Dr Martin Weatherhead

Quality Report

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Date of inspection visit: 15 September 2014
Date of publication: 05/02/2015

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

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Overall summary

We inspected the practice on 15 September 2014, as part of our new comprehensive inspection programme of Dr Weatherhead, Southwick Health Centre, The Green, Southwick, and Sunderland.

Of the patients we spoke with and who completed the CQC comment cards 28 were extremely complimentary about the care and treatment being provided.

The building was well-maintained and very clean. Effective systems were in place for the oversight and management of medication. Clinical decisions followed best practice. We found that the leadership team was very visible.

Our key findings were as follows:

* The information we reviewed from the practice and external sources showed they had a good track record for maintaining patient safety.

* The GPs looked at how they could continually improve the service and learn lessons from any incidents that had occurred.

* We observed staff behave in a professional manner and treat patients with dignity and respect.

We saw several areas of outstanding practice including:

* Dr Weatherhead was very effective at working with people who were addicted to substances and ran the practice flexibly, which meant people could be seen when in crisis.

* The practice hold a medicine stock to use when patients attend for review and forget to bring their own medicines, for example we ask patients to bring their own inhalers to use for reversibility testing during spirometry.

* For patients who do run out of their medication the practice will always arrange for a prescription to be done on the same day and for it to be delivered to the patient if they're unable to get to the practice.

* Patients found that the staff were non-judgemental and went out of their way to deliver equitable services to all.

* Dr Weatherhead offers learning disability health checks at home for those who find it difficult to come to the surgery.

The practice safely and effectively provided services for all patient groups. The staff were caring and ensured all treatments being provided followed best practice guidance. The practice was well-led and responsive to patients' needs.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety.Effective systems were in place to oversee the safety of the building and patients. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding and child protection referrals.

Are services effective?

The service was effective. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met. Consent to treatment was obtained appropriately.

Are services caring?

The service was caring. The 18 patients who completed CQC comment cards and 12 patients we spoke with during our inspection were complimentary about the reception staff and clinicians. All bar two patients found the staff treated them with respect and listened to their views. They all found the staff treated them with respect and listened to their views. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

The service was accessible and responsive to patients' needs. The practice made adjustments to meet the needs of patients,including having access to interpreter services.The practice responded appropriately to complaints about the service. Regular patient surveys were conducted and the practice took action to make suggested improvements.

Are services well-led?

The service was well led and effectively responded to changes. Governance and risk management structures were in place. The practice had a clear set of values which were understood by staff and recorded on the practice website. The team used their clinical audit tools, clinical supervision and staff meetings to assess the quality of service being provided and how to make improvements.

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 supported 200 older patients and clinicians were knowledgeable about these people's health needs. The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had developed a solid information base which covered the needs of their entire patient group.

The practice actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. Medication reviews were completed with all patients over the age of 75. Up to date registers were kept of patients' health conditions, carers' information and whether patients were housebound. The staff used this information to provide services in the most appropriate way and in a timely manner.

People with long-term conditions

Staff had a good understanding of the care and treatment needs of people with long-term conditions. The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had developed a solid information base which covered the needs of their entire patient group.

The practice closely monitored the needs of this patient group. We heard from patients that staff invited them for routine checks and reviews. We found staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. Staff regularly updated their skills and training in their specialist areas which helped them ensure best practice guidance was always being followed.

Mothers, babies, children and young people

The practice provided services to meet the needs of this patient group. There were comprehensive screening and vaccination programmes which were managed effectively. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had developed a solid information base

which covered the needs of their entire patient group. All of the staff we spoke with were responsive to parents' concerns about their children and ensured parents could readily bring children who appeared unwell into the practice to be seen. Staff were knowledgeable about child protection and a GP took the lead for safeguarding.

The working-age population and those recently retired

Dr Weatherhead was the lead GP for substance misuse in Sunderland and a strong advocate for services for this group of patients. The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had developed a solid information base which covered the needs of their entire patient group.

Staff had a programme in place to make sure no patient missed their regular reviews for their condition such as diabetes, respiratory and cardiovascular problems. Appointments were available prior to 9am and after 5pm.

