice website. Staff were committed to maintaining and improving standards of care. However there was limited written evidence to support that audits had been carried out. 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 was knowledgeable about the number and health needs of older patients using the service. The practice actively reviewed the care and treatment needs of older people and medication reviews were completed with all patients over the age of 75. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

The practice engaged 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

All of the staff had a very good understanding of the care and treatment needs of people with long-term conditions. The practice closely monitored the needs of this patient group and promoted approaches the patient could use to improve their quality of life. Staff invited those patients for routine checks and reminded them of appointments at clinics.

Staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems.

Mothers, babies, children and young people

The practice provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. We saw the practice had processes in place for the regular assessment of children's development.

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.

All of the staff were very responsive to parents' concerns and ensured parents could easily secure an appointment for their child when necessary.

Summary of findings

The working-age population and those recently retired

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.

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 advice on such things as Looking After Yourself , and Signs and Symptoms Suggestive of Cancer.

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.. The practice highlighted patients on the register for regular reviews.

The practice communicated with other agencies, for example health visitors, to ensure vulnerable families and children were monitored to make sure they were safe.

All of the staff had a very good understanding of what services were run within their catchment area such as supported living services, care homes and families with carer responsibilities.

People 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.

The practice worked in partnership with other local services to ensure patients experiencing poor mental health were supported. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision.

Summary of findings

What people who use the service say

We received five completed patient CQC comment cards and spoke with six patients who were using the service on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients were complimentary about the service. They felt the doctors and nurses were knowledgeable about their treatment needs. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy.

We looked at the results of the national GP survey for 2014 and of a patient survey conducted by the practice in October 2013 that collected the views of 100 patients who used the service. Both showed patients were very positive about the service they received.

83% of patients who had a preferred GP usually got to see or speak to that GP.

96% of patients found it easy to get through to the surgery by phone.

98% of patients would recommend the surgery to someone new to the area.

We found that the practice valued the views of patients and saw that following feedback from surveys and the patient participation group, changes were made in the practice.

Areas for improvement

Action the service SHOULD take to improve

- There was no formalised review process to demonstrate what the practice had implemented in terms of changing policy, or lessons learnt to avoid any reoccurrence following investigations of incidents.
- Staff had not received training in the safe guarding vulnerable adults.
- There was no evidence to show that checks had been carried out with the Nursing Midwifery Council (NMC) registration lists each year to make sure that the nurses were still deemed fit to practice.
- Prescription pads issued to each authorised prescriber did not include the name of the person making the supply and the serial numbers of the prescriptions in line with national NHS Protection guidance.

Dr Shetty and Partners

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 second CQC inspector, a practice manager and two CQC pharmacist inspectors.

Background to Dr Shetty and Partners

The practice is located in Pallion Health Centre, Sunderland and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the City of Sunderland. The practice is providing services to 7146 patients of all ages.

The practice has four GP's and two practice nurses. It is open 8am to 6pm Monday to Friday and also until 7pm on Wednesdays. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nurse clinics.

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

The practice is registered with the Care Quality Commission to deliver the regulated activities:

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury services and Family Planning.

Why we carried out this inspection

We inspected this practice 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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Detailed findings

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

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 a representative 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.

We carried out an announced visit on 28 August 2014 between 09.00 and 17.00

During our visit we spoke with a range of staff, including 2 GP's the practice manager, one person from administration and a receptionist.

There were no nurses available on the day of the inspection or any members of the patient participation group. However, following the inspection we contacted and spoke with a nurse and also a member of the patient participation group.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Safe patient care

The practice had some systems in place to monitor patient safety. Information from the Quality and Outcomes Framework (QOF) which is a national performance measurement tool showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

There was an incident reporting policy in place which outlined why incidents should be reported, how to report them and how they would be investigated. We spoke with staff and they were able to describe the incident reporting procedure. Internal investigations were conducted by the practice manager or a GP when any incidents occurred; however there was no documented record or formalised review or follow up to incidents following investigation.

