Eden Terrace Surgery

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.

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Summary of findings

Overall summary

Eden Terrace Surgery is situated near to the centre of Sunderland. The practice does not have any branch surgeries.

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG) and the NHS Local Area Team (LAT). Before the inspection we held a listening event where members of the public could tell us about their experiences of GP services within Sunderland. We also asked patients prior to our visit to complete CQC comment cards about their experiences of the service they had received. We spoke with representatives from the Patient Participation Group (PPG) and patients attending for appointments during the inspection. We spoke with all of the staff working in the practice on the day of the inspection.

We found that processes were in place to identify unsafe practices, and measures were put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence.

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

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

Patients said they were satisfied with the appointment systems operated by the practice. The practice had a policy for handling any concerns or complaints people raised. The practice responded to the needs of their practice population.

There was an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and reported feeling supported, motivated and valued by their peers.

The practice was safe, effective, caring, responsive and well led for all population groups.

Regulated activities

The practice registered with the Care Quality Commission (CQC) on 1 April 2013 to deliver care under the following regulated activities:-

- Diagnostic and screening procedures;
- Family planning;
- Maternity and midwifery services;
- Surgical procedures;
- Treatment of disease, disorder or injury.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The practice was safe.

Processes were in place to identify unsafe practices and measures put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence. Staff were aware of safeguarding procedures and took appropriate action when concerns were identified. The practice was clean and had adequate arrangements to reduce the spread of infections. The practice had effective processes for managing medicines.

Are services effective?
The practice was effective.

Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. The practice was regularly undertaking clinical audit, reviewing their processes and monitoring the performance of staff. There were care plans in place for those most at risk of poor or deteriorating health.

Are services caring?
The practice was caring.

All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Patients also reported they felt involved in all decisions surrounding their care or treatment. There were arrangements in place to support people when they reached the end of their life. The practice provided information to signpost carers to sources of support.

Are services responsive to people's needs?
The practice was responsive.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients said they were satisfied with the appointment systems operated by the practice. The practice had a policy for handling any concerns or complaints people raised. The practice worked collaboratively with other agencies, regularly sharing information to ensure good, timely communication of changes in care and treatment.

Are services well-led?
The practice was well-led.

Summary of findings

Staff were aware of the need to get things right for patients and the care of patients was their priority. Feedback we received from patients showed they felt valued and well cared for by staff. There was an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and reported feeling supported, motivated and valued by their peers. The practice had a Patient Participation Group (PPG), which had influenced the way the practice worked.

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 service for older people was safe, effective, caring, responsive and well led.

The practice had the lowest proportion of patients over the age of 65 compared to other local practices. Care was tailored to individual needs and circumstances, including the patients' expectations, values and choices. There was care planning in place for the most elderly and infirm. There were arrangements in place to support people when they reached the end of their life.

People with long-term conditions
The service for people with long-term conditions was safe, effective, caring, responsive and well led.

Care was tailored to individual needs and circumstances, including the patients' expectations, values and choices. The practice worked with other agencies to ensure continuity of care and good communication between different providers engaged in people's care. There were regular reviews undertaken of peoples' care and treatment related to their conditions, medications and life style choices to reduce the risk of deteriorating health. The practice had performed well on clinical indicators in the Quality and Outcomes Framework (QOF).

Mothers, babies, children and young people
The service for mothers, babies, children and young people was safe, effective, caring, responsive and well led.

The practice had a slightly lower proportion of patients under the age of 18 compared to other practices locally. The practice had processes in place to regularly assess the development of children and their health. Children and young people were offered access to childhood vaccinations. The practice offered access to advice and support with sexual health for young people. The practice understood when parental consent was needed for care and treatment of a child and how to assess when a child or young person would be considered competent to make their own decisions. The practice referred expectant mothers to local maternity and midwifery services.

The working-age population and those recently retired
The service for those of working age and recently retired was safe, effective, caring, responsive and well led.

Summary of findings

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. The practice had late opening hours until 7pm once a week and was routinely open until 6pm on weekdays. The practice provided signposts to other services, such as local support services and pharmacies.

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

The service for people in vulnerable circumstances who may have poor access to primary care was safe, effective, caring, responsive and well led.

