

# Southlands Medical Group

## 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.

### Ratings

<b>Overall rating for this service</b>	<b>Good</b>	
Are services safe?	<b>Good</b>	
Are services effective?	<b>Good</b>	
Are services caring?	<b>Outstanding</b>	
Are services responsive to people's needs?	<b>Good</b>	
Are services well-led?	<b>Good</b>	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Southlands Medical Group on 1 April 2015

Overall, we rated the practice as good. Specifically, we found the practice to be good for providing safe, effective, responsive and well led services; and outstanding for providing caring services.

Our key findings were as follows:

- Feedback from patients was overwhelmingly positive; they told us staff treated them with respect and kindness;
- We reviewed 49 completed CQC comment cards and spoke with 14 patients. They were all very complimentary about the care provided by the practice. Results from the National GP Patient Survey were well above local and national averages;
- Patients reported good access to the practice, with urgent appointments available the same day;
- Patients we spoke with told us they felt they had sufficient time during their appointment;

- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- There was a clear leadership structure and staff felt supported by the management team. The practice actively sought feedback from patients;
- The practice was clean and hygienic, and good infection control arrangements were in place.

We saw some areas of outstanding practice including:

- The practice had undertaken a significant amount of work in relation to access to the service. Separate systems were in place for patients to book planned (routine) and urgent appointments. There were daily clinics which were run by the nurse practitioner; patients did not need to book in advance to attend. The practice was part of a group of ten local GP practices taking part in an extended hours pilot.

# Summary of findings

Patients from those surgeries were able to access services at a local health centre between 8:00am and 8:00pm weekdays and between 9:00am and 5:00pm at weekends.

- There was a well-defined vision within the practice to put patients first. Staff understood that it may have been difficult for patients to make decisions about possible treatment during a 10 minute consultation. Patients were encouraged to go and consider their options and make a further appointment for a later date to discuss with a clinician. Despite the time constraints and pressures on appointments across GP practices nationally, the practice prioritised the welfare of patients and did not put pressure on people to make an immediate decision.
- The practice actively reviewed complaints and had recently reviewed its arrangements for managing and responding to complaints. The revised approach

demonstrated the people who use services were involved in the review of complaints. A decision had been taken to share (anonymised) details of all complaints with the Patient Reference Group (PRG), to promote openness and transparency. The PRG members we spoke with confirmed these arrangements were in place and told us they welcomed the opportunity to be involved in the process.

However, there was also an area of practice where the provider needs to make improvements.

The provider should:

- put plans in place to ensure clinical audit cycles are completed.

**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 practice is rated as good for providing safe services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. Effective staff recruitment practices were followed and there were enough staff to keep patients safe.

Good



### Are services effective?

The practice is rated as good for providing effective services.

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. Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. However, only a limited amount of clinical audits had taken place to improve patient outcomes.

Good



### Are services caring?

The practice is rated as outstanding for providing caring services.

Feedback from patients was overwhelmingly positive. Patients we spoke with and those who completed CQC comment cards were very complimentary about the practice.

Patients were active partners in their care. There was a well-defined culture within the practice to put patients first. Staff understood that it may have been difficult for patients to make decisions about possible treatment during a 10 minute consultation. Despite the time constraints and pressures on appointments across GP practices nationally, the practice prioritised the welfare of patients and did not put pressure on people to make an immediate decision.

Outstanding



# Summary of findings

Data showed that patients rated the practice much higher than others for almost all aspects of care, for example the proportion of patients who said their GP was good or very good at treating them with care and concern was 92%; the national average was 82%.

Patients' emotional needs were seen as being as important as their physical needs. A member of staff from the administration team was the nominated 'Champion for Carers' within the practice. Their role was to promote the awareness of patients with caring responsibilities and ensure such patients were informed about the support available.

