Dr Rex Obonna

Quality Report

Southwick Health Centre
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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.

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Summary of findings

Overall summary

The practice is based in Southwick Health Centre which is located in Sunderland. The practice is based at The Green, Southwick, Sunderland. It is a small practice with 2096 patients. The practice had not previously been inspected by the Care Quality Commission (CQC) and the provider declared full compliance when it was registered in April 2013. The practice does not have any branch surgeries, so the inspection was focused on this location.

Before the inspection we looked at a wide range of information we held about the practice as well as information the practice sent to us. We asked other organisations, such as the Sunderland Clinical Commissioning Group (CCG) and the local Healthwatch organisation, to share with us what they knew about the practice. We held a listening event where members of the public could tell us about their experiences of GP services within Sunderland. We also asked patients prior to our visit to complete CQC comment cards about their experiences of the service they had received.

We carried out an announced inspection on 26 August 2014. During the inspection we spoke with patients and staff. We also received 15 CQC comment cards completed by patients. Feedback from patients was very positive.

They told us they were satisfied with the care and treatment they received. Patients also reported they felt involved in all decisions surrounding their care or treatment, and felt safe using the practice.

The practice had planned its services to meet the needs of the different types of patients it served. Practice staff had made arrangements which helped to protect and safeguard patients. Patients told us they were treated with respect and dignity at all times. Patients also reported they felt involved in decisions surrounding their care or treatment. The practice was clean and hygienic throughout. However, we also identified Disclosure and Barring Service checks had not been carried out for all staff involved in patient care placing them at risk of being cared for by unsuitable staff. We have therefore found that the practice was in breach of regulation relating to:

*Requirements relating to workers.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Most aspects of the service were safe.

The practice had taken steps to protect patients from harm or injury. Patients told us they felt safe using the practice. The practice was clean and hygienic throughout and staff had completed training which helped them to keep patients safe and meet their needs. However, Disclosure and Barring Service (DBS) checks had not been carried out for all staff involved in patient care placing them at risk of being cared for by unsuitable staff.

Are services effective?

Are services caring?

The practice provided a caring service.

Patients were positive about the care and treatment they received from the practice. They told us they were treated with respect and dignity, and involved in making decisions about their care and treatment. They told us the practice staff provided a good service. Patients did not raise any concerns about the practice and its staff team.

Are services responsive to people's needs?

The practice provided a responsive service.

We found the practice understood and was responsive to the needs of the population groups it served and had taken reasonable steps to provide appropriate care and treatment. Patients said they were satisfied with the appointment systems operated by the practice and found it easy to access the practice by telephone.

Are services well-led?

The practice was mostly well-led.

The GP and practice manager had the capacity, capability and experience to lead effectively. The GP and their practice manager demonstrated a clear commitment to their patients and meeting their needs. This commitment was reflected in the positive feedback we received from patients who were satisfied with the care and treatment they received. Practice staff worked well together as a team. They were clear about, and competent in carrying out their roles and responsibilities. However, the practice lacked a robust, realistic strategy for achieving its priorities and delivering good quality care, which staff had been involved in developing.

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
We found action had been taken to assess the needs of, and provide care and treatment for, patients aged 75 years and over. This included taking steps to identify patients who would benefit from more support to help them avoid an unplanned hospital admission due to the complexity of their healthcare needs. Older patients had been informed who would act as their named doctor to help improve the continuity of the care they received. Practice staff had received training which helped them to meet the needs of older patients.

People with long-term conditions
We found action had been taken to assess the needs of, and provide care and treatment for, patients with long-term conditions. The practice had taken steps to identify patients who would benefit from more support to help them avoid an unplanned hospital admission due to the complexity of their healthcare needs. Patients with long-term conditions were offered relevant screening tests and health promotion advice to help them manage their healthcare needs. Practice staff had received training which helped them to meet the needs of patients with long term conditions.

Mothers, babies, children and young people
We found action had been taken to assess the needs of, and provide care and treatment for, mothers, babies, children and young people. Pregnant teenagers and women were provided with ante-natal and post-natal care. Women were provided with an ante-natal and post-natal care plan which contained important information telling them how to keep themselves and their unborn/new-born baby safe and healthy. The practice provided mothers and new babies with access to a weekly baby clinic where vaccination and immunisations were provided by the practice nurse. Young people had access to advice and guidance regarding sexual health, as well as access to appropriate treatment.

The working-age population and those recently retired
We found action had been taken to meet the needs of the working age population, including those that had recently retired. Patients were satisfied with practice opening times and access to appointments. Information about the practice and the services it offered was available on its web site. Health promotion information was available both in the waiting area and on the practice web site.

Summary of findings

The practice provided additional services such as warfarin and travel clinics, and patients were able to benefit from using 'Choose and Book'. The practice provided carers with access to information about where they could get more information and support.	
People in vulnerable circumstances who may have poor access to primary care The practice had taken action to meet the needs of vulnerable patients who might find it difficult to access primary care. The practice had a register of patients with learning disabilities and was using this information to ensure they received an annual healthcare check. The practice referred patients with alcohol and drugs addiction to appropriate secondary services such as 'Turning Point'. The practice manager told us they had very small number of patients within the practice population that could be classed as having poor access to healthcare because of their vulnerability.	
People experiencing poor mental health The practice had taken action to meet the needs of patients experiencing poor mental health. The practice had identified patients with dementia and mental health illnesses, and produced registers to help them deliver services to these groups of patients. Evidence obtained during the inspection showed these patients were receiving care and treatment which followed best practice. Patients with dementia and mental health illnesses were referred to suitable secondary services, for further assessment and treatment. (Secondary care refers to the care and treatment a patient receives in hospital, either as an in-patient or an outpatient.) The practice had taken steps to ensure its staff had the knowledge, skills and competence to respond to the needs of patients experiencing poor mental health.	

Summary of findings

What people who use the service say

During the inspection we spoke with five patients. We received 15 CQC comment cards completed by patients. The feedback we received indicated patients were satisfied with the care and treatment they received. Patients told us they received a good service which was caring and met their needs. They said they were treated with dignity and respect, and felt their privacy was promoted. We received positive feedback about the practice's appointment system and patients told us they found it easy to get through to the practice on the telephone. Patients said they were able to obtain an appointment within a reasonable amount of time. None of the patients we spoke to, or received feedback from, expressed concerns about how the practice operated. Of the patients who responded to the National GP Patient Survey (2014):

- 93% said they found it easy to get through to the practice by telephone;
- 97% said they found the receptionists at the surgery helpful;
- 87% said they usually waited 15 minutes or less after their appointment time to be seen;
- 87% described their experience of making an appointment as good;
- 98% said the last appointment they got was convenient;
- 90% said they were satisfied with the surgery's opening times.

