JR Nathan

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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Overall summary

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

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.

Processes are 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.

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

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

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

There is 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.

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?
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 should improve their handling and storage arrangements for blank prescription forms.

Are services 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.

Are services 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.

Are services responsive to people's needs?
The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients said they were satisfied with the appointment systems operated by the practice. The practice had a policy for handling any concerns or complaints people raised.

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

The practice had a Patient Participation Group (PPG). The practice had tried to obtain a demographical spread of patients to participate in its PPG, including representation from the largest local ethnic minority group living in the practice catchment area.

Summary of findings

The six population groups and what we found

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

Older people

The practice had a significantly lower proportion of patients over the age of 65 compared to other practices within the Sunderland CCG area. The practice was a single-handed GP practice; therefore all patients, including those within this population group, effectively had a named accountable GP.

We spoke with the GP who told us older people with dementia type illnesses had individual plans of care.

The practice manager told us the practice was involved with a team of healthcare professionals for patients who required end of life care. The team included district and Macmillan nurses. The practice contributed to ensure patients received appropriate co-ordinated care, including in the event of returning home after a hospital admission. Patients we spoke with from this population group confirmed this.

People with long-term conditions

Regular patient care reviews took place at 3 monthly intervals; for example for patients with chronic obstructive pulmonary disease (COPD) or diabetic conditions. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. The practice had achieved nearly all of its Quality and Outcomes Framework (QOF) points in 2012/13; the latest data available. The QOF is the annual reward and incentive programme detailing GP practice achievement results. It had achieved 99.3% 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.

Mothers, babies, children and young people

The practice had a slightly higher 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 processes for the early identification of problems and the timely follow up of these. 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 clinical staff to assess growth and development of young children, identify risk factors and opportunities for improving health. It also gave parents the

Summary of findings

opportunity to routinely discuss any concerns they had with their children. Signposting to services and activities available locally to families was also provided. This included initiatives such as 'preparing for baby', 'mums on the move' and 'early years mental health service'.

The working-age population and those recently retired

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

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. The practice had two open access clinics each week, late opening until 7pm one night a week and the practice 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. We saw health promotional material was made easily accessible to people of working age through the practice's website.

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

The practice had systems in place to identify patients, families and children who were at risk or vulnerable within this population group. The GP told us the practice worked closely with the local Salvation Army in order to have contact with homeless patients and temporary residents in the area. The practice manager told us the 'NHS Health Check' initiative had prompted contacts with many patients who wouldn't normally have had a reason to visit the practice. Patients received a letter from their GP or local authority inviting them for a free check.

People experiencing poor mental health

The practice had access to a specialist advisor for mental health. We were told the GP took the lead for the practice with regards to patients experiencing poor mental health. The nurse practitioner told us the practice maintained a register of patients experiencing poor mental health. The nursing staff were unclear when we asked them about the principles of decision making for those with poor mental health and assessing a patient's mental capacity. They said they would seek advice from the GP on these matters.

Summary of findings

What people who use the service say

All of the 11 patients we spoke with, which included two members of the practice's Patient Participation Group (PPG), were complimentary about the services they received at the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy.

We reviewed 17 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. One comment suggested a patient was disappointed with the length of time to obtain an appointment, however the majority of this patient's feedback was also positive.

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

- Communications with the surgery – 89%
- Booking an appointment – 86%
- Seeing a doctor – 88%
- Seeing your preferred doctor – 92%
- Surgery opening hours – 90%
- Overall satisfaction – 89%

Areas for improvement

Action the service SHOULD take to improve

The practice should improve their arrangements for the receipt, recording and storage of blank prescription forms on the premises.

The practice should take action to improve its arrangements for checking expiry dates on emergency medicines.

The practice should take action to improve staff's knowledge of the Mental Capacity Act 2005 for staff who provide care for patients with mental health conditions. This should include appropriate decision making processes involving those patients.