The practice had systems in place to identify patients, families and children who were at risk or vulnerable. The practice offered access to any patients in vulnerable circumstances such as foreign students, homeless patients and asylum seekers if they presented to the surgery. This was even when the patient had not been previously registered with the practice.

The practice understood the needs of the most vulnerable patients on their register and acted on these needs in the planning and delivery of its services.

People experiencing poor mental health

The service for people experiencing poor mental health was safe, effective, caring, responsive and well led.

The practice maintained a register of those experiencing poor mental health, so they could plan for and meet the needs of these patients. They undertook regular reviews of the care and treatment provided to these patients. There were care plans in place for those most at risk of deteriorating mental health. The practice understood the needs of the most vulnerable patients experiencing poor mental health on their register and acted on these needs in the planning and delivery of its services.

Summary of findings

What people who use the service say

During the inspection we spoke with nine patients, which included five members of the Patient Participation Group (PPG). They were all complementary about the services they received at the practice. The patients we spoke with reported they felt safe and had no concerns when using the service. They told us that all staff treated them with dignity and respect. Most patients said the doctors spent time with them to explain diagnosis and treatment.

We reviewed 30 CQC comment cards completed by patients prior to the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Words used to describe the practice included caring, first class, excellent, professional and a great service.

The latest GP Patient Survey completed in 2013/14 showed the large majority of patients were satisfied with the services the practice offered. The results were:

- Booking an appointment – 93.7%
- Seeing a doctor or nurse – 91.5%
- Surgery opening hours – 90.7%
- Overall satisfaction – 100%
- Patients who would recommend the practice: 96%

Eden Terrace Surgery

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 specialist advisor with experience of GP practice management and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Background to Eden Terrace Surgery

Eden Terrace Surgery is situated near to the centre of Sunderland. It is close to both the Sunderland Royal Hospital and University of Sunderland City Campus. The practice provides primary medical care services to patients living to the south of the river Wear and west of the city centre of Sunderland.

The provider is a partnership of Dr Amit Mandal and Dr Deepa Kanta Iyengar Sridhar. There is only one registered location. The practice is based on the ground floor and there is good access via local public transport. The practice is based close to a local metro line and is on major bus routes to and from Sunderland. There is no on-site parking and the immediate roads surrounding the practice have restricted parking. There is a patient toilet on site; however this is not accessible to most people with a physical disability due to its size and location. The practice provides services to approximately 2,500 patients of all ages.

The practice has two partner GPs, a practice nurse, a regular locum healthcare assistant, a practice manager and three reception and administrative staff.

The service for patients requiring urgent medical attention out of hours is provided by Primecare and the 111 service.

In Sunderland, overall, 4.0% of the population belongs to non-white minorities. The practice had a higher than average percentage of female patients between the ages of 15 and 34 and a higher than average percentage of male patients between the ages of 20 and 49 against national comparators. There were lower than average females over the age of 35 and males over the age of 54. This was consistent with the practice being based in an inner city area, with a high proportion of students living in the area. The practice had the lowest percentage of patients over the age of 65 in Sunderland. The average male life expectancy in the area was 75 and the average female life expectancy was 84. The practice told us they did not have any patients who lived in a care home.

For patients within the area 54.3% had a long-standing health condition and 48.7% had health-related problems in daily life.

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:

Detailed findings

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

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

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

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

We carried out an announced visit on 2 and 3 of September 2014. We spoke with nine patients and seven members of staff from the practice. We also spoke with carers and family members. We received 30 completed CQC comment cards.

Are services safe?

Our findings

Safe Track Record

The practice kept records of significant events that had occurred during the last year and these were made available to us. When an incident of patient safety was identified, this was reported immediately to one of the GPs or the practice manager, and action was taken where necessary to address any concerns about patient safety. Following this a slot was allocated at a team meeting to discuss and review the incident. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events. We saw two significant or critical events had been recorded in 2014. We saw details of the event, key risk issues, specific action required and learning outcomes and action points were noted.

We discussed the process for dealing with safety alerts with the GPs. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us the clinical IT system they used highlighted these alerts to staff and they also liaised with the lead pharmacist within the Sunderland Clinical Commissioning Group, to ensure they were aware of any safety alerts. We saw an audit had been carried out following receipt of a patient safety alert.