However, patient feedback also indicated that the practice could make improvements. For example, of the patients who responded:

- 69% said the last GP they saw or spoke to was good at listening to them;
- 60% said the last GP they saw or spoke to was good a treating them with care and concern;
- 59% said the last GP they saw or spoke to was good at involving them in making decisions about their care and treatment.

Areas for improvement

Action the service MUST take to improve

- The practice must take immediate action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff.

Action the service SHOULD take to improve

- Blank prescriptions were not stored in a locked cupboard within a locked room;
- Regular infection control audits were not carried out;
- Some staff did not have a written personal development plan and some had not had an annual appraisal;
- The practice did not have a Patient Participation Group.

Dr Rex Obonna

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a Practice Manager and an Expert by Experience. An Expert by Experience is somebody who has personal experience of using, or caring for someone who uses, a health, mental health and/or social care service.

Background to Dr Rex Obonna

The practice is one of three based at the Southwick Health Centre. Services are provided from the Southwick Health Centre, The Green, Sunderland, Tyne and Wear.

Dr Rex Obonna operates as a single-handed GP and employs a practice manager to oversee the day-to-day running of the practice. The practice also has a practice nurse and four reception/administrative staff. A member of the reception team is training to become a healthcare assistant. The practice is part of NHS Sunderland Clinical Commissioning Group (CCG).

The practice is responsible for providing primary care services to approximately 2,096 patients. The practice has a higher percentage of the practice population in the under 18 age group, and a higher deprivation score, than the England averages. Sunderland has some of the worst areas of deprivation in England, with over 40% of the population living within an area classified as one of the most deprived. The Southwick area, within which the practice is located, has high levels of health deprivation and significantly poorer life expectancy than the Sunderland average.

The practice does not provide its own out-of-hours service. When the practice is closed patients access out-of-hours care via a branch of Primecare which is based in the Sunderland area. An 'extended hours' service is available one day a week for patients who are unable to attend the practice during its normal opening hours.

Why we carried out this inspection

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the service. We carried out an announced visit on 26 and 27 August 2014. During our visit we spoke with a range of staff including: the GP; the practice manager; the trainee healthcare assistant; staff who worked in the reception team. We also spoke to a nurse practitioner who worked in the Southwick Healthcare Centre treatment room. This person was not employed by the practice. We spoke with five patients who were visiting the practice on the day of our visit. We received 15 CQC comment cards where patients had shared their views and experiences of the service with us. We observed how people were being cared for. We also looked at some of the records kept by the practice.

Are services safe?

Our findings

Safe patient care

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how this practice operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain.

The CQC had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The CQC had not been informed of any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local CCG did not raise any concerns with us about how this practice operated.

During this inspection, neither the patients we spoke to, nor those who returned CQC comment cards, raised any concerns about safety at the practice. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, arrangements had been made for a member of the team to review any national patient safety alerts that the practice received. Significant event reviews had been carried out in relation to most of the concerning events that had occurred at the practice. Staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We saw that records were kept of significant events. We reviewed significant event reports completed by practice staff over the previous 12 months, and the minutes of meetings where these were discussed. This showed the practice usually identified and responded consistently to safety related concerns when they occurred, and could therefore demonstrate they took action to provide safe patient care in response to these.

Learning from incidents

A system was in place for reporting, recording and monitoring significant events. The practice used a standardised form to record the outcome of any Significant Event Audit (SEA) they carried out. (SEA is a form of case-based audit which helps staff to critically analyse events which have had, or might have, a major impact on patients and to learn from such events to prevent reoccurrence.) We looked at a small sample of the SEAs carried out by the practice. We found that two of the three audits did not include sufficient detail. For example, important information about the patients' history and the physical examinations carried out had been omitted. Also, they did not contain sufficient analysis of what lessons had been learnt and how they might be used to improve patient outcomes. There was also no evidence that the original findings of the SEAs we looked at had been re-examined to identify whether the conclusions reached and actions taken had improved patient outcomes.

Safeguarding

The practice had a range of policies, procedures and systems in place to help keep patients safe. These included, for example, the protection of vulnerable adults and children. The child protection policy, written by the local CCG safeguarding lead, was comprehensive, and included an audit tool that practices could use to assess the effectiveness of their safeguarding children arrangements. The practice had not yet used the tool to assess the effectiveness of their arrangements. The practice's adult safeguarding policy was less comprehensive. For example, it did not include contact details of key professionals involved in safeguarding vulnerable adults and did not specify the level of training staff should complete.

The practice had devised a policy which provided staff with guidance on the role of a chaperone, when they might be needed and who should perform this role. The practice web site provided patients with information about their approach to providing a chaperone. However, a patient leaflet containing information about the practice did not cover the use of chaperones. We were told that none of the receptionists carried out chaperone duties, and this service was provided by the practice nurse or trainee healthcare assistant. The training records of the practice nurse did not include any evidence that they had received training to carry out this role. We were not able to speak to the practice nurse about this as they were on leave at the time of the inspection.

The GP acted as the safeguarding lead for the practice. They met regularly with other primary healthcare professionals to consider any current safeguarding issues, and to identify any action that needed to be taken and who should do this. Systems were in place to identify vulnerable patients at risk of harm or abuse. This included, for

example, adding a code to patients' notes to alert other staff at the practice to potential concerns about their health and welfare. Staff were clear about who acted as the practice safeguarding lead.

Most staff had received training in safeguarding vulnerable patients to a level that was appropriate to their role within the practice. However, the training records for the practice nurse did not include any evidence that they had completed adults safeguarding training. We were not able to speak to the practice nurse about this as they were on leave at the time of the inspection.

Monitoring safety and responding to risk

Patients told us they felt safe using the practice and identified no concerns. The practice had a range of processes in place for identifying new risks. This included carrying out Significant Event Audits to review what had happened and why. Whilst the evidence we obtained showed that appropriate action was taken in response to most new risks, we were told about a recent incident that had not been reported or reviewed as a significant event. The practice manager told us that once this had been identified, they had taken appropriate action to address this. The practice manager acknowledged that a SEA should have been carried out, and said this would be addressed following the inspection.

Practice meetings were used to identify and respond to new risks. The practice had recently employed the services of an external agency to prepare a staff handbook as well as policies and procedures relating to health and safety and human resources. The practice manager told us they were shortly due to complete training in carrying out risk assessments. However, no in-practice risk assessments had been completed.

A business contingency plan had been completed approximately four years ago. (The purpose of such a plan is to identify potential risks which could affect the capacity of the practice to deliver a suitable service in the event of foreseeable emergencies.) However, the plan had not been reviewed since it was first written which meant it was not up-to-date, and might not reflect any potential risks that had arisen since the plan was first drawn up. The practice manager agreed to address this matter following the inspection.