Outstanding practice

Our inspection team highlighted the following area of outstanding practice:

The support provided to patients during times of bereavement was considered to be outstanding practice. A sympathy card was routinely sent to the family and the practice recognised the importance of being sensitive to people's wishes at these times.

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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 commissioning of primary care services.

Background to JR Nathan

The practice is located in Riverview Health Centre, Sunderland and provides primary medical care services to patients living in the Hendon, Grangetown and central areas of the City of Sunderland. The practice is based on the ground floor and shares the premises with another GP practice and other healthcare professionals. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access. The practice provides services to just fewer than 2,400 patients of all ages.

The practice has one GP partner, a practice manager partner, a nurse practitioner, a practice nurse and two staff who carry out reception and administrative duties.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Detailed findings

Commissioning Group (CCG). We also held a listening event for the Sunderland area as a whole and spoke with two members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 26 August 2014. The inspection team spent eight and a half hours inspecting the service and visited the practice's surgery in Sunderland. We spoke with nine patients and six members of staff from the practice. We also spoke with carers and family members, as well as domestic staff who were employed to clean the health centre and another healthcare professional based there who had experience of working together with the practice. We spoke with and interviewed the Practice Manager, the GP, the Nurse Practitioner, the Practice Nurse and two staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 17 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Are services safe?

Our findings

Safe track record

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. The practice manager led on safety within the practice and managed this through the use of a team approach. Ideas to improve safety would only be implemented after consultation with clinicians and administrative staff. For example, the process for taking patients' contact details was reviewed and amended as the previous system had been found to be unreliable. Improvements had been achieved and could be demonstrated by the reduction in missed call-backs from the GP to patients who had requested this.

We saw action plans for improvement arising from complaints and incidents were discussed and recorded within staff meeting minutes. The practice manager told us they set reminders in their diary for these and they remained on the agenda until the action plan has been completed. We saw the practice had clearly defined systems, processes and standard operating procedures (SOP).

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. The practice manager was the nominated person to collate this information and staff we spoke with were aware of this. The practice manager also had responsibility for assessing whether any urgent or remedial action was required. We saw four significant or critical events had been recorded during the last 12 months. We saw details of the event, key risk issues, specific action required and learning outcomes and action points were noted. Staff meeting minutes showed these events were discussed widely within the practice, with actions taken to reduce the risk of them happening again.

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

Reliable safety systems and processes including safeguarding

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

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

The practice had a chaperoning policy and staff were aware of its content and how to access it. In addition to this, there was a sign on the door leading from the patient waiting area to the consulting rooms to inform patients of their right to request a chaperone. We saw that some staff had undergone chaperone training and were aware of their roles and responsibilities when supporting patients. Staff we spoke with told us the patient's decision to accept or decline the use of a chaperone was always recorded.

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

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent. The practice scheduled two 'open access' clinics per week and one of these was running on the day of our inspection. All of the patients who attended were seen by the GP or nurse during the session, depending on their preference or need.

Are services safe?

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

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

Medicines management

We found there were medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were kept stored securely, with access restricted to those that needed it. Medicines were checked regularly to ensure they did not go past their expiry date and remained safe to use. We found one medicine had passed its expiry date and this was removed immediately. Records were kept whenever any medicines were used. We were told the practice did not hold stocks of controlled drugs.

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.

The practice should improve their arrangements for the receipt, recording and storage of blank prescription forms. 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." It also states "Details of the delivery (of blank prescriptions) should be recorded electronically and/or using paper records." The practice was not following this guidance and some of the staff we spoke with who handled blank prescription forms were not aware of it. Staff told us boxes of blank prescription forms were kept in a locked room. This was confirmed by the practice manager. We were also told records were not kept of the first and last serial number associated with each box of blank prescriptions.

Cleanliness and infection control

We saw the practice was visibly clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. The practice had a range of policies and procedures relating to infection control. These included guidance for staff on washing their hands, use of antibacterial hand gel and contact with biological substances.