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

Learning from incidents

We were told that incidents were investigated when they occurred. However, there was no written evidence available to show any learning or lessons learnt from incidents that had taken place. We did see that action from an incident had been taken following a recent complaint investigation and shared with appropriate members of the team.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or drugs, or give guidance on clinical practice. They told us the alerts came into the practice via e-mail and they were disseminated to the GP and nurse who checked to see if they were applicable to the practice. If it was, then any action required was taken. Staff confirmed they were made aware of relevant safety alerts. Action was taken in response to alerts however; there was no written record of actions taken .

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. We reviewed the training files of two administrators and two members of the nursing staff. Training in safeguarding for children had been completed but not for safeguarding adults.

The practice had a lead GP for safeguarding. They had attended training to support them in carrying out this role. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews.

The practice offered patients a chaperone prior to any examination or procedure.

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

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.

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 were flexible in 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.

Medicines management

The practice had a comprehensive set of policies covering the safe handling of medicines.

Arrangements were in place to manage repeat prescribing safely, review dates were recorded and high risk medicines

were managed by GPs and not available on repeat prescription. However, we saw that a small number of prescriptions had been repeated without the scheduled review being undertaken by the doctor.

Medicines and oxygen for emergency use were readily accessible and were checked regularly to make sure they remained safe to use. Checks were in place to make sure that refrigerated medicines such as vaccines were stored at the correct temperature. Medicines were checked regularly and stock rotated, this ensured that medicines did not go past their expiry date and remained safe to use. Prescription pads were stored securely but records of pads issued to each authorised prescriber did not include the name of the person making the supply and the serial numbers of the prescriptions in line with NHS practice guidance.

There was a system in place to manage any medicine changes for patients discharged from hospital, or seen by external healthcare professionals.

The pharmacist from the Clinical Commissioning Group visited the practice every two weeks to offer support and advice to staff regarding the management of medicines.

Cleanliness and infection control

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 staff explained and demonstrated how they avoided handling patients' specimen tubes directly to minimise the risk of infection transmission. The practice did not have a lead for infection control at the time of the inspection as the previous person had recently left the practice.

Instructions about hand hygiene were available throughout the practice with appropriate facilities in each of the surgeries and clinical rooms.

We were told that the practice did not use any instruments which required decontamination between patients and all instruments were for single use only.

Each room had a privacy screen which was seen to be clean and hygienic.

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. Sharps boxes were not wall mounted but were stored safely to avoid risk to patients.

Staffing and recruitment

The practice's recruitment policy was in place and up-to-date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service. We looked at a sample of recruitment files for administrative staff and nurses. All staff had received a Disclosure and Barring Service check (DBS) to the level agreed for their post.

The practice manager also obtained health statements for all employees so they knew the person was physically and mentally able to perform their role.

There was no evidence to show that the practice checked Nursing Midwifery Council (NMC) registration lists each year to make sure the nurses were still deemed fit to practice.

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.

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 a business continuity plan to help it deal with emergencies that might interrupt the smooth running of the service such as power cuts and adverse weather conditions.

Staff spoken with and records seen confirmed that staff had received training in medical emergencies including resuscitation techniques. Staff were trained in basic life support and the treatment of anaphylactic shock (severe allergic reaction).

Are services safe?

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.

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), and fire extinguishers. We saw all equipment had been tested and that the provider had contracts in place for the testing of portable electric appliances. (PAT testing) on an annual basis and for the routine servicing and calibration, where needed, of equipment such as blood pressure cuffs and weighing scales.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

There were systems in place to measure the effectiveness of care and treatments. Care and treatment was delivered in line with best practice guidance. Doctors and nurses were able to prioritise patients and make use of available resources to ensure patients experienced the best possible outcome from their treatment. Patients were referred to secondary care in a timely manner.

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.

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 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.

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

Patients were involved in decisions about their care and treatment. The clinicians were familiar with and were following current best practice guidance.

The practice used management care plans for patients with long-term conditions. This supported the practice nurse to agree and set goals with patients which were monitored at subsequent visits.

Care was tailored to individual needs and circumstances, including a person's expectations, values and choices. Regular 'patient care reviews', involving patients and carers were completed.

Staffing

The 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. The practice had an induction programme in place, which covered a wide range of topics such as dignity and privacy, equality and diversity as well as essential training. Staff had accessed some on line training for Information Governance and safeguarding for children. However there was no written information to show the dates when training had been completed or when any updates were due.

The practice manager said she was in the process of organising training for health and safety, infection control and safeguarding for adults.