Medicines management

Arrangements had been made which helped to ensure the safe management of medicines. The GP told us they carried out annual patient medicine reviews. The latest complete QOF information (2012/2013) available to us indicated that the practice had exceeded the 80% standard for carrying out a medicine review and recording this in the notes of all patients prescribed repeat medicines, in the preceding 15 months. We were shown more up-to-date QOF information during the inspection which showed the practice continued to perform well in this area.

Patients were able to re-order repeat prescriptions using a variety of ways. This included ordering through local pharmacies, via the practice and by telephone. Although the practice web site advised patients they could register to obtain repeat prescriptions on-line, we were told this service was not well used. . The web site provided patients with helpful advice about ordering repeat prescriptions, including advising patients to allow 48 hours before visiting to obtain their repeat prescription. QOF information (2012/13) confirmed the number of hours from requesting a prescription to its availability for collection by the patient was 48 hours or less.

The practice had systems in place which were known by staff for the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. During the time we spent in the reception area, we observed three patients request repeat prescriptions. The receptionist dealing with these requests dealt with their queries competently, ensuring that two of the patients left with appointments for medicine reviews. We also observed the receptionist taking requests for repeat prescriptions over the telephone. They spent time talking with these patients to identify what they needed. They also checked the patients' electronic records to make sure the prescriptions requested were on repeat. We were told repeat prescription requests were sent through to the practice GP for checking and authorisation.

Blank prescriptions were stored in two rooms. We were told if these rooms were left unoccupied, they were locked to prevent unauthorised access. However, we did identify that the cupboards used to store blank prescription forms were not kept locked. The latest guidance issued by NHS Protect states, "As a minimum, prescription forms should be kept in a locked cabinet within a lockable room or area."

Are services safe?

We reviewed the arrangements for storing vaccines and maintaining the cold chain. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature.) We found regular checks of refrigerator temperatures had been completed to make sure vaccines and medicines were stored at the correct temperature in line with manufacturer's guidance.

The latest complete QOF information (2012/2013) available to us indicated that a prescribing adviser had met with practice staff at least annually, and that the practice had taken steps to comply with the guidance they received regarding prescribing medicines. The GP told us they also attended CCG meetings where prescribing guidelines were discussed. We were able to confirm that the GP had access to both local and national prescribing guidelines. We were told prescription audits had been carried out, but the GP was unable to recall any specific details.

Cleanliness and infection control

The practice was clean and hygienic throughout, and the patients we spoke with confirmed this. Arrangements had been made to ensure the practice was cleaned on a daily basis. The practice manager told us they had recently raised concerns about the quality of the cleaning service they received from NHS Estates, but the issue was not yet resolved. We were told the practice had not been provided with a copy of the schedule that NHS Estates cleaning staff worked to. The practice had recently carried out a cleaning audit, but a written record had not been kept of this.

The practice did not have a designated infection control lead and an infection control audit had not been carried out within the last 12 months. Although the practice had access to an infection control inspection checklist, they had not used this to assess the effectiveness of their arrangements. A member of staff training to become the practice healthcare assistant told us they had become more involved in infection control, particularly in relation to the cleaning of clinical areas. However, they were unable to confirm that the practice had an infection control policy, and did not know what to do in the event of a needle stick injury.

Protective paper covers for consultation couches, personal protective equipment and materials, and bins for clinical and sharps waste, were available in the clinical rooms we visited. Paper screens were available for the examination couches in the clinical rooms. Spillage and biohazard kits were available to enable staff to deal safely with spills of bodily fluids.

Legionella testing was carried out by NHS Estates staff and records were kept centrally. A Legionella risk assessment had been completed and checks were carried out to test for the presence of the Legionella bacteria.

Staffing and recruitment

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. The practice had one male GP and a practice nurse. We were told that patients presenting with same-day urgent care needs were never turned away, and that the GP had told his reception staff they could add extra appointments at the end of his daily surgery sessions.

Patients did not have the choice of accessing a female GP. We were told the practice had funding for eight additional sessions, and had in the past, employed a salaried, female GP. However, this person had left their employment almost two years ago and the practice had since been unable to recruit a female GP. We were told that a 'Capacity and Demand' exercise had been carried out in conjunction with Sunderland CCG a year ago and had identified no significant concerns. However, there was recognition within the practice management team that a female GP was needed, and possibly a second healthcare worker.

We looked at the records of the two staff that had been appointed since the practice's registration in April 2013. Written references and full employment histories had been obtained. Practice staff carried NHS Smart cards which contained a recent identification photograph. We were told staff's identities had been verified under the NHS Employment Check Standards process. Checks had been undertaken to make sure the recently appointed practice nurse was registered with their professional body the Nursing and Midwifery Council (NMC). We checked the NMC and General Medical Council (GMC) Register and found clinical staff employed at the practice were licensed to practice. However, we found DBS checks had not been obtained for either the practice nurse or the member of staff acting as a trainee healthcare assistant. This meant

patients who used the service were not fully protected from the potential risks of unsuitable staff being employed to care for them because effective recruitment and vetting procedures were not in place.

Dealing with Emergencies

The practice had access to equipment and medicines for managing emergencies. This included a defibrillator which was used to resuscitate patients who had stopped breathing. This item of equipment was stored centrally within the healthcare centre and could be accessed at all times by practice staff. Staff knew where to access it and checks were completed to make sure it was kept in good working order.

According to current best practice it is essential to provide a patient who is acutely breathless and deprived of oxygen with access to oxygen whilst they are being assessed and treated in the community. However, we identified that practice staff did not have access to a supply of high flow oxygen for emergency use in such cases. We found the practice only held a limited stock of emergency drugs on the premises. Also, the GP did not carry any emergency medicines in their doctor's bag. There is no specific guidance informing GPs which emergency drugs must be kept on the premises and in their bag. However, a risk assessment had not been carried out to inform the decisions that had been made regarding the availability of emergency drugs.

Staff told us they were clear about the action to take in the event of a medical emergency. All relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training during the previous 12 months. Each clinical room had a 'panic button' call system which could alert colleagues in the event of an emergency. These arrangements helped to protect patients and staff from the risk of harm in the event of a foreseeable emergency.