The practice had a nominated infection control lead. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. We saw the practice carried out an infection control inspection, with the most recent of these completed in July 2014. There were no actions identified as being required following this.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were also contracts in place for the collection of general and clinical waste. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all but one of the sharps bins had been signed and dated as required. The practice manager told us they were aware of the sharps bin that wasn't annotated correctly and said they would rectify this.

The practice manager explained the premises were owned by NHS Property Services and all fixtures and fittings were supplied and maintained by them. The cleaning of the premises, including the practice, was also provided by the owners. There was a daily cleaning schedule for the premises and some tasks that were to be completed on a weekly basis. We spoke with one of the cleaning staff who

Are services safe?

showed us checklists were completed to demonstrate the cleaning was taking place. They also showed us records to support the twice-weekly flushing of the water systems in the premises to help prevent legionella contamination.

Staffing and recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. For example, applicants would be invited to attend an interview and satisfactory references would be sought prior to a firm 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 a year ago. We reviewed the records for this member of staff and found the appropriate checks had been completed.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. The practice manager said when the GP was on leave or unable to attend work, a GP from the other practice within the building provided locum cover. We were told on a small number of occasions, this arrangement had been reciprocated.

We spent some time during the morning observing how the staff handled the patients who arrived to use the open access clinic. At busy times, we saw staff kept patients informed of how long they could expect to wait and the clinician they would be seeing. This was well received by the patients involved.

Dealing with Emergencies

The practice had emergency response plans in place. This included for disruption due to unforeseen changes in staffing levels or loss of essential supplies or facilities. Equipment for dealing with medical emergencies was seen to be available within the practice, including emergency medicines. Staff we spoke with told us they had been trained to perform cardiopulmonary resuscitation (CPR).

Equipment

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

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We found care and treatment was delivered in line with recognised practice standards, local and national guidelines. The practice manager told us they received guidance issued by the National Institute for Health and Care Excellence (NICE) electronically. They then printed and circulated it to clinical staff as a prompt. All of the clinical staff we spoke with said they used information based around NICE guidance. We were told this information could be accessed in a number of ways from a number of sources. The practice didn't have a standard approach that was used by all clinicians.

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

Staff we spoke with described how they carried out comprehensive assessments which covered all patients health needs. They explained how care was planned to meet identified needs and how patients were reviewed at regular intervals to ensure their treatment remained effective. For example, the GP explained that patients with long term conditions such as chronic obstructive pulmonary disease (COPD) and diabetes were invited into the practice every three months to have their medication reviewed for effectiveness.

Patients we spoke with said they felt well supported by the GP and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who filled in CQC comment cards. Patients also told us they felt the practice had asked them to provide relevant information about themselves when they registered.

Patients were referred appropriately to other services, where there was a need to do so. The GP would record this in the patients' consultation notes and update the practice's paper-based referral book. On a daily basis the practice manager would review this book and arrange for patients referrals to be made.

We found that processes were in place to seek and record patients' consent and decisions were made in line with relevant guidelines. Staff we spoke with were able to describe the consent process, however some of the nursing staff lacked confidence in the use and application of the Mental Capacity Act 2005. They said they would consult with the GP for guidance on this.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing clinical audit cycles. We saw and were told the results of these were discussed at staff meetings and more widely with relevant organisations. The nursing staff told us they had limited involvement with clinical audit in the practice. Examples of clinical audits included capacity and demand, referral rates for dermatology and childhood eczema, patient waiting times in the practice and weight reduction. 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. For example, the referral rate to secondary care for childhood eczema dropped from 25% of child patients identified with eczema to 16% a year later, when re-audited. The analysis of these results showed improved management of childhood eczema within the practice, with improved outcomes for the patient and their family.