There was no formal appraisal system in place; however staff were able to raise issues directly with the practice manager. Staff spoken with told us that they preferred this approach and they could request specific training where it was relevant to their role. 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, and we saw evidence that this had taken place

Are services effective?

(for example, treatment is effective)

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 meetings with other healthcare professionals. These included with district nurses, health visitors, and midwives.

The GPs described how the practice provided the 'out of hours' service with information, to support, for example end of life care. 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.

Information received from other agencies, such as accident and emergency or hospital outpatient departments was read and action taken by the GPs on the same day.

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 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.

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available. The practice had recently developed booklets for patients with problems with their blood pressure or heart conditions. Both booklets gave help in how to recognise and possibly reduce symptoms, by changes in their lifestyle and what action to take if they felt unwell.

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.

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. Words used to describe the approach of staff included caring, respectful, considerate, polite, and obliging.

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.

Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was a room available if patients wished to discuss something with them away from the reception area. We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Telephone calls in respect of discussing results and booking appointments were taken in a room at the back of the reception desk. We observed staff were discreet and respectful to patients.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was in the waiting area and on each consulting and treatment room door.

One patient told us they felt supported by the GP. They accepted they may be kept waiting for their appointment as they felt the GP was spending time with patients. We saw the receptionist advising patients that there was a delay with appointment times. A patient told us they had to travel quite a distance to get to the surgery but was happy to do this.

Another patient had been registered at the practice since they were a child. They had no problems getting an appointment with either a GP or a nurse.

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.

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. The GP's had started completing care plans for the 2% of their patients who were at high risk from their conditions. A copy of the care plan was also given to the patient to ensure their involvement.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005. GPs and nursing staff told us relatives, carers or an advocate were involved in helping patients who required support with making decisions.

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations. Written consent was obtained for gynaecological examinations. The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted.

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

We saw that access to interpreting services was available to patients, should they require it.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The health centre in which the practice was situated was purpose built. It provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was lift and stair access throughout the building.

The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter for patients with a hearing impairment.

The practice was working hard to encourage people with a disability such as a learning disability to come in to the practice and made longer appointments available with the GP and a nurse to ensure there was plenty of time to discuss problems.

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

Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs.

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.

Access to the service

The PPG survey in October 2013 showed that patients were able to be seen by the practitioner of their choice. Patients we spoke with also confirmed this. It was found that most appointments were made by telephone and patients found their appointment time convenient.

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. Patients were seen to be given a variety of appointment times so they could choose one to fit in with their schedule. Emergency appointments were available twice daily, during morning and afternoon surgeries. In the patient survey the making of appointments on-line was described as good. Out of hours enquiries were redirected to the practice's contracted out of hour's provider, Northern Doctors.

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.

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 and complaints

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

We saw that there was a complaints procedure in place and on display throughout the practice. The patients we spoke with were all aware of the process to follow should they wish to make a complaint.

There was evidence of complaints, the initial response from the practice and the investigation that had taken place. There had been learning from a recent complaint which had been shared with appropriate members of the team.

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.

Are services responsive to people's needs?

(for example, to feedback?)

None of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 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

The practice manager, GPs and staff we spoke with were very clear on their roles and responsibilities. They all demonstrated a deep understanding of their area of responsibility and each one clearly took an active role in ensuring that a high level of service was provided on a daily basis. Staff we spoke with were able to describe the values of the practice and their desire to provide patients with an effective, high quality service. The practice website outlined the roles and responsibilities of staff and patients and also encouraged patients to become involved in the running of the practice.

Practice meetings were held every 3 months for all staff and minutes were taken by the practice manager. There was also a daily half hour meeting with the GP's and practice manager. Minutes of these meetings were taken when anything significant was discussed.

Meetings were available on Wednesdays if the practice manager or nurses had anything they needed to discuss. Ad hoc meetings were held if a significant event had occurred.

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.

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 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.

The governance arrangements ensured that responsibilities in the practice were clear. The GP partners took an active leadership role for overseeing that the systems in place were consistently being used and were effective. For example there were processes in place to highlight 2% of high risk patients and ensure they had care plans and the patients had their own copy.