Equipment

The provider had a range of equipment in place. This included medicine fridges, a defibrillator, sharps boxes (for the safe disposal of needles), and fire prevention equipment. We saw regular checks of the equipment took place to ensure it was in satisfactory working condition. Key staff had recently undertaken fire warden training to help them protect patients and staff in the event of a fire. All fire equipment had service dates clearly visible. Fire tests were carried out by the building caretaker. We were told other building safety related checks were carried out by NHS Estates. We contacted a representative from NHS Estates who was able to confirm relevant building and equipment related checks had been completed.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

As part of our planning we looked at information which highlighted the practice as having more patients attending accident and emergency (A&E) than the England average. The GP was aware of this and provided explanations of why this might be the case. We were told patients with chronic obstructive pulmonary disease (COPD) and asthma could get very anxious and this sometimes precipitated an unplanned admission into hospital. We were told steps were being taken to set up a new local psychological service to try and address this issue. Information leaflets about this new service were available in the reception area. The GP was also aware of the CCG's work in relation to improving patients' experience of urgent care services in Sunderland. We saw the practice had put systems in place to help it develop, monitor and improve the quality of the care and treatment provided to patients. For example, the latest complete QOF information (2012/13) showed the practice had participated in an external peer review with a group of local practices to compare its data on A&E attendances and agree an improvement plan.

The information we held about the practice indicated it had identified and recorded the numbers of patients with asthma, COPD, chronic heart disease and diabetes. We found the numbers of patients identified was in line with the expected prevalence for these groups of patients. This indicated that the practice was good at targeting proactive care for those patients likely to have complex healthcare needs.

The GP told us the care and treatment they provided was evidence based and informed by relevant quality standards, such as local guidelines and those provided by the National Institute for Health and Care Excellence (NICE.) The GP told us they could see up to 16 patients in one session, and that because time was limited they would, where necessary, check the relevant NICE guidelines following a patient consultation. In these cases, we were told the patient would be contacted separately to discuss their care and treatment. We found the practice had put systems in place to fast-track patients who needed specialist assessment and diagnosis.

Arrangements had been made to meet the needs of new patients wishing to register with the practice. The practice offered new patients a personal health check. This included a health assessment by the practice nurse and, where appropriate, a referral to the GP. We were told the assessment covered areas such as past medical and family histories and a measurement of any risk factors. During our inspection reception staff provided good support to a new patient wishing to register with the practice.

Arrangements were in place to ensure informed consent was obtained for the care and treatment provided to patients. Guidance was available and provided staff with advice about how they should seek informed consent from patients, including children, who might find it difficult to provide valid consent. The GP demonstrated an understanding of how to apply the Gillick competency test when assessing the needs of children and young people. Staff told us they never provided any care and treatment without first seeking a patient's permission.

Management, monitoring and improving outcomes for people

We found outcomes for patients who used the practice were mostly in line with expected norms. The latest complete QOF information (2012/13) showed the practice had achieved 90.6% of the overall points available to them. For example, the data showed the practice had achieved maximum points indicating the delivery of good clinical care to patients with, for example, asthma; heart failure; cancer; chronic obstructive pulmonary (lung) disease; dementia and depression. The practice had almost achieved all of the points available to them for delivering clinical care which met nationally accepted standards to patients with coronary heart disease, diabetes, hypertension, or those who had suffered a stroke or mini-stroke. However, the practice had performed less well in relation to the care and treatment provided to patients with chronic kidney disease, epilepsy and osteoporosis. The practice manager told us steps had been taken to address these shortfalls during the 2013/14 QOF year. For example, they told us that more patients aged between 18 and 55 years of age taking antiepileptic drugs had received information and counselling about contraception, conception and pregnancy in the preceding 12 months.

The practice manager told us they were responsible for providing complete, accurate and timely performance information to enable QOF data to be submitted, and that

Are services effective?

(for example, treatment is effective)

systems were in place to enable this to happen. The practice manager said they constantly monitored the QOF information to monitor and review the performance of the practice against specified clinical standards.

The practice had undertaken at least two clinical audits during the previous 12 months. (Carrying out clinical audits helps GPs to measure and improve the quality of the clinical care they provide to patients.) We were told the practice had carried out an Osteoporosis/drug audit within the last 18 months and that a re-audit was due to take place shortly after the inspection. The practice manager was able to tell us about the improvements they made to the care and treatment of patients with this condition. Another clinical audit was also underway at the time of our inspection. This was measuring how well cervical smear test results were recorded by practice staff.

Staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. The GP and practice nurse were registered with their respective regulatory bodies, i.e. the GMC and the NMC. This meant they were considered fit and safe to practise.

We were told practice staffing levels were subject to constant review to ensure they remained relevant and appropriate. It was clearly evident that the GP was dedicated to his patients and committed to providing a personal approach that a single-handed practice enabled and required. The feedback we received showed that patients were very happy with the practice and the care and treatment they received. However, because of the workload, a decision had been made to recruit a female GP to work at the practice. For well over two years the practice had been unable to fill this post.

We were told locum cover was provided for the GP when they took leave. We were told that arranging locum cover was sometimes difficult and, although cover was always provided, the practice was unable to secure consistency of locum cover. We were also told that some locums refused to carry out home visits. The GP told us a doctor from another practice in the same healthcare centre carried out some home visits in his absence.

The practice had already recognised that, without additional help, the practice nurse was struggling to deliver all of the work associated with chronic disease management, as well as other areas of their work. The practice was currently training a member of the administrative team to act as a healthcare assistant in order to reduce some of the pressure on the practice nurse.

Cover was not provided for the practice nurse when they took leave. We spoke to the practice manager about this. They said the practice's chronic disease clinic appointments, and other work carried out by the practice nurse, were scheduled ahead and planning took place to enable commitments to be met without the need to bring in a locum nurse. We were told if a clinic could not be rearranged, for example, the vaccination and immunisation clinic, it would be delivered by the GP, supported by the practice manager who had completed relevant training. We confirmed the practice manager was not undertaking any clinical tasks.

Arrangements were in place to provide staff with opportunities for continued learning, including protected time learning, access to external training courses and attendance at practice and clinical team meetings. We were able to confirm that clinical staff had completed training relevant to their roles and responsibilities. The P had made arrangements to participate in an annual appraisal process. They had an agreed appraiser who was responsible for confirming they had complied with re-validation requirements. The GP also attended Sunderland CCG learning events to help support his continuing professional development.

During the inspection we asked to look at the induction training records for the practice nurse and trainee healthcare assistant. However, we were told that although both staff had received an induction, these had not been documented. The practice manager agreed to address this mater following the inspection.

Working with other services

The practice had made arrangements to promote multidisciplinary working with other services. For example, district nurses and health visitors were invited to attend primary healthcare team meetings at the practice. We looked at a sample of meeting minutes and saw that the primary healthcare team proactively reviewed patients with complex needs who were judged to be at risk of harm, or were nearing the end of their life. The practice worked in partnership with the community midwifery team to provide pregnant women, mothers and children with a suitable

Are services effective?

(for example, treatment is effective)

service which met their needs. The practice had also provided out-of-hours and emergency care services with access to care plan information for patients with palliative care needs. This enabled these services to access patients' medical records in the event of an emergency.