Accessible information was provided to help patients understand the care available to them. We found there was a patient-centred culture and staff treated patients with kindness and compassion. Staff we spoke with were aware of the importance of maintaining patient confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were either in line with, or better than the local Clinical Commissioning Group (CCG) and national averages. Findings from the National GP Patient Survey, published in January 2015, showed most patients were satisfied with practice opening hours, telephone access, and appointment availability. For example, of patients who responded to the survey, 82% said they were satisfied with the practice's opening hours. This was above the local CCG average (81%) and national average (76%).

The practice had undertaken a significant amount of work in relation to access to the service. Separate systems were in place for patients to book planned (routine) and urgent appointments. Patients we spoke with during the inspection commented that this system worked well. Many spoke positively of the daily open access nurse practitioner clinics.

Services had been planned to meet the needs of the key population groups using the practice. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a well-established Patient Reference Group (PRG), who held the practice to account. There was an accessible complaints procedure, with evidence demonstrating the practice made every effort to address any concerns raised with them. Complaints were shared with the PRG and patient members were involved in the ongoing review of concerns raised.

Good



## Are services well-led?

The practice is rated as good for providing well-led services.

Good



# Summary of findings

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had a very active patient reference group (PRG).

# 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 is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 1.5 percentage points above the local Clinical Commissioning Group (CCG) average and 2.9 points above the England average.

The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits.

Good



### People with long term conditions

The practice is rated as good for the care of patients with long-term conditions.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients with long-term conditions such as asthma and diabetes, were offered regular reviews and an annual check of their health and wellbeing, or more often where this was judged necessary by the nursing team.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with asthma. This was 2.0 percentage points above the local CCG average and 2.8 points above the national average.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. We saw the practice had processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying

Good



# Summary of findings

and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as school nurses and health visitors.

Appointments were available outside of school hours and reception staff had been trained to take note of any urgent problems and notify the doctor, of an unwell child or parental concern. The premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12 month and 24 month old babies and five year old children were in line with the local CCG area.

Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. Nationally reported QOF data (2013/14) showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines.

## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. All of the nurses were trained in cervical cytology.

Patients could order repeat prescriptions and book appointments on-line. The practice was open between 8:00am and 6:00pm. However, the practice was taking part in a local extended hours service which meant that their patients were able to access appointments seven days a week. Appointments were available until 8:00pm on weekdays and between 9:00am and 5:00pm at weekends at a local health centre.

We saw health promotion material was made easily accessible through the practice's website. This included signposting and links

Good





# Summary of findings

to other websites including those dedicated to weight loss, sexual health and smoking cessation. The practice provided additional services such as smoking cessation advice clinics, travel vaccinations and minor surgery.

## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Systems were in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered regular reviews.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

**Good**



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with mental health needs. This was 9.7 percentage points above the local CCG average and 9.6 points above the England average. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care plans in place for patients with dementia. Patients experiencing poor mental health were sign posted to various support groups and third sector organisations.

**Good**



# Summary of findings

## What people who use the service say

We spoke with 14 patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed 49 CQC comment cards which had been completed by patients prior to our inspection.

All patients were very complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system.

The latest National GP Patient Survey published in January 2015 showed the large majority of patients were satisfied with the services the practice offered. The results were:

- GP Patient Survey score for opening hours – 82% (national average 76%);
- Percentage of patients rating their ability to get through on the telephone as very easy or easy – 94% (national average 71%);
- Percentage of patients rating their experience of making an appointment as good or very good – 73% (national average 73%);
- Percentage of patients rating their practice as good or very good – 80% (national average 86%);
- The proportion of patients who would recommend their GP surgery – 86% (national average 78%).

## Areas for improvement

**Action the service SHOULD take to improve**

**Action the provider SHOULD take to improve:**

- Put plans in place to ensure clinical audit cycles are completed.

## Outstanding practice

The practice had undertaken a significant amount of work in relation to access to the service. Separate systems were in place for patients to book planned (routine) and urgent appointments. There were daily clinics which were run by the nurse practitioner; patients did not need to book in advance to attend. The practice was part of a group of ten local GP practices taking part in an extended hours pilot. Patients from those surgeries were able to access services at a local health centre between 8:00am and 8:00pm weekdays and between 9:00am and 5:00pm at weekends.