Reliable safety systems and processes including safeguarding

All staff had received relevant training on safeguarding. The GPs had received training to level three in safeguarding and the nurse had received level two training. A log containing records of this was made available to us and we asked members of medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible in the reception office. Practice staff were able to tell us who the GP lead for safeguarding was in the Sunderland area, from whom they could access further information and advice.

A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken by all nursing staff, including the Health Care Assistants. If nursing staff were not available to act as a chaperone, two receptionists had also undertaken training and understood their responsibilities when acting as chaperones. Clinicians documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record.

Monitoring Safety & 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 a GP, a nurse, a locum healthcare assistant, 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.

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

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

A significant event identified in the practice, had led to learning and improvement in what staff should do when a patient presented at the surgery with abdominal or chest

Are services safe?

pains. An aide memoire had been implemented in helping non-clinical staff to identify what action to take in these circumstances. We saw this was displayed in the reception office for staff to refer to.

Medicines Management

We found there were medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were stored securely, with access restricted to those that needed it. Medicines were checked regularly to ensure they did not go past their expiry date and remained safe to use.

We saw fridge temperatures where medicines were stored were checked daily to ensure the medicines were stored in line with manufacturer's guidance. Records of these checks were maintained.

The practice had a process and audit trail for the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. We saw evidence to confirm this was put into practice.

The practice had a process for the management of information received from other services, including from out of hours services and for hospital discharge letters. Information, once received, was passed to the GP for review and patients' records updated.

Cleanliness & Infection Control

The practice had a lead for infection control, who had undertaken further training in September 2014 to enable them to provide advice on the practice infection control policy and carry out training for staff.

We saw the practice was visibly clean and tidy. There was a daily cleaning schedule for the premises and some tasks that were to be completed on a weekly basis. 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 for staff on washing their hands, use of antibacterial hand gel and contact with biological substances. We saw the practice carried out infection control audits.

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.

There were arrangements in place to ensure the safe handling of specimen samples dropped off by patients. Gloves were available for staff when dealing with specimens.

Staffing & Recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. For example, applicants would be invited to attend an interview and satisfactory references would be sought prior to a job offer and start date being agreed.

The practice had a small, well established staff team, with the most recently recruited member of staff joining the practice in 2010. We reviewed the records for this member of staff and found the appropriate checks had been completed. The practice was in the process of applying for a Disclosure and Barring Service (DBS) check for all staff members and showed us evidence this was in progress.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. There were arrangements in place to ensure cover for staff absences.

Dealing with Emergencies

The practice had emergency response plans in place. This included if there was disruption due to unforeseen changes in staffing levels or loss of essential supplies or facilities. The practice had buddy arrangements with two other local practices to ensure continued access to services in the event of the practice premises being unavailable due to an emergency.

We saw there was equipment for dealing with medical emergencies available within the practice, including emergency medicines and a defibrillator. However, there was no emergency oxygen available on site.

Staff we spoke with told us they had been trained to perform cardiopulmonary resuscitation (CPR). There were appropriate arrangements in place to ensure that staff knew what to do in the event of a fire in the practice.

Are services safe?

Equipment

The practice had a range of equipment in place that was appropriate to the service. We saw regular checks took place to ensure it was in working condition. The practice had installed in the last year new smoke alarms and replacement fire extinguishers. There was evidence that staff were trained in the use of fire extinguishers on an annual basis.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

All clinical staff we interviewed were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence and from the local health commissioners. They told us these were discussed in clinical meetings. However, they told us they did not take notes of this element as part of the meetings minutes.

The practice used EMIS web software as their clinical system. The GP told us how this helped them adopt best practice guidelines, as the system incorporates National Institute for Health and Care Excellence (NICE) endorsed templates to guide diagnosis, care and treatment. The GP also told us they attended the Time In Time Out (TITO) sessions delivered by the local Clinical Commissioning Group to ensure their practice was kept up to date.

We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where people were booked in for recall appointments. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2012 / 2013. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored high on clinical indicators within the QOF.

The practice undertook regular reviews of elective and urgent referrals. For example, the practice had recently audited the referrals to Ear, Nose and Throat consultants. The practice follows up any referral where the patients should be seen within two weeks, because a diagnosis of cancer was suspected, to ensure the patient attended the appointment.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included effectiveness of cervical smear tests, drug interactions and effectiveness of particular drugs. One of the GPs undertook an audit following a patient safety alert regarding the interactions between some prescribed drugs. The clinical audits showed evidence of quality improvement processes that delivered improved patient care and outcomes through the review of care and implementation of change.