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

The practice was aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. The practice maintained a register of patients who had learning disabilities as well as those people who had carer's responsibility including young carers. We found that all of the staff had a good understanding of what services were active within their catchment area such as supported living services and care homes. Staff were knowledgeable and proactive when safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received safeguarding training in the last 12 months.

People experiencing poor mental health

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision. The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had developed a solid information base which covered the needs of their entire patient group.

Summary of findings

What people who use the service say

We received 18 completed patient CQC comment cards and spoke with 12 patients who were using the service on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients we spoke with were extremely complimentary about the staff and clinicians, as were 16 patients who completed the CQC comments cards. Patients indicated that they felt this was the best practice in England and the support provided was second to none. Patients told us they found the staff to be very helpful and felt they were treated with respect.

The national GP survey results published in December 2013 found that in general the practice was found to be better than expected nationally. We saw that 90% of respondents in the December 2013 survey found it easy to make an appointment. We did note that 48% of respondents reported they were able to make an appointment with their preferred GP. However, the June 2014 survey showed that this had improved to 73% of the 390 patients who completed the survey could see their preferred GP.

We heard that staff had looked at how to make it easier for patients to obtain appointments and had introduced an on-line booking system for appointments. Appointments with the nurse and GP could be made at least six weeks in advance. Patients told us that they found it easy to make an appointment. All of these patients commented that they could make an appointment both for the same day and many weeks in advance. Over the last year five comments have been made by patients on the NHS choices website and these were in respect of their very positive experience of the service.

Patients we spoke with told us they were very happy with the service and felt the GPs made sure they received the best course of treatment for them. We heard that, when needed, the GP on call rang them to discuss their symptoms and would ask them to come to see them when this was appropriate. We heard that if they had a telephone consultation patients found that it was easy to obtain the medicines the GP had prescribed and could get the prescription the same day if needed. The patients told us that the practice nurses were very responsive and they could readily get appointments to see them.

We were told that the staff were all committed to providing the best care possible and really cared about their wellbeing. Patients discussed how the GPs had been extremely supportive. They all told us the doctors and nurses were competent and knowledgeable about their treatment needs. They told us that the service was very good and staff were very respectful.

Areas for improvement

Outstanding practice

Our inspection team highlighted the following areas of good practice:

Dr Weatherhead was extremely responsive to patient needs and ensured that all were seen. For anxious patients the reception staff try and book appointments at times that they can be seen first. The practice always attempts to accommodate patients who rely on a carer or relative who works to bring them to the surgery and will alter the appointment times accordingly.

Dr Weatherhead provides addiction clinics for patients who were addicted to substances across Sunderland. We heard from these patients that he ensured they were all treated in a non-judgemental manner.

Dr Weatherhead's practice offers Learning Disability health checks at home for those who find it difficult to come to the surgery.

The practice routinely follows up patients who have presented to A&E and sometimes the walk in centres

(depending on the reason for presentation). For those patients who don't contact the surgery or make an appointment they always attempt to organise a routine home visit as follow up.

Doctors will advise patients whether a prescribed med would be cheaper to buy over the counter.

The practice is keenly aware of the demographics of the area they serve and don't charge for any private work that patients would have to fund themselves, e.g. housing forms, letters to support appeals and so forth.

The practice supports a food bank by giving weekly donations of food and the doctors identify patients who could receive a food parcel and a free meal and discuss this resource with them.

Dr Martin Weatherhead

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and the team included a second CQC inspector, a GP, and a practice manager.

Background to Dr Martin Weatherhead

Dr Weatherhead is registered with CQC to provide primary care services, which includes access to GPs, minor surgery, family planning, ante and post natal care. The practice provides GP services for 3706 patients living in the Southwick area of Sunderland. Apart from Dr Weatherhead three salaried GP, a practice nurse and a healthcare assistant work at the practice. Dr Weatherhead is contracted for two days per week to provide substance misuse GP services in the Sunderland area.

The practice is open Monday, Tuesday, Thursday and Friday, 8.30 am to 6pm, and on a Wednesday from 8am to 7.30pm. Patients can book appointments in person, via the phone and online. Appointments can be booked for up to six weeks in advance for the doctors and the nurse.