Systems to monitor and improve quality and improvement

The practice did not have formal systems for monitoring all aspects of the service and there was limited evidence of clinical audits being used. However there was evidence in place to show that patient's with long term conditions were reviewed and longer appointments were being offered with the GP and nurse. This reduced the number of appointments and times the patient needed to go to the practice.

We saw there were systems for monitoring the on-going fitness of clinicians to practice were in place.

Patient experience and involvement

The practice had an active PPG (patient's participation group) with 12 regular members. We saw that this group discussed how the service operated and listened to their insights into the patient experience. From a review of the minutes of their meetings we found the PPG was very effective and engaged. Their views were listened to and used to improve the service being offered at the practice. For example the introduction of a local as opposed to a costly 0845 phone number had been in response to patients' feedback.

They had also recently carried out a survey to highlight the number of patients who were also carers. At the last PPG meeting two people came from Sunderland Carers Centre, which provides help and respite/day care to carers.

Patients we spoke with were positive about the care they received. Many had been coming to the practice for all of their life. In the survey undertaken by the (PPG) in October 2013 96% of the respondents recorded satisfaction with the services provided by the practice and 88% had no concerns with the practice.

Staff engagement and involvement

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 areas for improvement. The practice posted the results of the survey on their website. We saw results

Are services well-led?

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

from the most recent survey in October 2013 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 contribute to these discussions.

Learning and 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 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, however there was no written documentation to support this. 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 health and safety policy which included clear guidance for staff. Staff meeting minutes showed evidence of cascading information. A comprehensive business continuity plan was in place.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety.

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.

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.

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

Care was tailored to individual needs and circumstances, including a person's expectations, values and choices. Regular 'patient care reviews', involving patients and carers were completed.

Clinicians supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their overall care. GPs acted as a coordinator and navigator of care where this was appropriate. Clinicians made referrals to specialists in an appropriate and timely way.

A range of health promotion advice and information related to various conditions including advice on self-management were on display in the practice. Clinicians proactively case managed and completed long-term monitoring of these patients' needs.

Access to services, including flexible appointment times and same day telephone consultations where appropriate, were available.

People were signposted to patient groups and supported to access a support network.

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 a person's expectations, values and choices. Regular 'patient care reviews', involving patients and carers were completed.

Clinicians supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their overall care. GPs acted as a coordinator and navigator of care where this was appropriate. Clinicians made referrals to specialists in an appropriate and timely way.

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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

There were arrangements in place to identify children and young patients who were being abused or were at risk of being abused and ensure that appropriate action was taken. Staff demonstrated that they had an understanding of the indicators of abuse and would take action if abuse was suspected. Staff had access to contact details for child protection team at the local authority.

There were regular baby clinics held in the practice to give parents and their young children access to a vaccine service and advice as necessary. Six week baby checks were carried out and health and development checks were undertaken as appropriate. If children did not attend for appointments then the staff followed this up with the health visitor.

We found that the practice responded to the needs of parents, babies, children and young people. The appointments system meant that they were able to attend the practice at a time that suited them. Appointments were available outside school hours.

Working age people (and those recently retired)

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

Our findings

The practice offered a choice of appointment times system for people who were working, which enabled access for this group.

Care and treatment was considered in line with current published best guidelines for this patient group. These patients' needs were consistently met. Referrals to secondary care were made as soon as the need was identified.

The practice had a clear complaints policy and responded appropriately to complaints about the service. Patient surveys were conducted, which covered their satisfaction with the service and the practice took action to make suggested improvements.

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

Open access to the service was provided, which meant all people from the catchment area could register with the practice. The practice provided sign-posting to specialist support groups.

The practice proactively assessed and monitored the practice population needs, including for people in vulnerable circumstances. People were encouraged to participate in health promotion activities, such as breast screening, cytology, smoking cessation. Staff took time to listen to people from this population group.

The practice had a structured approach to addressing health needs and inequalities. Patients told us they felt able to trust the practice staff with personal information.

People experiencing poor mental health

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

Our findings

The practice proactively assessed and monitored the practice population needs, including for patients with mental health needs, including within hard to reach groups.

Care was tailored to their individual needs and circumstances, including their physical health needs. Including annual health checks for people with serious mental illnesses.

The practice proactively offered access to a variety of treatments such as listening and advice, and counselling services.