As part of our pre-inspection analysis of information, we identified the practice was an outlier for the identifying of asthma and chronic obstructive pulmonary disease (COPD). This was according to the most recently available General Practice Outcome Standards (GPOS) data. COPD was a very significant disease within Sunderland. The British Lung Foundation had ranked Sunderland fifth in the national top COPD hotspots across England. People in Sunderland were 51% more likely to be admitted to hospital with COPD than the England average. The practice had achieved full QOF points in these areas, which meant that when patients were diagnosed with these conditions appropriate follow up action was taken.

The practice showed us examples of care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice. This included care plans for patients with long term conditions who were most at risk of deteriorating health and whose conditions were less well controlled. People with poor mental health and the most elderly and frail patients were also included. These patients all had a named GP or clinical lead for their care. One GP took the lead on care for the elderly and the other GP took the lead on sexual health and care for younger people. They were also the clinical lead for sexual health across the Clinical Commissioning Group (CCG) area.

Effective Staffing, equipment and facilities

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

Staff we spoke with told us about training and professional development available to them. This included time allowed to maintain their current skills and the opportunity to learn new ones. They confirmed they had received appraisals and had identified learning and development plans as part of this process. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and

Are services effective?

(for example, treatment is effective)

updating of their skills. The GP in the practice was registered with the General Medical Council (GMC) and was also required to undertake regular training and updating of their skills.

Revalidation was the process for doctors to demonstrate at regular five-yearly intervals that they are up-to-date and fit to practise. Within the practice GPs were on track for their revalidation. One GP had gone through the revalidation process last year and the other GP was due to go through the revalidation process in October 2014.

The patients we spoke with told us they were confident staff knew what they doing and were trained to provide the care required.

The practice had processes in place for managing the performance of staff. The practice manager told us they used team and one-to-one meetings to discuss these matters where appropriate. They said it was important that staff felt part of a team, as they believed trust was essential in the work they did. They told us staff took pride in their job and working as part of a team.

The facilities and equipment in use within the practice were appropriate for the services provided.

Working with other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. This usually included district nurses and health visitors. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us about how the practice referred patients for secondary care. When a referral was identified, the practice always tried to book an appointment, using the choose and book system, before the patient left the surgery.

They told us that all test results and patient letters from consultants and specialists were first seen by the doctor. Necessary actions from these were identified and carried out. The letters were then administratively coded and scanned onto the clinical records. The GP who reviewed the correspondence was responsible for any action required. They recorded the action required, and where appropriate arranged for the patient to be contacted and seen clinically.

We spoke with clinical staff about the how information was shared with the Out of Hours services in the local area, 111 and Primecare. Staff told us that patient information received from the out of hours service was of good quality and received on time in the morning. The practice manager confirmed that all faxed information from the out of hours provider, whether that be the 111 service or from Primecare was passed to the GP to review. The GP then identified any action needed and passed the information to the administrator to scan and attach to the electronic clinical patient notes. Staff told us that this normally happened on the same day the information was received.

The practice participated in a shared care protocol for some patients. This was where the prescribing was transferred to the GP while the consultant retains overall clinical responsibility for the care of the patient. This process ensured the monitoring of safety and effectiveness of medication and sharing of information between partner organisations.

Health Promotion & 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 or nursing staff employed by the practice. 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.

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health. Test kits for chlamydia and gonorrhoea were available for young people under the age of 25. This supported good sexual health awareness for this population group. The practices'

Are services effective?

(for example, treatment is effective)

website provided links to other sources of information for patients on health promotion and prevention. This included on weight management, sexual health and smoking cessation.

Are services caring?

Our findings

Respect, Dignity, Compassion & 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 we received reflected this. We received 30 comment cards, all of which spoke positively about the quality of the staff and the service as a whole. Words used to describe the approach of staff included friendly, kind, helpful, caring, efficient and professional. None of the CQC comment cards completed raised any concerns in this area.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 50 patients undertaken by the practice. The evidence from these demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Results on the NHS patient survey were all similar or better than expected when compared with other practices.