As part of our pre-inspection analysis of information, we identified the practice was an outlier for the prescribing of hypnotics medicines. This was according to the most recently available General Practice Higher Level Indicators (GPHLI) data for 2013/14. We saw the practice had already identified this as an area for improvement and had completed a clinical audit on the prescribing of benzodiazepines. These medicines were highly addictive and have been known to contribute to drug related deaths through fatal respiratory depression. The audit was completed by the GP and practice manager with support from a pharmacy advisor. The aim of the audit was to review the care of patients on benzodiazepine therapy with the aim of safely withdrawing them from this medicine. The audit covered 26 patients over an 18 month period and had resulted in a 96.2% reduction of patients taking benzodiazepines, with the remaining 3.8% of patients still on the reduction programme. The practice now aims to review this bi-annually.

Are services effective?

(for example, treatment is effective)

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 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.

Some of the nursing staff we spoke with were uncertain about the principles behind decision making with regards to patients who may lack the capacity to make decisions for themselves. They said they would refer to the practice's policies and speak with the GP in these circumstances. For example, one staff member we spoke with was uncertain how they would deal with a request from a parent of an adult child with learning disabilities who asked for contraceptive medicines for their adult child.

We were told new staff were supported with an induction programme. The practice manager told us they covered a lot of the local working arrangements, with the clinical staff covering the other aspects of the practice. We spoke with the most recently appointed member of staff who confirmed they had been through an induction process. 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 has 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.

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. The practice manager spoke of their involvement in a locality initiative with primary care, community care, social services and housing involvement. The also told us the practice had access to a specialist advisor for mental health which worked seamlessly. Staff also spoke well of the relationships they had with district nurse and health visitors. We spoke with a district nurse based within the same building who told us they felt the practice communicated very well with their team. The practice had forged close links with their Clinical Commissioning Group (CCG) and met on a quarterly basis with their prescribing advisor. This included the review of prescribing patterns with the aim of achieving cost effective prescribing and improved patient care.

The practice had systems are in place for recording information from other health care providers. This included from out of hours services and secondary care providers, such as hospitals. The practice manager described how the practice had access to the local hospitals' information systems. This allowed them to obtain, for example, blood test results to be added to the practice's records when patients were discharged.

Health, promotion and prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. These were completed by the GP 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.

Some of the patients we spoke with told us they were on long term medicines. They confirmed they were asked to attend the practice regularly to review their conditions and the effectiveness of their medicines. The staff we spoke with said patients were invited to attend the practice by letter and the patients we spoke with confirmed this.

There was a limited range of information on display within the practice reception area. The practice manager told us this was due to restrictions placed upon them by the

Are services effective?

(for example, treatment is effective)

owners of the premises. The practices' website provided some further 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 and empathy

All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on CQC comment cards we received reflected this. Of the 17 CQC comment cards completed, 12 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included caring, respectful, considerate, polite, understanding and helpful. None of the CQC comment cards completed raised any concerns in this area.

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

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. We saw information about the chaperone service offered was clearly displayed on the doors leading to the consulting rooms. 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 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. The practice manager told us the practice's patient participation group (PPG) had helped to support the production of a local carer's centre handbook.

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. Contact would also be made with the family with the aim of establishing if they wanted or needed any further support or signposting to other agencies. Support was tailored to the needs of individuals, with consideration given to their preference 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

Patient's 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.

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with, including the practice manager and GP, said patients whose first language wasn't English often relied on relatives to interpret for them. Further discussion with the GP and practice manager established this would not be appropriate in most cases. For example, it may not be appropriate for a younger person to be involved in discussions regarding their parents' sexual health, and vice versa. The GP acknowledged this practice should be reviewed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

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

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

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

Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required. We saw a repeat prescription request box was fixed to the wall next to the reception desk.

We saw patients received support from the practice following discharge from hospitals or following the return of test results. This included through the timely provision of post-operative medicines and follow-up appointments with the GP or nurse as required.

The practice manager showed us some work the practice had done under the heading of 'Action Around Alcohol'. The pilot aimed to develop and enhance alcohol misuse services offered by the practice and had been proposed in response to the high numbers of patients presenting with alcohol problems.