The practice also operates a nominated GP on call system each day. Patients who need an urgent review will be offered this service and contacted by the GP on call who will determine whether the symptoms can be treated via a telephone consultation or ask the patient to come in that day.

The practice treats patients of all ages and provides a range of medical services.

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

Diagnostic and screening procedures

Family planning

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- 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 the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 15 September 2014 and spent seven hours at the practice.

We reviewed all areas of the practice including the administrative areas. We sought views from patients both face-to-face and via CQC comment cards. We spoke with the practice manager, Dr Weatherhead, a GP, the nurse, the two pharmacist staff (one employed by the practice and one by the CCG), two administrative staff, and the receptionists on duty.

We observed how staff treated patients visiting and ringing the practice. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Are services safe?

Our findings

Safe Track Record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was correctly identifying and reporting significant events and they were meeting expected targets. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at the significant events from January 2014 which had been reported to NHS England using the incident reporting system. The records showed staff were have a process in place for identifying and reporting incidents.

The practice had systems in place to monitor patient safety. We saw that apart from reviewing incidents, individual GPs also completed evaluations of the changes their practice made to outcomes for people. Dr Weatherhead was a member of the LMC as well as an active participant in the local CCG networks. We saw that he had used lessons learnt from these environments to review and develop the operation of the practice.

Staff provided us with evidence to show they actively reported any incidents that might have the potential to adversely impact patient care. Staff told us they viewed this process as a positive process to ensure they provided excellent patient care. Staff could readily describe their roles of accountability in the practice and what actions they needed to take if an incident or concern arose. Concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible.

The practice minutes of meetings we reviewed showed that new guidelines, complaints, incidents and significant events, were discussed at each meeting. The staff we spoke with discussed the use of incident analysis and how this assisted them to develop the care provided.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence to confirm that staff had completed a significant event analysis which included identifying any learning from the incident.

We saw evidence to confirm that, as individuals and as a team, staff were reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were thoroughly investigated and the information was analysed to check if trends were evident. The practice manager was able to show us how this analysis informed the way the practice operated. The team recognised the benefits of identifying any patient safety incidents and near misses.

From the review of complaint investigation information we saw that the practice manager ensured complainants were given a full feedback and asked for detailed information about their concerns. We saw that the practice then checked if the complainant was satisfied with the outcome of the investigations and any actions made to improve the service.

Reliable safety systems and processes including safeguarding

The practice had up to date 'child protection' and 'vulnerable adult' policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers. Staff had access to contact details for both child protection and adult safeguarding teams. The staff routinely supplied reports for and at times attended child protection meetings. Staff were knowledgeable about the actions they needed to take and took appropriate action to discuss issues with the Safeguarding GP Lead in the area.

All the staff had received training in safeguarding and child protection the last 12 months. Dr Weatherhead was the lead for safeguarding in the practice and had completed level three safeguarding training as well as the equivalent level of training in child protection. Staff were knowledgeable about the types of abuse to look out for and how to raise concerns. For example, the deputy practice manager told us about the child protection and safeguarding concerns they had recently raised with the local authority safeguarding team. The GPs outlined discussions they had with the GP safeguarding lead for the Sunderland area.

When safeguarding concerns were raised, staff ensured these alerts were put onto the patient's electronic record.

Staff were proactive in monitoring patient attendance at Accident and Emergency. They had systems in place to

follow up patients who had been to A&E, as well as to walk-in centres. These were brought to the GP's attention, who then ensured patients who did not attend for an appointment following their visit to A&E were contacted and home visits arranged where necessary. The practice also routinely monitored children's' attendance for child immunisation clinics; health screening and non-attendance for appointments. The GPs proactively made sure these checks were completed and would schedule routine home visits to make sure all was okay if children and vulnerable adults had not attended for an appointment.

From our discussions we found that GPs were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. We saw there were effective systems in place to ensure the staff remained up to date with the latest developments. For example at clinical meetings GPs discussed changes to guidance, clinical audits reviewed implementation of latest best practice and staff regularly attending clinical conferences.