There was a well-defined vision within the practice to put patients first. Staff understood that it may have been difficult for patients to make decisions about possible treatment during a 10 minute consultation. Patients were encouraged to go and consider their options and make a

further appointment for a later date to discuss with a clinician. Despite the time constraints and pressures on appointments across GP practices nationally, the practice prioritised the welfare of patients and did not put pressure on people to make an immediate decision.

The practice actively reviewed complaints and had recently reviewed its arrangements for managing and responding to complaints. The revised approach demonstrated the people who use services were involved in the review of complaints. A decision had been taken to share (anonymised) details of all complaints with the Patient Reference Group (PRG), to promote openness and transparency. The PRG members we spoke with confirmed these arrangements were in place and told us they welcomed the opportunity to be involved in the process.

# Southlands Medical Group

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP, a practice nurse and a specialist advisor with experience of GP practice management.

## Background to Southlands Medical Group

Southlands Medical Group is registered with the Care Quality Commission to provide primary care services. It is located in the Ryhope area of Sunderland.

The practice provides services to around 5,300 patients from one location; Ryhope Health Centre, Black Road, Ryhope, Sunderland, SR2 0RX. We visited this address as part of the inspection. The practice has two GP partners, two salaried GPs, a nurse practitioner, two practice nurses, a practice manager, and seven staff who carry out reception and administrative duties.

The practice is part of Sunderland Clinical Commissioning Group (CCG). The practice is situated in an area where there are pockets of high deprivation. The practice population is made up of a higher than average proportion of patients over the age 65.

The practice is located in a purpose built single storey building. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

Surgery opening times at the practice are between 8:00am and 6:00pm Monday to Friday. Patients can book appointments in person, on-line or by telephone.

The practice provides services to patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

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

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

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

- 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:

# Detailed findings

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of concern across the five key

question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 1 April 2015. We spoke with 14 patients and nine members of staff from the practice. We spoke with and interviewed three GPs, the practice manager, two members of the nursing team and three 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 49 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

The practice had a good track record for maintaining patient safety.

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. 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. We (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice. We met with the local Clinical Commissioning Group (CCG) before we inspected the practice and they did not raise any concerns with us.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice Outcome Standards (GPOS) and the Quality and Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous 12 months, and the minutes of meetings where these were discussed. The records looked at showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

### Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. We spoke with the practice manager about the arrangements in place. They told us that all staff

had responsibility for reporting significant or critical events. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at staff meetings to ensure learning was disseminated and implemented.

We saw there had been a significant event in relation to an emergency outside the practice premises. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The event had been discussed within the practice and protocols were revised to ensure the practice could provide appropriate assistance should such an event occur again. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

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. Any alerts were initially received by the practice manager; information was then forwarded to clinicians and other staff where necessary. Each alert was discussed at a clinical meeting to ensure staff were aware of any necessary action. We saw minutes confirming these discussions had taken place.

### Reliable safety systems and processes including safeguarding

The practice had well established systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. These provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible.

There was an identified member of staff with a clear role to oversee safeguarding within the practice. Staff we spoke with said they knew which of the GP partners was the safeguarding lead. This GP was responsible for ensuring staff were aware of any safeguarding cases or concerns.

## Are services safe?

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out).

The practice had a proactive approach to anticipating and managing risks to patients and recognised this was the responsibility of all staff. In addition to the formal notes on clinical records, the practice manager maintained a 'keep an eye on' register. All members of staff were able to record any safeguarding concerns they may have had about patients. This was confirmed when we spoke with staff from various teams within the practice. The practice manager then ensured the clinicians were aware of the information. Details were also shared with health visitors during their regular meetings.

The clinicians discussed ongoing and new safeguarding issues at their weekly meetings, and also held regular meetings with health visitors. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

We saw records which confirmed all relevant staff had attended training on safeguarding children. All of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Nurses at the practice had completed Level 2 which is more relevant to the work they carry out whilst all other staff attended Level 1 training sessions. This was confirmed by the staff we spoke with.