The practice had a PPG, which had recently merged with the 'East Locality' patient group. We spoke with two members of the PPG before the inspection. They both told us the practice took notice and responded to requests and concerns the group fed back to them. An example given was the issue of car parking. We were told despite the practice not owning the premises or car park, it was felt they had attempted to improve the situation in consultation with the landlord. This followed some feedback given by the PPG.

Access to the service

Patients we spoke with and those who filled out CQC comment cards all said they were satisfied with the appointment systems operated by the practice. This was reflected in the results of the most recent GP Survey 2013/14. This showed 86% of respondents were satisfied with booking an appointment and 90% were satisfied with the practice's opening hours.

Patients could make appointments in a number of ways. They could call into the practice or request an appointment over the telephone. 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 also offered two open access clinics each week, on Tuesday and Thursday mornings from 8.30am until 10.30am. Patients could turn up and be seen by the GP or nurse practitioner without an appointment at these times. The practice also offered a late surgery until 7pm every Tuesday evening, in addition to being open until 6pm on other weekdays. This allowed people who worked 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.

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. We were also shown by the GP

Are services responsive to people's needs?

(for example, to feedback?)

the system used to ensure patients returned to the practice for follow-up appointments. They told us they had found this to be effective and helped to identify patients who hadn't returned when required. In these instances, the patient was contacted directly by practice staff to remind them of the need to attend their follow-up appointment.

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

Concerns and 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 handled all complaints in the practice.

We saw the practice had received one formal complaint within the last 12 months. We reviewed this and found the complaint had been acknowledged on receipt and investigated fully. The practice had openly admitted to the mistake made and had openly apologised to the patient. As a result of the complaint, some of the practice's procedures had been reviewed and updated following the complaint investigation. It was noted within the practice's review of the complaint they were disappointed the patient had failed to respond to their second apology. The practice therefore remained unaware if the patient was satisfied with the outcome, despite efforts made to contact them.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly. We were told the practice used to have a 'comments box' in place, however restrictions placed on the practice by the owners of the premises meant this was no longer possible. The practice manager told us they had raised this with the owners previously, without being able to make any progress. We saw information relating to comments, complaints and suggestions was included on the practice's website and within the practice leaflet for patients to refer to.

None of the nine patients we spoke with on the day of the inspection said they'd felt the need to complain or raise concerns with the practice before. In addition, none of the 17 CQC comment cards completed by patients indicated they had felt the need to complain.

Are services well-led?

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

Our findings

Leadership and culture

There was an established management structure within the practice. The practice manager, GP 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 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. Several of the staff told us about how they 'mucked in' and helped colleagues during busy periods or when the need arose. Staff reported feeling supported, 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 GP and that 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.

We saw there was an understanding of the leadership needs of the organisation. The practice manager and GP both said they were aware of the need to make progress with succession planning. They told us they had discussed this from time to time without formalising their discussions or the process itself. The practice manager told us their main concern was to maintain continuity of care for their patients.

Governance arrangements

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

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. For example, the provision of a locum GP from a neighbouring practice on the occasions the GP was on leave or unable to attend work.

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 and improvement (leadership)

The practice had systems in place to monitor and improve quality. We saw evidence of audit activity within the practice during the last 12 months. Full clinical audits had been undertaken in a number of areas, including prescribing. The audit and re-audit of prescribing patterns had resulted in improvements in the quality of prescribing within the practice for various medicines groups. For example, the prescribing of benzodiazepines had been reduced by over 96% over an 18 month period.

Audits had also been completed on referral rates for certain conditions and appointment timekeeping. Each audit showed evidence of the results having been analysed and records of improvements made or actions required.

Patient experience and involvement

The practice had a PPG. We spoke with two current members of the group who told us it had recently merged with the 'East Locality' PPG. They felt being part of a larger group had given them the potential to have more influence locally. Membership of the group was by invitation from the practice. It was felt the practice had tried to get a demographical spread of patients to participate. Both of

Are services well-led?