Medicine management

The practice had reviewed the needs of their patient group and decided to hold a medicine stock to use when patients attend for review and forget to bring their own medication, for example we ask patients to bring their own inhalers to use for reversibility testing during spirometry. For patients who may run out of their medication the practice will always arrange for a prescription to be done on the same day and for it to be delivered if they're unable to get to us.. Therefore the practice had completed all the necessary processes to allow them to keep stock medicines such as insulin and other medicines for long-term conditions. In light of this the practice employed their own pharmacy support and in addition to this worked with pharmacy support from the CCG. Both of these team members supported the clinical staff in keeping up to date with medication and prescribing trends.

From our review of documents we saw that there were up to date medicines management policies in place. The GPs reviewed medicine for patients on an annual basis or more frequently if necessary. Medicines were kept securely and could only be accessed by the clinical staff and CCG pharmacy staff. There were appropriately stocked equipment bags ready for doctors to take on home visits. We saw evidence that the doctor's bags were regularly checked to ensure that the contents were intact and in date.

Clear records were kept whenever any medicines were used. Arrangements for the storage and recording of controlled drugs or medicines that require extra checks were followed. Medicines we checked, other than one box of tablets that had just gone out of date, were all in date, stored appropriately and staff ensured stock was used in a systematic order. The practice manager explained they checked the stocks at the end of the month and at that time the medicine was in date. They did monthly checks so expected this box to have been noted and removed but felt they should look at removing tablets the month before the expiry date as a way to reduce the potential for this issue to occur. Any changes in medication guidance were communicated to clinical staff in person and electronically via the webform for prescriptions.

GPs reviewed their prescribing practices as and when medication alerts were received. We noted that within the practice clinical meetings, GPs and nurses were sharing latest guidance on changes to medication and prescribing practice. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to critically evaluate their practices and the service being provided.

There were standard operating procedures (SOP) in place for using certain drugs and equipment. These documents ensured all clinical staff followed the same procedures. The SOPs were reviewed, were in date and clearly marked, which ensured staff knew it was the current version.

Prescription pads and repeat prescriptions were stored securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. They were also able to describe the additional checks required when giving out prescriptions for controlled drugs.

Cleanliness & Infection Control

Patients commented that the practice was clean and appeared hygienic. The practice does not own the building and their landlord had the responsibility for managing the cleaning services and ensuring good infection control measures were in place. The practice had recently developed their own infection control audit to ensure they

could check that the areas of the building they used were up to a good standard. We saw that the overall cleanliness of the building was good. The practice was cleaned in line with infection control guidelines.

We spoke with the nurse who had the lead role for infection control and found them to be knowledgeable. We found the practice had a comprehensive system in place for managing and reducing the potential for infection.

We inspected all the treatment and clinical rooms. We saw that all areas of the practice were very clean and processes were in place to manage the risk of infection.

There was an up-to-date Infection Control Policy in place. A needle stick policy was in place, which outlined what to do and in event of this happening and who to contact. We saw updated protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice. Spillage kits were available for staff to use if bodily fluids were spilled and the staff knew how to use them

Infection control training was part of induction for all staff. Clinical staff completed this training at induction and then refresher training on an annual basis. Non-clinical staff completed the training during their induction and had access to the information produced by the infection control lead.

We observed good hand washing facilities to promote high standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/ consulting rooms and in reception. Couches were washable and there were easy clean flooring in treatment areas. Curtains were on a cleaning schedule managed by the landlord, which included fire retardant treatment after cleaning.

We were told the practice did not use any instruments which required decontamination and that all instruments were for single use only. Checks were carried out and recorded to ensure items such as instruments, gloves and hand gel were available and in date.

Equipment

The practice manager had contracts in place for annual checks of fire extinguishers, 'portable appliance testing' and calibration of equipment.

Emergency drugs were stored in a separate locked cabinet and vaccines were stored in a vaccine fridge. Temperature logs for the vaccine fridge were routinely completed. A log of maintenance of clinical and emergency equipment was in place and there was a record noted on the log when any items identified as faulty were repaired or replaced. We saw that the landlord ensured portable appliance tests (PAT) were completed on all electrical equipment on an annual basis and that the last checks were in date. The practice had made arrangements for the routine servicing and calibration, where needed, of medical equipment. The records we saw confirmed that the equipment at the practice was safe to use.