Arrangements had been made which helped to ensure that incoming information, such as blood test results and hospital discharge letters, were dealt with promptly. For example, we were told the GP and practice manager looked at incoming information at the start of the day, and e-tasks would be sent to the relevant staff, depending on the type of information received. We were told the GP would make a decision about whether they needed to telephone a patient or see them face-to-face, to discuss test result outcomes. We spoke to the reception staff who were aware of the above process. They confirmed that it worked as described to us by the GP.

Health, promotion and prevention

Arrangements had been made to support people to live healthier lives. Staff demonstrated a commitment to achieving the best possible outcomes for their patients. Health promotion work was carried out by the practice nurse. The training records for the practice nurse showed they had the skills, knowledge and competencies required to carry out health promotion and preventive care and treatment, or where this was not case, they had taken action to undertake further training. The practice provided a range of services, clinics, and other specialist services. Information relating to health promotion and free dual testing kits for sexually transmitted diseases were available in the reception area. The practice website included helpful information about a range of common ailments and conditions and how they could be best managed. It also contained other helpful information such as details of how patients could access local health and social care services.

New patients were offered a health assessment on registering with the practice. This included a review of their current health and lifestyle. A new patient was registered with the practice during our inspection. We found that the patient was well supported through this process. They told us they were happy with how they had been looked after.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The information we looked at as part of our preparation for this inspection showed that the practice mostly performed as 'similar to expected' in the caring domain when compared to other practices in the Sunderland CCG area. According to other information we looked at the practice performed less well with regards to patient satisfaction, the quality of consultations and the overall quality of care patients received. However, this differed from what patients told us at the inspection. The five patients we interviewed all said they received good quality care. This was also the feedback we received from the 15 patients who completed CQC comment cards.

Patients were treated with kindness, dignity and respect, and their privacy was promoted. For example, privacy curtains were available in the GP and practice nurse consultation rooms. A separate room, close to the reception area, was available should a patient indicate they wished to speak confidentially about a private matter.

Patients we spoke with said they were treated with dignity, and their privacy was respected. Of the patients who responded to the National (2014) GP Patient Survey, 66% were satisfied with the level of privacy when speaking to receptionists at the surgery. However, 24% said that other patients could overhear what they said and they were not happy with this. (10% of patients did not respond to the survey question.)

Reception and management staff were courteous and spoke respectfully to patients at all times. They listened to patients and responded appropriately. Of the patients who participated in the National (2014)GP Patient Survey, 97% said they found receptionists at the practice 'helpful'.

Arrangements were in place to offer patients the option of having a chaperone present during their consultation. We were told the practice nurse, trainee healthcare assistant or practice manager acted as chaperones when required. Patients who answered our question about the availability of chaperones all said they had been offered one. Information about how to access a chaperone was available in the reception area and on the practice website.

Arrangements had been made to provide patients with the support they needed to cope emotionally with their care and treatment. Of the respondents to the National (2014) Patient GP Survey:

- 82% of patients had confidence and trust in the GP;
- 71% of patients said they were given enough time to discuss what they wanted at their appointment;
- 69% of patients said the GP was good at listening to them;
- 60% of patients said the GP was good at treating them with care and concern.

Although some of these percentages fell below the Sunderland CCG area average, only a very small percentage of patients said the practice was poor in these areas. Percentage scores for the practice nurse were slightly higher. Patients who responded to the questionnaire sent out by the GP for their annual appraisal, provided very positive feedback about his performance.

Some of the patients we spoke with said they had been referred to various support groups and had been provided with printed information about their particular healthcare conditions. Information about a range of support groups was available on the practice website.

Involvement in decisions and consent

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the National (2014) GP Patient Survey, 71% of patients said the GP was good at explaining tests and treatments and 58% said they were good at involving them in decisions about their care. Again, although some of these percentages fell below the Sunderland CCG area average, only a very small percentage of patients said the practice was poor in these areas. Percentage scores for the practice nurse were higher. Of the patients we spoke with, all said they had been involved in decisions about their care and treatment, and that staff had taken time to explain things in an understandable manner.

We confirmed that informed consent was obtained from patients before the practice carried out any minor surgery procedures. A template was used to record the outcome of discussions with patients about consent. We explored the

Are services caring?

use of best-interest decision-making for patients without capacity to consent. We found the GP had limited understanding of the Mental Capacity Act and was unsure whether or not a suitable policy was in place.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the diverse needs of the population it served and took action to provide what patients needed. We looked at how the practice met the needs of older patients and patients with long-term conditions. The practice had taken steps to identify patients who would benefit from more support to help them avoid an unplanned hospital admission in an emergency situation due to the complexity of their healthcare needs. Older patients had been informed who would act as their named doctor to help improve the continuity of the care they received. Patients with long-term conditions were offered relevant screening tests and health and promotion advice to help them manage their healthcare needs. Practice staff had received training which helped them to meet the needs of older patients. However, we found arrangements had not yet been made to identify a specific member of staff to be responsible for coordinating the care of each patient in line with an agreed care plan.

Reasonable adjustments had been made which helped patients with disabilities, and patients whose first language was not English to access the practice. For example, consultation rooms and the reception area were on the ground floor. Patients were able to access the first floor treatment and minor surgery rooms via a passenger lift. Patients with physical disabilities were able to enter and leave the main health centre via automatic doors. Disabled parking was available in the healthcare centre parking area as were toilets for patients with disabilities. Access to an interpreter service was available for use by patients whose first language was not English.

The practice did not have an active Patient Participation Group (PPG.) We were told that some years ago, the practice had taken steps to set up a PPG but that this had not worked, and since then no further action had been taken. PPGs are an effective way for patients and the practice to work together to improve the services they provide. We spoke to the practice manager about this. They recognised they should re-look at this area to try to develop an effective PPG.

Access to the service

The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on its website The practice offered patients different ways of accessing appointments. These included accessing appointments by visiting the practice, contacting the practice by telephone and making appointments on-line. We observed staff responding to appointment requests and we looked at the practice appointment booking system. We found the appointment system was well organised and offered a range of appointments. We were told patients were able to book an urgent 'on the day' appointment or a bookable appointment in advance. Extended hours appointments were offered between 6:30pm and 7:30pm each Wednesday. Where patients needed to be seen urgently, and there were no appointments available, reception staff had permission to extend the GP's morning and afternoon sessions. This meant no patients with urgent care needs would be turned away. The GP triaged all requests for home visits and handled any complex patient telephone calls. We found these arrangements enabled the practice to respond more flexibly to patients with urgent same-day care needs requesting immediate appointments, or requests for home visits. The practice manager had undertaken a capacity and demand audit which had been submitted to the local CCG. No formal feedback had yet been received. The outcome of this audit showed that patients were satisfied with access to appointments. Following the audit the practice changed its extended hours provision from early morning to a late evening slot to help ensure better patient uptake of appointments.