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

the group members we spoke with said they now had a patient from the local Bangladeshi community within the group. They felt this had been a positive move and had helped to involve that section of the community more.

From the minutes of the PPG and the patient surveys which the practice undertook regularly there was evidence that feedback from patients was acted on. For example requests had been made with regards to car parking at the practice. We saw that the practice manager had spoken with the owners of the premises to raise the issue. The PPG had its own page on the practices website, which included its most recent annual report and patient survey data.

Other comments from members of the PPG showed they felt their work had made a real difference to patients, both of the practice and within the local community. They told us about two initiatives they had been involved with; monies donated to a local carer's group for the production of booklets and the funding of some dementia friendly signage at a local bus station.

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

The practice carried out an annual patient survey and reviewed its findings in partnership with its PPG. The results were also compared with the previous year's results to identify any improvements or areas for improvement. The practice posted the results of the survey on their website. Improvements were noted with regards to access to the service, with car parking noted as an area of concern. Areas for action had been agreed based on the results from the survey and members of the PPG we spoke with said these were being followed through.

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. We saw copies of minutes taken to confirm this. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points.

Management lead through learning & improvement

We saw practice staff met 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 midwife. 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 and 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 significantly lower proportion of patients over the age of 65 compared to other practices within the Sunderland CCG area. The practice was a single-handed GP practice; therefore all patients, including those within this population group, effectively had a named accountable GP.

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. Patient's individual circumstance, such as domestic arrangements and input from occupational therapists and carer's of patients was considered. We spoke with the GP who told us older people with dementia type illnesses had individual plans of care. These were put in place with the help of community matrons. Information was shared appropriately with other services, where there was a need to do so. For example, where 'Do Not Attempt Resuscitation' (DNAR) orders were in place, copies of these were faxed to the practices out of hours GP service.

The practice manager told us the practice was involved with a team of healthcare professionals for patients who required end of life care. The team included District and Macmillan Nurses and met every three months to review any patterns or trends. They also maintained daily contact and each patient had a named District Nurse.

The practice helped to ensure patients received appropriate co-ordinated care, including in the event of returning home after a hospital admission. Patients we spoke with from this population group confirmed this.

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.

People with long term conditions

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

Our findings

Care was tailored to individual needs and circumstances, including the patient's expectations, values and choices. We spoke with the GP and nurses who told us regular patient care reviews took place at 3 monthly intervals; for example for patients with chronic obstructive pulmonary disease (COPD) or diabetes conditions. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. The nurse practitioner had a leading role in this area. The practice also had the facility to refer patients onto specialist services, such as clinics for patients with diabetes.

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 99.3% 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 higher 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.

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.

Signposting to services and activities available locally to families was also provided. This included initiatives such as 'preparing for baby', 'mums on the move' and 'early years mental health service'.

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.

Working age people (and those recently retired)

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

Our findings

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

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. The practice had two open access clinics per week, late opening 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.

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

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 and always sent letters to the carers of these patients asking them to accompany them to their appointments.

The GP told us the practice worked with the local Salvation Army in order to have contact with homeless patients and temporary residents in the area. The practice manager told us they found adopting an informal, friendly, non-threatening approach paid dividends when dealing with patients in vulnerable circumstances.

The practice manager told us the 'NHS Health Check' initiative had prompted contacts with many patients who wouldn't normally have had a reason to visit the practice. (The 'NHS Health Check' is for adults in England aged 40-74 without a pre-existing condition. It checks their circulatory and vascular health and what their risk of getting a disabling vascular disease is. Patients received a letter from their GP or local authority inviting them for a free check.

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.

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 manager told us the practice had access to a specialist advisor for mental health. We were told the GP took the lead for the practice with regards to patients experiencing poor mental health.

The nurse practitioner told us the practice maintained a register of patients experiencing poor mental health. They completed medication reviews for these patients and followed a standard template for this process. They said they would not assess a patients' mental capacity and were unclear when asked about the principles of decision making. They would seek advice from the GP on this.

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.