Staffing & Recruitment

The practice's recruitment policy was in place and up-to-date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service. We looked at a sample of recruitment files for GPs, administrative staff and nurses. We saw that the practice independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists. The practice manager also obtained health statements for all employees so they knew the person was physically and mentally able to perform their role. The recruitment procedure ensured appropriate staff were employed.

We saw that as a routine part of the quality assurance and clinical governance processes the provider checked the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year to make sure the doctors and nurses were still deemed fit to practice.

Dr Weatherhead and practice manager had agreed in conjunction with commissioners what would be safe staffing levels and the rotas showed that these were consistently maintained. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses had been allocated lead roles such as for infection control, respiratory disease, mental health, learning disability and the Mental Capacity Act 2005. We found that the practice

Are services safe?

manager and senior staff monitored how effectively lead staff fulfilled their role. This included routine checks to ensure that GPs and nurses were using the latest guidance and protocols. Findings were routinely analysed and any emerging risks were immediately fed back to the staff so action could be taken to improve service delivery.

Monitoring Safety & Responding to Risk

There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual and monthly checks of the building, the environment and equipment. Staff were in the process of improving the risk assessments they completed. They had recently implemented an infection control audit and were working through the recommendations identified in the first run through of this audit. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

The practice manager and Dr Weatherhead oversaw the rota for clinicians. They had reviewed and developed the GP appointment system. This had led to a responsive design being in place, which allowed the practice to meet fluctuations in demand for appointments. Appointments could be made up to six weeks in advance and an online booking system was available as well as via telephone or in-person booking. The practice found that often appointments with Dr Weatherhead were all booked for the full six weeks but he would happily run clinics until all the patients seated at the close of surgery were seen. Also GPs provided a telephone consultation service. The practice manager ensured that sufficient staff were on duty to deal with expected demand; including home visits and daily telephone consultation sessions.

Arrangements to deal with emergencies and major incidents

Comprehensive plans to deal with any emergencies that may occur and could disrupt the safe and smooth running of the practice were available. A detailed business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Reception staff we spoke with were knowledgeable about the business continuity plans and described how they had used the plan when telephone and IT systems failed.

The practice manager had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Emergency medicines treatment of cardiac arrest, anaphylaxis and hypoglycaemia were available for use.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Dr Weatherhead specialises in the treatment of people with an addiction and many of the patients visiting this practice were receiving treatment for this as well as the physical health conditions associated with this condition as well as a chaotic lifestyle. The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work which allowed the practice to focus on specific conditions.

The GPs and nurse we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and we confirmed this was being used. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of depression. The review of the clinical meeting minutes confirmed this happened. Staff providing gynaecology and family planning services received regular updates about this service. They, in line with the expectations of the Royal College of General Practitioners guidelines, were assessed in their delivery of these services as well as other general practice expectations. The health care assistant was qualified to monitor physical health such as blood pressure and to take blood samples.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to and for children and young people Gillick assessments were completed.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. Examples of clinical audits included, audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. We also saw that the practice's management of long-term condition such as diabetes was in accordance national expectations. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. The GPs we spoke with provided a range of examples to show how they, in line with guidance, completed condition specific audits on treatment offered to patients with long-term conditions. In addition to this, as a part of the re-validation process, GPs had completed two yearly evaluation cycles, which aimed to determine whether changes to the practice had been sustained and had improved access for patients. They had been completing this type of evaluation for over ten years.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of Quality and Outcomes framework (QOF) performance. For example we saw an audit regarding the prescribing of analgesics and hypnotics. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. We saw that the practice run a lot of audits through EMIS such as referrals requested by GPs to ensure that no referrals have been missed; audits of MDA and CAS alerts and inadequate smears.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided**.** The QOF report from 2012-2013 showed the practice was supporting patients well with all conditions such as, asthma, diabetes and heart failure. The practice had one area that was not rated at 95% + and that was for working with people who

had a learning disability. We discussed this with the practice manager and found that they had in-depth knowledge of these patient groups. We heard that only a very small number of people with a learning disability were registered at the practice and they all had attended for the annual health check. QOF information for 2013-2014 indicated the practice confirmed that they had improved their figures for meeting the target related to learning disability. GPs told us this reflected their commitment to maintaining and improving outcomes for patients.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had clearly reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective Staffing

From our review of information about staff training we saw that, the induction programme covered a wide range of topics such as dignity and privacy, equality and diversity as well as mandatory training such as safeguarding children. The management team ensured that the clinicians had access to a variety of training resources. The practice manager had purchased an e-learning training resource and this meant all staff could readily update both mandatory and non-mandatory training. We saw that the mandatory training for all staff included fire awareness, information governance, first aid, and safeguarding. Staff also had access to additional training related to their role. For example reception staff told us they had received conflict resolution and customer care training. We confirmed that staff had the knowledge and skills required to carry out their roles.