We observed staff who worked in reception and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. The reception desk fronted directly onto the patient waiting area. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. We saw voices were lowered and personal information was only discussed when absolutely necessary.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. We saw information about the chaperone service offered was clearly displayed on the patient notice board. We were told that some staff had completed chaperone training. A private room or area was also made available when people wanted to talk in confidence with the reception staff.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in the treatment room so that patients' privacy was maintained during investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

The practice provided services for people who cared for others (carers). This included working with local organisations and maintaining a practice register of carers. One GP had previously won an award, following nomination by a carer of a patient, for services to carers. There was information displayed in the waiting room to direct those patients who provided care for others to sources of support in their role as carer.

Support was provided to patients during times of bereavement. The GP and practice manager both told us a sympathy card was sent to the family once the practice had been notified of the loss of a loved one. They would also phone the family with the aim of establishing if they wanted or needed any further support or signposting to other agencies. The practice maintained a register of patients receiving end of life care. The practice provided accommodation for a counsellor once a week, which allowed appointments to be made for patients within the local community.

Support was tailored to the needs of individuals, with consideration given to their preferences at all times. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

Involvement in decisions and consent

Patients we spoke with reported they felt involved in all decisions surrounding their care or treatment. They went on to say a full explanation was given to them by their clinician about their treatment or medication and they were given options to consider. Information provided by patients who filled in CQC comment cards reflected this. The staff we spoke with said consent to treatment was always sought and documented within the patients' records. The patient survey information we reviewed

Are services caring?

showed patients responded positively to questions about their involvement and planning and making decisions about their care and treatment. They generally rated the practice well in these areas. The results from the practices' own survey showed that 100% were satisfied with the GP consultation. We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

Practice staff told us that they had a large ethnic minority population within the practice boundaries. As well as English both doctors also spoke other languages including Hindi and Bengali.

We saw that access to interpreting services was available to patients, should they require it. On the day of the inspection we saw an interpreter visited the practice to support a family whose first language was not English. We saw that arrangements were made for the same interpreter to support at a follow up appointment.

Reception staff also told us they made use of the translation service provided by google when a patient first presented to the practice. They also used an interpreting service by telephone. This helped staff to understand the needs of the patient and enable an appointment to be booked where an appropriate interpreter could be available.

We spoke with the nurse and doctors about how decisions were made where someone did not have capacity to make their own decisions. They were able to give examples of where they had made decisions in the best interest of someone who lacked capacity. This was in line with the Mental Capacity Act. They told us how they would consult with carers and other health and social care professionals who knew the person well.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

We spoke with the GP about those patients most at risk of having poor access to primary care services. They told us they had a small number of asylum seekers registered with the practice. Although they had no patients registered with the practice who were homeless at the time of our inspection, they had patients in the past that had become homeless whilst registered with the practice. They told us these patients remained on the practice register. The GP told us that it is their policy that they will see patients who were at most risk, such as homeless people and asylum seeks when they present to the surgery.

Practice staff told us that because the practice was relatively small, they felt they could get to know their practice population well. When we asked about those most at risk of poor access to primary care, the practice were able to tell us who these patients were and what action they had taken to reduce the barriers for them to access care and treatment. There had been little turnover of staff over the last four years, which enabled good continuity of care and accessibility of appointments with a GP of choice. All patients who needed to be seen urgently were offered same-day appointments and there was an effective triage system in place.

We found that practice understood the needs of the practice population and systems were in place to address identified need.

The practice worked collaboratively with other agencies, regularly sharing information (such as special patient notes) to ensure good, timely communication of changes in care and treatment.

Access to the service

The practice had recognised the needs of the different groups in the planning of its services. They told us that a high number of students registered as patients during university term times. They told us that where foreign students were attending the university, they often found that groups of students from particular courses, countries or regions would register. They told us this was because students recommended the practice to others students that they knew. They told us they had built up relationships with the University. University pastoral staff would refer patients to the practice if they did not already have access to primary care elsewhere.

Practice staff told us that they had a large ethnic minority population within the practice boundaries. As well as English both doctors also spoke other languages including Hindi and Bengali. Patients had a choice as to whether to see a male or female doctor. They told us about how the practice respected the culture and beliefs of patients and gave examples of how they respected patient choice during the period of Ramadan.

The practice had made arrangements so that people with physical disabilities were able to access the service. There was a bell at the front door, and a sign telling patients to ring it if they needed assistance to access the building. Both the treatment and consultation room were on the ground floor. The practice had decided not to utilise upstairs accommodation to see patients, because although this would have given extra space, good access arrangements could not be guaranteed for all.