The practice had a chaperone policy. We saw posters on display in the consultation rooms to inform patients of their right to request a chaperone. Staff told us that a practice nurse or a member of the administration team undertook this role. Staff we spoke with were clear about the requirements of the role and had undergone Disclosure and Barring Service (DBS) checks.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

### Medicines management

There were clear systems in place to manage medicines. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw medicines were in date and good systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

There was a clear policy for ensuring medicines were kept at the required temperatures (for example, some vaccines needed to be stored in a refrigerator). The policy described the action to take in the event of a potential failure of the refrigerator. Staff confirmed the procedure was to check the refrigerator temperature every day to ensure the vaccines were stored at the correct temperature. We saw records of the daily temperature recordings, which showed the correct temperatures for storage were maintained.

Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines authorising nurses to administer them. We saw up-to-date copies of directions were held by each of the nurses.

There were systems in place to ensure GPs regularly monitored patients medicines and re issuing of medicines was closely monitored, with patients invited to book a 'medication review', where required. A part time pharmacist worked with the practice to monitor medicines and ensure the prescribing of medicines was safe. This was to confirm the practice operated in line with national NHS guidelines.

A nurse practitioner was employed within the practice. They were currently undertaking a prescribing course, which would enable them to independently prescribe some medicines to patients. As part of the training the nurse practitioner would suggest a prescription. This would be discussed with a GP, who would then sign the prescription if necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw records of blank prescription form serial numbers were made on receipt into the practice and when the forms were issued to GPs. Blank prescriptions were securely stored at all times.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice.

## Are services safe?

The protocol covered, for example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

### Cleanliness and infection control

We looked around the surgeries and saw they were clean, tidy and well maintained. 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 nurse practitioner was the nominated infection control lead. We saw there was an up to date infection control strategy and detailed guidance for staff about specific issues. For example, hand hygiene and use of protective clothing. All of the staff we spoke with about infection control said they knew how to access the practice's infection control procedures. Staff attended annual training courses on infection control.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The consultation and treatment rooms had flooring that was impermeable, and easy to clean. The privacy curtains in the consultation rooms were changed every six months or more frequently if necessary. We saw records were maintained so staff knew when they were due to be cleaned.

The practice had a contract for cleaning services. We looked at records and saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the buildings.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there were bags for patients to put their own specimens in. The nursing staff then wore personal protective equipment when transferring the specimens for testing.

We confirmed that an up-to-date legionella risk assessment had been completed (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. Fire extinguishers were serviced regularly by the building owners. The practice maintained records showing when the next service was due.

Minor surgery was carried out at the practice. We saw there were appropriate arrangements for the disposal of single-use surgical instruments.

### Staffing and recruitment

The practice had an up to date recruitment policy in place that outlined the process for appointing staff.

We looked at a sample of three personnel files. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity and references had been carried out, prior to staff starting work.

The practice manager and all staff that were in contact with patients had been subject to DBS checks. All of the GPs had undergone DBS checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate.

## Are services safe?

We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, by helping colleagues working on the front reception desk receiving patients or by answering the telephones. Staff told us there was always enough staff on duty to maintain the smooth running of the practice and ensure patients were kept safe.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)). They told us they routinely checked with the GMC and NMC to assure themselves of the continuing registration of staff. These checks were not formally documented but the practice manager said they would maintain records of future checks.

### **Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

There were clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. The practice regularly monitored the number of extra urgent appointments used to ensure that staffing levels were sufficient to meet demands.

The practice had systems in place to manage and monitor health and safety. The fire alarms and emergency lights were regularly tested by the building owners. There were annual fire evacuation drills. We saw records confirming these checks had been carried out.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with regarding emergency procedures knew the location of this equipment. Staff attended annual fire safety training and two members of the team were designated fire wardens.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. A resuscitation trolley was located in the main treatment room. The defibrillator and oxygen were accessible and records of weekly checks were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plans were held by the practice manager and GPs at their homes so contact details were available if the buildings were not accessible.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the practice's performance and patients were discussed at weekly clinical meetings.