Of the patients who participated in the National (2014) GP Patient Survey: 93% said they found it 'easy' to get through on the telephone to someone at the practice; 83% said they were able to see, or speak to their preferred GP; 90% said the practice opened at times that were convenient to them; 87% said they usually waited 15 minutes or less after their appointment time to be seen and reported they didn't normally have to wait too long to be seen. We talked to five patients about their experience of using the practice. None raised concerns about access to appointments. When we checked the patient appointment system, we found appointments were available for the remainder of the week.

The practice's brochure provided information about, for example, the range of services offered and how patients could obtain medical support outside of surgery hours.

Are services responsive to people's needs?

(for example, to feedback?)

Health promotion literature, and information about services provided at the practice, was available in the reception area. The practice website provided patients with information about opening hours, how to obtain repeat prescriptions, and what to do in an emergency. These arrangements helped to provide patients with appropriate information about what the practice provided and how they could promote their own health and wellbeing.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice had a detailed complaints procedure which provided information about how patients could make complaints and how any complaints received would be handled. However, the practice website contained only limited information in relation to this. Patients were advised to contact the practice manager if they had any concerns. The practice manager was the designated person for handling any complaints about the practice.

The practice complaints policy stated, 'All complaints, whether written or verbal, will be recorded by (the practice manager) in the dedicated complaints record.' We were told the practice received 'many complaints' which were handled informally, to ensure they were addressed promptly. However, we were told that no records had been kept of these informal complaints.

The practice had received five formal complaints during the last five years. Records of these complaints indicated the practice had taken action to resolve the issues raised with them. On the day of the inspection we observed a patient meeting with the practice manager. This was to discuss concerns raised by the patient. Following the meeting, it was evident that the patient was satisfied with the outcome and this was confirmed by the practice manager.

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 information we looked at as part of our preparation for this inspection showed that the practice mostly performed as 'similar to expected' in the well-led domain when compared to other practices in the Sunderland CCG area. The most complete QOF information (2012/13) available to us showed that the practice had performed well with regards to practice management.

The GP and practice manager had the capacity, capability and experience to lead effectively. Both had worked at the practice for a considerable length of time and were experienced professionals. They demonstrated a clear commitment to their patients and worked as many hours as were necessary to meet the needs of their patients. This commitment was reflected in the positive feedback we received from patients who were very satisfied with the care and treatment they received. Leadership presence was notable. The practice manager made themselves available to the team and patients throughout the working day. Practice staff worked well together as a team. They were clear about, and competent in carrying out their roles and responsibilities. Staff enjoyed their work and had developed a good rapport with the patients who used the practice.

The practice lacked a robust, realistic strategy for achieving its priorities and delivering good quality care. The practice had a development plan but it had not been reviewed for at least four years. The practice manager acknowledged the plan needed updating to reflect the current priorities of the practice. The GP told us they were looking at what opportunities there might be for closer working with other local practices.

Governance arrangements

Staff understood what they were accountable for and systems had been developed to support the day-to-day work they were expected to carry out.

Systems and processes were in place which helped staff to report on and monitor the performance of the practice. Clinical audits were being carried out. Clinical meetings and staff meetings provided opportunities to review issues affecting the day-to-day running of the practice. The practice had developed policies and procedures which provided staff with clear guidance about how they were expected to carry out their roles. However, the practice manager had difficulty providing us with some of the policies and procedures we asked to look at, due to a recent IT system update. Most policies and procedures were being reviewed by an external contractor to make sure they were up-to-date. A staff handbook had recently been prepared and forwarded to the practice. We were told that some of the policies and procedures referred to within the new staff handbook had yet to be written.

The practice manager regularly monitored the performance of the practice to make sure QOF targets were achieved. We were told detailed weekly monitoring meant that any potential problems with meeting QOF targets were identified early and appropriate action could be taken to address them. The practice manager told us they had purchased a bespoke software package to help them prepare for this inspection and ensure compliance with the regulations underpinning their registration with the CQC. However, the package was not comprehensive and some sections of it had not been implemented.

Systems to monitor and improve quality and improvement (leadership)

The GP and practice manager understood the challenges to providing good quality care, and were taking steps to consider how the practice might operate in the future. However, the practice did not have a leadership development strategy, and there was no agreed plan in place setting out the future development of the practice.

Staff told us they felt supported and valued, and the practice team worked well together to meet the needs of its patients. Staff said they felt comfortable raising issues, and it was clear all practice staff were committed to delivering good patient care.

The practice manager was not aware of the Productive General Practice programme. However, when we brought this to their attention, they took immediate steps to find out more about it. (The Productive General Practice programme assists practices to operate more efficiently by helping them to review the way they work and prepare practice improvement plans.

Patient experience and involvement

Are services well-led?

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

The practice did not have an active PPG. The views of 29 patients had been sought as part of the GP's yearly appraisal. This showed patients were satisfied with the service they received.

Of those patients who responded to the National 2014 GP Patient Survey:

- 82% of patients reported that they had confidence in the GP;
- 71% of patients said the GP was good and giving them enough time;
- 69% of patients said the GP was good at listening to them.

Patients provided similar feedback regarding their contact with the practice nurse. For example, 81% said the practice nurse was good at giving them enough time and 80% said they were good at listening to them.

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

The practice recognised the importance of obtaining the views of patients and those close to them, and it was clear staff placed considerable emphasis on listening to patients on a day-today basis. Patients were encouraged to send any comments or suggestions they had via the practice website. We saw that in 2013, the GP had used the General Practice Assessment Questionnaire (GPAQ) to gather the views of 29 patients about the care and treatment he provided. Staff working at the practice had also been consulted as part of this survey. Feedback received from both patients and staff was positive. However, arrangements had not been made to carry out an in-practice patient survey covering the wider operation of the practice.

Management lead through learning and improvement

Systems had been put in place to enable the practice to continuously review their performance against the current year's QOF performance indicators The practice manager told us they used the QOF and practice IT systems to identify how well the practice was performing and what action was needed to improve performance.

Practice staff were committed to continuous learning and improving how they carried out their roles and responsibilities. We found evidence of on-going staff training, and we were able to confirm that staff had, for the most part, completed the training they needed to carry out their work at the practice. For example, the practice manager was suitably qualified and regularly completed training relevant to the management of the practice. Arrangements had been put in place to support the practice's healthcare assistant to gain experience and complete training to enable them to carry out this role. However, we identified that because appraisals were not taking place, staff did not have clear objectives focussed on improvement consistent with the practice's vision and values. The failure to carry out regular appraisals could mean that staff do not receive an evaluation of their performance and, where necessary, receive the support they need to develop and improve their work performance.