There was a patient toilet downstairs. However this was very small and could not be easily accessed by patients who had physical disabilities such as those who used wheelchairs. We spoke with the GP partners about this. They told us that they had considered other arrangements, but had been hampered by the physical limitations of the building. We asked if they had asked for expert advice on alternative solutions and they said they had not. The practice still planned to find alternative premises in the medium to long term nearer to the current premises.

The practice had access to large print information for patients who were visually impaired, and gave us examples of how they had met the needs of visually impaired patients. However this was not advertised within the waiting room area or on their website. The practice had a hearing loop; however this was not working on the day of the inspection.

Patients could make appointments in a number of ways. They could call into the practice or request an appointment over the telephone or on-line. This ensured they were able

Are services responsive to people's needs?

(for example, to feedback?)

to access the practice at times and in ways that were convenient for them. The practice website outlined how patients could book appointments and organise repeat prescriptions online.

The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on the practice's website and practice leaflet. Out of hours enquiries were redirected to the provider's contracted out of hour's provider, Primecare. The practice had a late night surgery on a Monday night until 7pm, as well as being open other weeknights until 6pm. This allowed people who worked or were at school during the day or were unable to get to the practice a choice of when they wanted to see the GP.

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

Patients we spoke with and those who filled out CQC comment cards all said they were satisfied with the appointment systems operated by the practice. This was reflected in the results of the most recent GP Survey 2013/14. This showed 92.7% of respondents were satisfied with booking an appointment and 89.1% were satisfied with the practice's opening hours, which were both better than the England and Local CCG averages.

Meeting people's needs

The practice worked with other agencies 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.

We saw the practice had systems in place to ensure the timely referral of patients. Practice staff told us they routinely followed up test results for patient with secondary care services, for example, hospitals.

Concerns & Complaints

The practice 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 reviewed the practice policy on complaints, concerns and comments and looked at the patient complaints leaflet. The practice had not had any complaints within the last two years.

Although the practice brought the complaints policy to the attention of patients by ways of information in the practice leaflet and by a poster in the waiting are of the practice, the practice did not advertise its complaints policy on its website.

The patients we spoke with did not raise any concerns with us and told us they had no complaints. This was supported by the 30 CQC comment cards, which all contained positive feedback on the practice.

Are services well-led?

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

Our findings

Leadership & Culture

There was an established management structure within the practice. The practice manager, GPs and staff we spoke with were clear on their roles and responsibilities. All of them demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. We saw there was an understanding of the leadership needs of the organisation.

We found staff had been allocated lead roles for key areas, for example, infection control and safeguarding. Staff described their aim was to provide patients with an effective, high quality service. It was evident there was a strong team-working ethic among the practice staff. The practice manager and other staff told us about how important team work was to them and that they all took pride in their work.

Staff reported feeling supported, motivated and valued by their peers.

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

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

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

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to all staff in paper copy in the reception office. We looked at 16 of these policies and procedures and found they covered the relevant areas in sufficient detail and incorporated national guidance and legislation. They had been regularly reviewed and updated. We also found clinical staff had defined lead roles within the practice, for example, for the management of long term conditions.

The practice held regular meetings where governance, quality and risk were discussed. We saw the most recent notes of these meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that the clinical team regularly discussed QOF data at team meetings and through appraisal sessions.

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. The practice had a system in place for monitoring all aspects of the service. The practice manager told us staff challenged existing arrangements and looked to continuously improve the service being offered.

Systems to monitor and improve quality & improvement (leadership)

The practice had systems in place to monitor and improve quality. We saw evidence of audit activity within the practice during the last 12 months. Full clinical audits had been undertaken in a number of areas, including prescribing of tramadol. The audit and re-audit of prescribing patterns had resulted in improvements in the quality of prescribing within the practice for some medicines.

Each audit showed evidence of the results having been analysed and records of improvements made or actions required.

The GP told us that the patient list had increased by 25% over the last four years. This had created a strain on appointment availability. The practice introduced telephone triage to address this and had extended the surgeries when needed.

Are services well-led?