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. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where patients were booked in for recall appointments. This ensured patients had routine tests, such as blood or spirometry (lung function) checks to monitor their condition.

Nationally reported data taken from the Quality and Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 97.8%) for the majority of the 20 clinical conditions covered. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually.)

Although the practice had achieved a high overall score for QOF the exception rate was high compared to other practices (11.6%, compared to a national and local average of 7.9%). GPs told us if a patient did not attend appointments or respond to invites then they would be 'exempted', as per the QOF guidelines (QOF includes the

concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect).

We discussed the reasons behind the high exception rate. The practice had analysed the data and told us the rate was high because many patients continued to decline review appointments. Processes had been put into place to ensure these patients were cared for appropriately, this included limiting repeat prescriptions to weekly supplies of medicines, so whilst patients still had their medicines, they had to attend the practice more regularly. The practice had also established that a further reason for the high exception rate was the number of patients on maximal therapy (this is where a patient had been prescribed the maximum number of medicines, but their condition wasn't fully controlled, QOF rules stated these patients could be excepted from the performance data).

We were told patient safety alerts and guidelines from NICE were discussed at relevant team meetings to enable shared learning. We saw minutes of practice meetings where new guidelines were shared with staff, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

Patients we spoke with said they felt well supported by the GPs 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.

Interviews with three GPs and two practice nurses demonstrated that the culture within the practice was to refer patients onto other services on the basis of their assessed needs, and that age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

We found the practice was not completing effective clinical audits. We asked to see examples of clinical audits that had been undertaken in the last year. We saw evidence of several single audits, however, there were no recent completed cycles. The lead GP partner was in the process of carrying out a two stage audit on the use of a type of

# Are services effective?

## (for example, treatment is effective)

medicine. We saw evidence of the work on the first stage of the process. The practice was aware that this was an area for development and had put plans in place to ensure audit cycles were completed.

The practice used an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices. We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that performance was generally in line with other practices in England in most areas.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. Every member of staff in the practice had an individual training plan which set out which training had been completed and when it was next due. Once a month the practice closed during the afternoon for protected learning time (Time In, Time Out sessions).

The continuing development of staff skills and competence was recognised as integral to ensuring high quality care. Role specific training was provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. The practice provided staff with equality and diversity training. Staff were proactively supported to acquire new skills and share best practice. For example, one of the doctors was training to become a GPwSI (GP with a Special Interest) in sexual health; this would enable the practice to offer a much improved service for patients in the future. Some of the reception staff had been supported to undertake a qualification in Customer Service (NVQ Level 3). Staff told us they had sufficient access to training and were able to request further training where relevant to their roles.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller

assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with NHS England).

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and future career development plans were discussed. Staff told us they felt supported.

Appropriate arrangements had been made to ensure the practice was adequately staffed. The practice had a protocol for booking annual leave. One of the administrative team members was the lead for maintaining the staff rota. This helped to ensure that sufficient numbers of clinical and non-clinical staff were always rostered on duty.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

### Working with colleagues and other services

The practice had positive working relationships and had forged close links with other health and social care providers, to co-ordinate care and meet patients' needs.

Some staff had external roles which encouraged partnership working. For example, the lead GP partner was the chair of the local Clinical Commissioning Group (CCG) and the practice manager had developed close links with a local Carer's service.

We saw various multi-disciplinary meetings were held. For example, regular palliative care meetings were held, which involved practice staff and the district and Macmillan nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. Staff commented they worked well with the local CCG and felt supported.

The practice was part of a group of practices in the Sunderland East locality. This group of ten practices had carried out extensive work on an 'extended hours' pilot. This enabled patients from all practices to access appointments between 8:00am and 8:00pm weekdays and between 9:00am and 5:00pm at weekends. Patients we spoke with felt this was a beneficial service.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We

# Are services effective?

(for example, treatment is effective)

saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hour's provider and the ambulance service.

## Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had been fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

All of the GP practices in the area used the same computerised patient records system. The practice manager had been involved in setting up a working group to roll this out to the local District Nursing team. This had been successfully trialled and meant the district nurses could access patients records when carrying out home visits.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and taking action to address any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked.

## Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a practice policy on consent, this provided guidance for staff on when to document consent.

Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgery procedures or contraceptive implants.

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Some staff had recently received specific training on consent and the MCA. Decisions about or on behalf of patients who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. The GPs described the procedures they had followed where people lacked capacity to make an informed decision about their treatment.

## Health promotion and prevention

The practice identified people who needed ongoing support and were proactive in offering this. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients with dementia. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to dementia patients. The data indicated that 85% of patients with dementia had received a range of specified tests, six months before or after being placed on the practice's register. This was 12.6 percentage points above the local CCG average and 11 points above the England average.

The QOF (2013/14) data confirmed the practice supported patients to stop smoking, using a strategy that included the provision of suitable information and appropriate therapy. The data showed the practice had obtained 99.4% of the points available to them for providing support with smoking cessation. This was 5.2 percentage points above the local CCG average and 5.7 points above the England average. The practice had also obtained 100% of the points available to them for providing cervical screening to women. This was 0.8 percentage points above the local CCG average and 2.5 above the England average.

## Are services effective? (for example, treatment is effective)

Patients with long term conditions were reviewed each year, or more frequently as necessary. Arrangements were in place to contact patients who did not attend to ensure they received a review. Nursing staff carried out home visits to carry out reviews for patients who were housebound.

New patients were offered a 'new patient check', with a nurse, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice offered a full range of immunisations for babies and children, as well as travel and flu vaccinations, in line with current national guidance. Vaccination rates for 12 month and 24 month old babies and five year old children were in line with the local CCG area.



# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

There was a strong and visible patient-centred culture. We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP survey (January 2015). The scores in relation to patients' last appointment with a doctor or nurse were well above national averages. For example,

- 100% of patients said they had confidence and trust in their GP (compared to 93% nationally)
- 94% of patients said they had confidence and trust in their nurse (compared to 86% nationally)
- 92% of patients said the GP treated them with care and concern (82% nationally)
- 91% of patients said the nurse treated them with care and concern (compared to 78% nationally).

We spoke with 14 patients during our inspection. All were happy with the care they received from the practice and said their dignity and privacy was respected. Patients commented that the practice provided a very good and high quality service.

We reviewed 49 CQC comment cards which had been completed by patients prior to the inspection. Patients had completed all of the CQC comment cards issued to the practice. Comments were overwhelmingly positive. Words used to describe the approach of staff included sympathetic, caring, courteous, respectful and helpful. Several patients commented on the high quality care they and their families had received.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in those rooms could not be overheard.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overheard. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

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. Information regarding patient confidentiality was contained within the practice information leaflet.

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.

### Care planning and involvement in decisions about care and treatment

Patients were active partners in their care. The lead GP partner told us about the practice ethos in relation to care and treatment. This was 'no decision about me without me'. They described how they made decisions with patients and not for them. There was a well-defined culture within the practice to put patients first. Staff understood that it may have been difficult for patients to make decisions about possible treatment during a 10 minute consultation. They told us patients were encouraged to go and consider their options and make a further appointment for a later date to discuss with a clinician. Despite the time constraints and pressures on appointments across GP practices nationally, the practice prioritised the welfare of patients and did not put pressure on people to make an immediate decision.

This was confirmed when we spoke with patients. They told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand.

Patients were satisfied with the level of information they had been given. We reviewed the 49 completed CQC comment cards, patients felt they were involved in their care and treatment.

The results of the National GP Patient Survey from January 2015 showed patients felt involved in their care and treatment. The scores for doctors and nurses were all well above the national average:

- 94% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 85% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%)



## Are services caring?

- 86% said the last nurse they saw or spoke to was good at listening to them (national average 79%)
- 83% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 67%).