The staff files we reviewed showed that staff of all disciplines received annual appraisal and the clinicians had access to regular clinical supervision sessions. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager. The practice had procedures in place to support staff in carrying out their work. For example, newly employed staff were supported in the first few weeks of working in the practice. An induction programme included time to read the practice's policies and procedures and meetings with the manager to help confirm they were able to carry out the role. Staff told us they had easy access to a range of policies and procedures needed to support them in their work.

The practice manager kept a record of all training carried out by clinical and administration staff to ensure staff had the right skills to carry out their work. The practice had a rolling programme of half day training for staff, on one afternoon each month. GPs had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development.

The GPs received both internal appraisals and an external professional appraisal. They, as well as the nursing staff also routinely accessed clinical supervision. The appraisals involved a 360 degree process for clinicians; which ask staff to complete a personal reflection on their skills and behaviour. Internal colleagues were also asked to provide open and honest feedback about the appraisee's interpersonal skills and clinical competence.

Systems were in place to monitor staff refresher training to ensure they had the right skills to carry out their work. The clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis. Staff that would use the defibrillator had received regularly training to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest.

Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR) and other emergencies such as fire and floods.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. Dr Weatherhead was an active participant in all of the local clinical networks as well as the LMC. He was the driving force for developments in the treatment of substance misuse in the Sunderland area and provided clinics in other practices.

Are services effective?

(for example, treatment is effective)

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, such as accident and emergency or hospital outpatient departments was read and actioned by the GPs on the same day.

The practice kept up to date registers for patients with long term conditions such as learning disability, asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication; for example for mental health conditions. We heard that the practice staff had formed strong links with the community nursing services and secondary care services.

Information sharing

Systems were in place to ensure that information clinicians within the practice, as well as when referrals were made to secondary care, needed to plan and deliver treatment. We saw that staff ensured this was made available to relevant staff in a timely and accessible way. Staff discussed results with patients in private. Staff were effective when communicating with all the diverse types of patients who used the practice and we heard them change their communication styles to meet patients' needs. Staff then monitored the 'choose and book' system to ensure the patients were seen in a timely manner.

Consent to care and treatment

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2004. GPs and nursing staff told us relatives, carers or an advocate were involved in helping patients who required support with making decisions. We saw that clinicians ensured they obtained patients consent for all treatment plans.

We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's parent or legal guardian.

Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services the practices provided and local support groups.

QOF information showed the practice performed well regarding health promotion and ill health prevention initiatives. For example, in providing flu vaccinations/ smoking cessation advice, screening for depression and providing physical health checks for patients with severe mental health conditions.

The practice also provided patients with information about other health and social care services such as carers' support. We saw a range of information posters and leaflets in the practice and on the practice website. Staff we spoke with were knowledgeable about other services and how to access them.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. Patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nursing staff.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The service had a patient dignity policy in place. Staff we spoke with were aware of the importance of providing patients with privacy. A room was available if patients wished to discuss something with the reception staff away from the reception area and we saw this being used. The design of the reception area ensured confidentiality was maintained when staff booked appointments for patients. We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Satisfactory arrangements were in place to ensure telephone calls in respect of discussing results and booking appointments were taken in a room at the back of the reception desk remained confidential.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. The consultation room doors were routinely locked when patients were being seen. We observed staff were discreet and respectful to patients.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was in the waiting area to help ensure patients were aware of this facility. Staff we spoke with were knowledgeable about the role of the chaperone and had received training to carry out this work. Patients we spoke with told us about access to chaperones and felt confident that this was effective, as it was always used with them when needed. Patients also told us that they felt the staff and GPs effectively maintained their privacy and dignity.