The practice had made arrangements to report on, and learn from, significant events and incidents that had occurred at the practice. However, we identified that some improvements were needed to strengthen their practice in this area.

Identification and management of risk

The practice had an up-to-date health and safety policy which included guidance on how to carry out workplace risk assessments. The policy identified which practice staff were responsible for overseeing health and safety arrangements. Staff also had access to a health and safety handbook which set out the responsibilities of the practice and their employees.

The practice had employed the services of an external agency to carry out a comprehensive health and safety risk assessment in April 2014. This provided the practice with an assessment of what it was doing well and what shortfalls needed to be addressed. One of the shortfalls concerned the practice not having obtained any recorded evidence from NHS Estates that relevant risk assessments had been carried out in relation to the premises in which the practice was based. The practice manager said they had experienced difficulties obtaining access to this information.

Although we did not identify any specific health and safety concerns in relation to the building, we found the practice

Are services well-led?

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

had not taken steps to identify, address and manage potential risks within the practice itself. For example, the practice had not assessed the potential risks associated with, for example, its infection control arrangements.

We found the practice did not have an up-to-date emergency contingency plan. This could affect the practice's capacity to continue to operate in the event of an unexpected disaster, incident or major disaster.

Older people

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

Our findings

The practice planned and delivered services aimed at meeting the needs of older people. We were told the practice had taken steps to implement a proactive care programme aimed at preventing unplanned admissions of older people into hospital. This included using a specialist risk assessment tool to help them identify the most vulnerable patients who were at risk of unplanned hospital admission due to the complexity of their healthcare conditions and needs.

In response to changes in the GP General Medical Services contract, the practice had also written to each patient aged 75 years and over, confirming the GP would act as their named doctor. Providing a named GP helps improve continuity of care and the coordination of services for patients.

We were told that, where the practice had been made aware of a patient's discharge from hospital, action would be taken to invite them in for a review of their medicines within 72 hours of their returning home. However, we were also told the practice's capacity to do this was 'hampered' by the fact that hospital discharge letters might arrive at the practice anywhere between one week and six months after the patient was discharged. We were told that an audit had not been carried out to determine the extent of this problem and its impact on patient safety. We found the practice had a safe system in place which helped to ensure they made a prompt response to any hospital discharge letters they received.

The practice had taken steps to ensure that its staff had the knowledge, skills and competence to respond to the needs of older people. We saw evidence confirming that the practice nurse had undertaken training which helped them to meet the needs of older people with a range of complex conditions. For example, they had completed training in: smoking cessation; Chronic Obstructive Pulmonary Disease (COPD); Spirometry (which is a lung function test); sexual health; immunisation for health and diabetes and suicide prevention. The nurse had also completed a diploma in asthma management and a certificate in cervical cytology and breast awareness. The trainee healthcare assistant was undertaking training provided by a nationally recognised training body. Training completed to date included: professional skills for non-clinical staff; diabetes; chronic kidney disease and taking blood pressure. We saw that more training had been planned and a support and mentoring system was in place.

Information relevant to the needs of older people was available in the reception waiting area and on the practice web site. For example, the web site included information about how patients could access an over 65 years of age assessment.

Arrangements were in place to support older people with multiple conditions to maintain a good quality of life. For example, older people with multiple healthcare conditions were invited for an annual review to monitor their health and well-being. We were told the practice nurse reached a verbal agreement with older patients about how they could manage their health and conditions. The practice manager confirmed the practice nurse did not use a template to record the outcome of any agreements reached with patients regarding the management of their condition.

The practice told us they had previously maintained a carers' register but were not doing so at present. We were also told that although the new patient registration obtained information about whether a patient acted as a carer, this information had not been used to set up a carers' register. Maintaining a carers' register helps alert practice staff that a patient acts as a carer and may need extra help to manage this. The practice manager told us they would look at the benefits of setting up a carers' register. They said they were due to meet with a local carers' organisation to see how they could work together. Information about support for carers was available in the reception area.

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

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We were told the practice nurse was responsible for the delivery of chronic disease management. The practice offered patients access to a variety of clinics and services. This included daily clinics of varying appointment lengths for patients with long-term conditions such as diabetes, asthma and COPD. We were told the practice used the 'Two-Visit' approach to working with patients with long-term conditions. This involved patients undergoing relevant screening tests and completing self-assessment questionnaires at an initial appointment with the nurse, before attending a second visit to discuss results. The length of appointments with the practice nurse varied from 10 minutes up to an hour depending on the type of consultation taking place. We were told the second visit focused on setting achievable personal goals and action plans with the patient, and encouraging and promoting their capacity to manage their own health. However, we were told the practice nurse did not record the outcome of these appointments using a personalised care plan template.

The practice made use of information technology to help them with their patient 'call and recall' system. We were told regular QOF checks were carried out to identify which patients on each of the chronic disease registers were due for a health review. Following each appointment the practice nurse sent the practice manager an e-note asking that the patient's next follow up appointment be booked and entered onto the practice IT system. We were told this system worked well, with few errors being made.

We were told the practice had taken steps to implement a proactive care programme aimed at preventing unplanned admissions of patients with long-term conditions into hospital.

The practice had taken steps to improve medicine safety for patients with long-term conditions by having arrangements in place to respond to incoming hospital discharge letters and other notifications.

The practice had taken steps to ensure that its staff had the knowledge, skills and competence to respond to the needs of patients with long-term conditions.

The practice had made arrangements to support and enable multi-disciplinary working. For example, 'Special Patient Notes' (SPN) had been prepared for patients with complex health and social care needs who were nearing the end of their life. We were told information about the needs of this group of patients had been entered onto a clinical patient management system which could be accessed by out-of-hours primary care and emergency services professionals. This helped to ensure that patients received the care and support they need because it provided healthcare professionals with access to real-time patient care plan information.

Mothers, babies, children and young people

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

Our findings

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of mothers, babies, children and young people. The latest complete QOF (2012/2013) information we had access to showed the practice had obtained the maximum number of points for the additional services they provided. This included: the provision of ante-natal care; screening and child development checks at intervals consistent with national guidelines and contraceptive advice to young people.

Women who might be pregnant could have a pregnancy test carried out by the practice. We were told that once the results had been received, the patient would be given an appointment with the GP to discuss the outcome.

On confirmation of pregnancy, we were told a referral would be made to the community midwifery service. Women received a one hour midwife appointment at the practice. We were told this appointment was used by the community midwife to ask questions about the patient's general health, family and social history and previous pregnancies. The midwife also assessed whether there were any potential risk factors associated with the pregnancy. If concerns were identified, we were told the midwife would make a referral to the practice GP if they thought medicines might need to be prescribed, or to a specialist consultant or midwife if a pregnancy was thought to be high-risk. We were told the vulnerability risk assessment completed by the midwife was scanned by the practice and uploaded into patients' notes to help ensure that the practice GP was aware of any potential or actual health concerns. The midwife working at the clinic had access to the practice's medical records to help them assess patients' health and wellbeing.