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

Patient Experience & Involvement

The practice had gathered feedback from patients through the patient participation group and patient surveys.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 50 patients undertaken by the practice. The evidence from these demonstrated that patients were satisfied with the care and treatment provided by the practice and how they were treated. Results on the NHS patient survey were all similar or better than expected when compared with other practices.

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

The practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with five representatives of the PPG who explained their role and how they worked with the practice. They told us the group meet every two months. They gave example of the areas the group had been asked to comment and provide ideas for. This included use of the appointment system and a move to purpose built premises. They told us the practice was responsive to ideas and suggestions made by the PPG. They told us that the practice had planned to move premises, to improve the facilities within the practice and be in larger custom built premises. However this would have meant the practice moving some distance from its current location. A survey went to all patients registered with the practice and 75% of patients said they did not want the practice to move to bigger premises as they found the current location convenient. The practice listened to this and did not move premises.

The practices most recent survey demonstrated that 100% of patients surveyed were satisfied with the service, access to appointments and the speed of being seen by clinical staff. The practice had gathered information to support consideration of alternative appointment times to increase access. However the majority of patients were satisfied with the current opening hours and appointment times.

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 to raise any concerns they had.

Management lead through learning & improvement

We saw practice staff met regularly on a monthly basis. Meetings included the whole staff team, clinical and non-clinical and also included members of the external multi-disciplinary team such as the District Nurse and Health Visitor. Minutes from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement.

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

Identification & Management of Risk

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents. We spoke with the practice manager and GP about how the practice planned for the future. They told us thoughts and informal discussions around action planning and predicting future risks had taken place. They said these thoughts and discussions were yet to be formally documented or a plan of action put into place.

Older people

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

Our findings

The practice had a lowest proportion of patients over the age of 65 compared to other practices within the Sunderland CCG area. One GP took the lead in care for older people and they were the named GP for all patients in this age group.

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. The practice showed us examples of care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice and was in place to reduce the number of avoidable admissions to hospital. This included care plans for the most elderly and frail patients. The practice, as part of a locality exercise, had reviewed the number of avoidable admissions to determine if any action could have prevented them. They found no common themes in admissions.

The practice helped to ensure patients received appropriate co-ordinated care, including in the event of returning home after a hospital admission.

The practice worked with services based in the community to support patients to receive the care they required. For example, there were regular meetings with district nurses to discuss the care of the most at risk and vulnerable older patients.

Patients were offered pneumococcal and flu vaccination to help them stay healthy and well. Take up rates for these were in line with national averages.

There were arrangements in place to identify older patients who were being or who were at risk of being abused and ensure that appropriate action was taken.

There were effective processes to ensure that, in the event that an older person lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with were knowledgeable about the Mental Capacity Act.

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. Greater flexibility was shown for those most at risk, such as those receiving palliative care.

There was information available in the waiting room to sign post patients to other sources of support. This included where the patient acted as a carer for someone else.

The practice had engagement with carer groups in the locality. The practice maintained a register of those patients who were carers.

There were arrangements in place to support people when they reached the end of their life. Support was provided to patients during times of bereavement. The GP and practice manager both told us a sympathy card was sent to the family once the practice had been notified of the loss of a loved one. They would also phone the family with the aim of establishing if they wanted or needed any further support or signposting to other agencies. The practice maintained a register of patients receiving end of life care. The practice provided accommodation for a counsellor once a week, which allowed appointments to be made for patients within the local community.

People with long term conditions

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

Our findings

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. The practice nurse held regular chronic disease management clinics to review and monitor patients with long term conditions and give relevant support where needed. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their conditions. There was care planning in place for those patients whose long term conditions put them most at risk of deteriorating health and whose conditions were less well controlled.

The practice worked with services based in the community to support patients to receive the care they required. For example, there were regular meetings with district nurses to discuss the care of the most at risk and vulnerable patients.

Patients with a long term condition were identified and a code was put onto their electronic patient record. This assisted the practice with maintaining up to date disease registers and in recalling patients for their health reviews.

As the practice had a quite a small patient list, we found that staff knew their patient population well. They were able to give us examples of how they adapted the service well to meet the needs of individual patients.

The practice was achieving nearly all of its Quality and Outcomes Framework (QOF) points for the latest data available in 2012/13. It had achieved 99.1% of the available points for the 'clinical domain indicator groups'; a significant number of which related to the management of patients with long term conditions.

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.