Patients commented that they were treated with respect and dignity.

The most recent practice national patient survey showed that 88% of patients of the 106 people who responded said reception staff were exceptional or good at listening and dealing with any requests. The practice had a clear set of values about patients being treated courteously and the information they supplied was only shared with clinicians on a need to know basis. This was reflected in the practice charter.

Patients told us they were happy to see any GP and the nurse as they felt all were competent and knowledgeable. Most patients told us that they found Dr Weatherhead to be an exceptionally good GP and felt he was totally non-judgemental. They told us that appointment system worked and when Dr Weatherhead was on duty they could always come in as they would be seen. The national GP patient survey (June 2014) found that 73% of patients reported that they could always see their preferred GP. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hour's service.

Care planning and involvement in decisions about care and treatment

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations. Written consent was obtained for joint injections and gynaecological examinations. The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted. The national GP patient survey (December 2013) found that 94% of patients said they were fully involved in making decisions.

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

Patient/carer support to cope emotionally with care and treatment

We received 18 completed patient CQC comment cards and spoke with 12 patients who were using the service on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical health care needs and those who had various levels of contact with the practice. All these patients were complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurses were competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

We saw that the staff had detailed knowledge of the patients they served and kept registers in respect of who had learning disabilities; carer responsibilities; mental

Are services caring?

health needs and complex health conditions. Staff provided additional support mechanisms for these people such as home visits; organising early appointments for nervous patients; arranging appointments around carer's availability. The practice also had good links with local psychological and counselling services and we saw they proactively referred patients to these services as well as to treatment services for people with addictions.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice held information about the prevalence of specific diseases such as coronary disease; respiratory disease and also completed disability registers. This information was reflected in the plan for the services provided, for example screening programmes, vaccination programmes and annual reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations. Often the GPs would schedule routine home visits for these patients to ensure they received treatment in a timely manner.

The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter for patients with a hearing impairment. Guidance and information about using interpreter services and the contact details was available for staff to use. Staff were knowledgeable about interpreter services that were available when English was a second language for patients. Patients' electronic records contained alerts for staff; for example whether patients required additional assistance in order to ensure the length of the appointment was appropriate.

The practice also provided prescriptions on the same day and kept a stock of commonly needed medicines for those patients who struggled to get their prescription prior to their medicine running out.

Tackling inequalities and promoting equality

Staff we spoke with were knowledgeable about how to support the patients who used the service. Dr Weatherhead and the team routinely work with people who experience addictions and live very chaotic lifestyles because of this condition. All the staff were trained to work with people who could be intoxicated and at times challenging.

Dr Weatherhead's vision for the practice was one where patients received a wraparound service that met their individual needs. It was his intention that all of the GPs and clinicians made sure that they closely understood each patients care needs and their level of health and wellbeing. This had led to staff taking a deep interest in patients experience and altering their service to ensure it supported patients. For example anxious patients were given appointments, which meant they could be seen immediately upon their arrival at the practice. Routine home visit were regularly utilised for patients experiencing difficulty visiting the surgery because of physical health needs.

The practice also held comprehensive information about all of the patients who used the service and could readily identify patients who required a care plan and who were carers. These were shared with district nursing services and out of hours GPs. The staff told us how they supported patients facing economic difficulties and we heard that the practice donated to local food banks and ensured patients were aware of this resource. The practice also signposted patients to various support networks such as shelters, addiction services such AA and NA as well as social services.

Access to the service

The GPs and the clinicians had proactively managed the appointment booking system. The national GP survey results published in December 2013 showed they were performing above the national average. The patients responded positively about the contact with GPs and in most areas they scored 90% satisfaction rates. The patients were 96% satisfied with the GPs listening skills and ability to explain treatment decisions. Areas that indicated a poorer response rate related to making an appointment being easy with a 76% response. As a result the practice had re-advertised all of ways patients could make appointments. We saw this had led to an improvements of 2% in the June 2014 national survey satisfaction levels, which confirmed the practice's own survey results

Listening and learning from 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. There was a designated responsible person who handled all complaints at the practice.

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

Are services responsive to people's needs?

(for example, to feedback?)

they wish to make a complaint. Patients we spoke with told us they had never needed to complain about the service. They felt the staff were constantly looking at how to improve what they did and within this process had looked at the service from the point of view of the patient.