Arrangements were in place to support women to access both ante-natal and pre-natal care. Clinical staff, including the community based midwife, signposted women to local support groups such as the' Well Baby' and the 'Bumps to Baby' Clinics. These clinics provided patients with advice on health, education, parenting and accessing further education or training opportunities. We were told signposting patients to these clinics and support groups was important because it gave them access to a specialist health visitor who could provide advice on smoking, breast-feeding, depression, weaning, childhood ailments and sexual health. The practice manager said practice clinicians and the community based midwife encouraged breastfeeding using the Baby Friendly Initiative.

The practice manager told us women were provided with an individualised ante-natal and post-natal care plan. These covered details of the healthcare professionals involved in their care, and information about the support they would receive after giving birth as well as what to do in the event of an emergency. Pregnant women who smoked were automatically referred to a smoking cessation service at their first booked appointment.

The practice provided mothers and new babies with access to a weekly baby clinic where vaccinations and immunisations were administered by the practice nurse. The practice received a weekly list of which patients were due vaccinations and immunisations, and this informed the work carried out by the practice nurse at the clinic. We were told that, should the practice nurse not be available, the practice GP would provide the necessary vaccinations and immunisations or action would be taken to re-schedule clinic appointments. We were told clinicians at the practice checked the immunisation status of all children at every available opportunity. The practice web site included detailed information about what vaccinations and immunisations should be given and when.

The practice GP told us they had 'high numbers of teenage pregnancies'. We were told referrals were made to social services and pregnant young patients would be encouraged to attend the weekly community midwife led clinic. The practice GP was aware that, although these young women might attend the practice for emergency contraception, most were not seeking advice and support with contraception.

We were told there was a local family planning clinic to which the practice would make referrals. Free Chlamydia and Gonorrhoea testing kits were available in the waiting room along with health information about these

conditions. The provision of this service helped young people to test for these conditions in the comfort of their own home, and encouraged them to seek advice and help at the practice.

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 had taken action to plan its services to meet the needs of the working age population, including those that had recently retired. The practice opened hours from 8:30am to 6.30pm, and extended hours were provided each Wednesday between 6:30pm and 7:30pm, to enable working patients to access later appointments. Patients were provided with access to a range of health related services to help them improve their health and wellbeing. These included asthma checks, family planning, smoking cessation and well women clinics. New patients were provided with a healthcare check following registration.

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

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

Our findings

The practice planned and delivered services aimed at meeting the needs of vulnerable patients who might it difficult to access primary care. We looked at the most complete QOF information (2012/13)

we had access to for this practice. We saw that the percentage of patients with learning disabilities on the practice list was 0.48% (nine patients) and was below the local CCG average. The practice was able to produce a register of patients aged 18 years and over with learning disabilities. An alert flag had been placed on each patient's medical records to ensure that all staff would know about their learning disabilities. We were told that some of the patients with learning disabilities also had other conditions, and that their needs in these areas were addressed via chronic disease clinics carried out by the practice nurse. We were able to confirm that, in addition to this, arrangements had also been made for this group of patients to receive an annual health check.

The practice nurse had had the opportunity to shadow a specialist learning disability nurse carrying out healthcare reviews. The practice nurse had then carried out three annual healthcare reviews for patients with learning disabilities. We were told patients with learning disabilities received an hour long appointment with the practice nurse and, where necessary, a further 20 minute appointment with the GP. Appointment times were agreed which were convenient to the person and their carer. The practice nurse had made plans to carry out one annual healthcare check each month to ensure each patient received one A patient 'call and recall' system was in place which meant that any follow-up appointments and future reviews were added to the calendar system used by the practice.

The GP told us they had 'quite high numbers of patients presenting with drug and alcohol abuse'. However, the practice had not produced a register of patients who had these addictions. The practice manager said they were aware of which patients were active Methadone users. We were told when patients presented with symptoms of addiction, the GP would refer them to specialist providers such as 'Turning Point' or 'Counted4', which is a Sunderland based service offering treatment for those suffering from substance misuse. The practice had developed useful links with a GP from another practice in the same healthcare centre who also worked for 'Counted4', and with the on-site pharmacy that provided Methadone prescriptions. The on-site pharmacy informed the practice when a Methadone prescription was issued. This enabled the practice to update patients' medical records and place an alert on them informing staff to avoid prescribing particular types of medicines.

The practice manager told us they had very small numbers of patients within the practice population that could be classed as having poor access to healthcare because of their vulnerability. There were no sex workers registered with the practice, and the practice population did not include any members of the travellers' community. We were told a small number of asylum seekers attended the practice and would be seen by the GP, but often failed to attend again as they moved out of the area quickly. The practice had one patient who was homeless and it had registered them as a patient and provided care and treatment even though they had no known address.

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 had made arrangements to meet the needs of patients experiencing poor mental health. For example, the most complete QOF information (2012/13) available to us showed that the practice had identified patients with dementia and produced a register to help them deliver services to this group of patients. The practice obtained 100% of the QOF points available to them for the dementia care and treatment they delivered. This showed they were following best practice in these specified areas. For example, we found that: 81.1% of patients diagnosed with dementia on the register had had their care reviewed in the preceding 15 months; 100% of patients on the register with a new diagnosis of dementia had received recommended checks and tests; 87.5% of patients identified on the practice's mental health register had a comprehensive care plan documented in their records that had been agreed with them and their supporters. The practice also scored well with regards to some of the other tests and checks they were expected to provide to this group of patients.

We were told that, where considered appropriate, the GP would refer patients to appropriate secondary services for further assessment and treatment. This included referrals being made to the Improving Access to Psychological Therapies (IAPT) services and counselling and memory clinics for patients with dementia. (IAPT is an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders.) The practice also made referrals to the local crisis intervention team where it was felt patients would be benefit from immediate treatment and support. The practice also signposted patients to the local MIND service which is an independent charity run by local people, for local people with mental health needs.

The practice had the knowledge, skills and competence required to respond to the needs of patients experiencing poor mental health. For example, the practice nurse had completed training in suicide prevention and basic counselling skills. The GP had completed continuing professional development in mental health issues.

The practice supported patients' needs in relation to health promotion and the prevention of ill-health. For example, the practice provided patients with information about how they could access local support groups, as well information on health, wellbeing and recovery. Good advice about how to access mental health support was available on the practice web site including, for example, details of organisations able to offer help and support, such as the Alzheimer's Society.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Patients who used the service were not fully protected from the potential risks of unsuitable staff being employed to care for them because effective recruitment and vetting procedures were not in place.**