Mothers, babies, children and young people

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

Our findings

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

We saw the practice had processes in place for the regular assessment of children's development. This included for the early identification of problems and the timely follow up of these. The GP told us the midwife who worked in partnership with the practice had an important role with safeguarding children, which included the early identification of needs and the ability to offer help early. This included working with other healthcare professionals, including health visitors.

There were arrangements in place to identify children and young patients who were being or were at risk of being abused and ensure that appropriate action was taken. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a policy and processes that covered child health and family support. This included a programme of health and development reviews. These were to allow them to assess growth and development of young children, identify risk factors and opportunities for improving health. It also gave parents the opportunity to routinely discuss any concerns they had with their children. The programme ran from an initial neo-natal examination within the first 72 hours of birth through to vaccinations up to the age of 18 years. The practice referred expectant mothers to local maternity and midwifery services.

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.

The GPs we spoke with understood when parental consent was needed for care and treatment of a child and how to assess when a child or young person would be considered competent to make their own decisions.

The practice offered access to advice and support with sexual health for young people.

The practice had engagement with carer groups in the locality, including young carers. The practice maintained a register of those patients who were carers.

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

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.

The practice had late opening hours until 7pm once a week and was routinely open until 6pm. This increased the likelihood of patients who worked (and those recently retired) being able to see a clinician when they needed to do so. Patients we spoke with from this population group said they were satisfied with their ability to access appointments at the practice.

The practice gave patients choice when referring to secondary care. This included choosing a hospital or healthcare location which was most convenient for them. This could be near to where they work.

We found the practice had information and advice to patients about general health conditions.

We saw health promotional material was made easily accessible to people of working age. This was through leaflet and notices in the waiting room area and through the practice's website. This including signposting and links to other sources of information related to weight loss, sexual health and smoking cessation.

The practice held information about local pharmacies and their opening times, including those that were open outside normal working hours. This information was given to patients on request.

The practice engaged with the local student population, including students from other countries. The practice participated in students' fresher week and provided information to students on the services they offered. They told us they had built up relationships with the University. University pastoral staff would refer patients to the practice if they did not already have access to primary care elsewhere.

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

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

Our findings

The practice had systems in place to identify patients, families and children who were at risk or vulnerable within this population group. For example, the practice maintained a register of patients with learning disabilities. The practice highlighted patients on the register for regular reviews.

The GP told us that access to GP services was offered to any patients in vulnerable circumstances, who requested it at the practice. This included those patients who identified themselves as homeless and asylum seekers. He told us that all patients were treated in the same way and were given advice to ensure they could access appropriate healthcare and treatment, such as a check-up at registration, breast screening, cytology and advice about the impact of social factors on health, such as smoking and use of alcohol.

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.

As the practice had a quite a small patient list, we found that staff knew their patient population well. They were able to give us examples of how they adapted the service well to meet the needs of individual patients including patients who were visual impaired and people with learning disabilities.

There was access to interpretation services for those whose first language was not English or for those patients who communicated through sign language. As well as English both doctors also spoke other languages including Hindi and Bengali.

The practice had actively engaged in promoting their services to local minority ethnic groups. The GPs had visited the local Bengali centre.

The practice had a list of support services for patients with drugs and alcohol problems in the locality.

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 maintained a register of patients experiencing poor mental health. They completed medication reviews for these patients.

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.

A counsellor from the mental health organisation, Mind, used a consultation room in the practice to enable them to see patients closer to home. Patients were able to self-refer themselves to Mind to access this service.

For those patients with enduring poor mental health the practice put in place care plans to determine how they would support patients to achieve improved mental health.

There were effective processes to ensure that, in the event that a patient lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with were knowledgeable about the Mental Capacity Act.

The practice reported that they had access to services provided by the local crisis team if a patient presented at the surgery with a mental health crisis. However they told us that there was often a delay in this service responding.

The GPs used flexible prescribing patterns for those identified at risk due to poor mental health. This included issuing daily or weekly prescriptions for those at risk of self-harming with medication. As the practice population was small and the number experiencing poor mental health was also small, practice staff told us the GPs were able to closely monitor the needs of this group.

The practice had a Community Psychiatric Nurse (CPN) who normally visited the practice every few weeks, depending on the needs of patients registered with the practice. The CPN used consultation rooms in the practice to ensure access to mental health services nearer to home for patients.