From a review of the complaints records, covering the last year, we saw that the practice manager thoroughly investigated concerns. We heard how this approach was welcomed by patients and gave them confidence that their concern would be addressed.

Are services well-led?

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

Our findings

Vision and strategy

All the discussions and evidence we reviewed confirmed that the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and each one clearly took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice had a clear vision and set of values which were understood by staff and were available on the practice website. The practice's mission statement included a commitment to involving patients in their own healthcare and the development of the service. Dr Weatherhead was a strong advocate for patient-centred care.

There was a schedule of regular weekly, monthly and quarterly meetings within the practice. Staff told us this helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to the partners. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

The team worked collaboratively and used their understanding of the effectiveness of the service to shape and improve the practice. From our discussions and review of the evidence we confirmed that this had led to the practice being consulted by local healthcare services about developments in the delivery of care in the local area.

Governance Arrangements

We found that the practice had implemented systems for monitoring all aspects of the service and these were designed to be used to plan the service and to make improvements to the service. The practice managers and GPs led on the individual aspects of governance such as complaints, risk management and audits within the practice. The systems in place ensured strong governance arrangements were in place.

Dr Weatherhead actively oversaw that the systems in place were consistently being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. Practice staff routinely ran EMIS audits around all aspects of the service and shared this with Dr Weatherhead who then discussed the findings with the team. All of the clinicians we spoke with discussed how they used this information to as a group identify gaps and solutions.

Leadership, openness and transparency

The GPs and clinical staff held regular clinical meetings where they discussed changes to clinical practice. The practice also scheduled meetings for the whole staff team, clinical, non-clinical and operations management. Staff were encouraged to attend various staff meetings and we saw from the minutes of the clinicians meetings that they discussed improvements that could be made to the service. Our discussions confirmed that the whole team were highly focused and very open to exploring how they could improve. We confirmed that this had led to a constant cycle of improvement and demonstrated the practices desire to constantly strive for excellence.

There was evidence of forward planning within the practice around the need to review and update policies and check the accuracy of current risk management tools.

The practice regularly submitted governance and performance data to the CCG. We saw evidence that demonstrated the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing, medicines management and safeguarding meetings and shared information within the practice.

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

Staff were responsive to patients' needs and had tried to encourage them to share their views and suggestions. The practice had created patient participation groups (PPG) over the years but found participants had difficulty sustaining their involvement, so the practice had looked at other ways to gather people's views about their service, any changes they made and what they could do better. We saw that surveys were regularly completed and a system was in place for patients to make comments via a suggestion box. We also heard that the practice had advertised the PPG and asked for participants each quarter with little success. The practice manager was looking at other ways to encourage patients to join such as virtual participation.

Are services well-led?

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

Information about the PPG was available on the practice website and the practice manager was re-advertising that they wanted to form an active group for patients to air their views in the practice newsletter.

Management lead through learning and improvement

The practice used information they collected for the Quality and Outcomes framework (QOF) and national programmes such as vaccination and screening to monitor patient quality outcomes. GPs told us they worked with the pharmacist from the CCG in identifying which clinical audits to carry out. Clinical audits were also carried out following significant events and complaints. These were discussed within the practice through a schedule of meetings with staff groups.

Staff told us they had annual appraisals which included looking at their performance and development needs. The practice completed clinical supervision sessions for all of the relevant staff. External appraisals of GP's were also undertaken as a way of monitoring the quality of care provided by staff.

The GPs, the nurse and the practice manager all contributed to risk management, clinical audits, staff training and significant event analysis. It was evident that quality monitoring was taking place and action taken to improve quality. Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training. All of the systems we reviewed showed that the practice was effectively monitored by the practice manager and senior staff.

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

Patients were able to sign up on line or complete a form and hand it in to reception staff if they were interested in joining the patient participation group. Patients were encouraged to send their comments, suggestions and questions via a comments box, the practice website and in person.

We saw that complaint investigations were thorough and impartial. We saw that a process was in place to analyse each complaint to see if themes were emerging or to look at trends in complaint rates or topics. No themes were evident but the staff proactively looked for lessons that could be learnt.

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.