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice did not have many patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

### **Patient/carer support to cope emotionally with care and treatment**

Patients' emotional needs were seen as being as important as their physical needs. Patients we spoke with on the day of our visit were positive about the emotional support provided by the practice. Patients told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring and took time to help and support them.

We observed staff during the inspection and saw positive interactions with patients. For example, one patient requested a sick note and the reception staff were aware that it was close to a bank holiday so made arrangements to issue it quickly. Another receptionist went out to guide a patient of another practice to where they needed to be. It was evident that staff went out of their way to help and support patients.

We saw there was a variety of information on display throughout the practice. There were several noticeboards with a range of information regarding common health conditions and local support groups.

The practice routinely asked patients if they had caring responsibilities and had set up a carer's register to help them identify and make sure they were receiving the professional support they needed. There was a dedicated noticeboard in the waiting room and a detailed information pack for carers. The practice worked closely with a local carer's service (Sunderland Carers), staff regularly attended workshops hosted by the service to help improve their understanding and approach to caring for carers. This had resulted in a member of staff from the administration team being nominated as the 'Champion for Carers' within the practice. Their role was to promote the awareness of patients with caring responsibilities and ensure such patients were informed about the support available.

Cards congratulating new parents on the birth of their child were sent out soon after the practice had been notified of the birth. The cards also contained some information about the baby clinics, immunisation programme and other services offered.

Support was provided to patients during times of bereavement. Staff told us that if families had suffered bereavement, this was followed up by the practice, with either a visit or telephone call depending upon the circumstances. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice was responsive to the needs of the local population. The majority of patients we spoke with and those who filled out CQC comment cards said they felt the practice was meeting their needs. 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.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the patient's medical record. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from January 2015 reflected this; 91% (86% nationally) of patients thought the doctors and 86% (81% nationally) thought nurses gave them enough time.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. The practice nursing team was responsible for delivering most of the chronic disease care and treatment needed by patients. The practice offered patients with long-term conditions, such as asthma and diabetes, an annual check of their health and wellbeing, or more often where this was judged necessary by the nursing team. Of the patients who participated in the National GP Patient Survey, 80% said the last nurse they saw was good at explaining tests and treatment (this was above the national average of 77%).

The Quality and Outcomes Framework (QOF) data (2013/14) showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care (this was 3.3 percentage points above the national average). The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the

needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. Nationally reported QOF data (2013/14) showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines.

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices across Sunderland to discuss local needs and service improvements that needed to be prioritised. Staff told us they had a close working relationship with the CCG. One of the GPs was the Chair of the CCG and the practice therefore took part in many initiatives. This included involvement in the commissioning and development of an extended hours pilot.

The practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs.

The practice had established a Patient Reference Group (PRG) to help them to engage with a cross section of the practice population and obtain patient views. A PRG is made up of practice staff and patients that are representative of the practice population. The main aim of a PRG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We spoke with two members of the PRG; they explained their role and how the group worked with the practice. The representatives told us the PRG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had. They gave us examples

# Are services responsive to people's needs?

(for example, to feedback?)

of improvements that had been made following discussions between the PPG and the practice. This included alterations to the premises and the introduction of background music in the waiting room and corridors.

## Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, the computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. Where patients were identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure their needs were met. There was a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or a learning disability. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received regular healthcare reviews and access to other relevant checks and tests. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need.

Free parking was available directly outside the building. The doors providing access to the surgery were automated. We saw the consulting rooms were large with easy access for all patients. There were also toilets that were accessible to disabled patients and baby changing facilities for use. A hearing loop system was in place for patients who experienced difficulties with their hearing.

Only a small minority of patients did not speak English as their first language. Staff told us that usually the patient was accompanied by a family member or friend who would translate for them. There were arrangements in place to access telephone interpretation services for urgent appointments or book an interpreter to accompany patients where appointments were booked in advance.

Staff attended annual equality and diversity training sessions. The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference.

## Access to the service

The practice was open between 8:00am and 6:00pm Monday and Friday. There were no evening or early morning appointments available at the surgery. However, the practice was part of a group of ten local GP practices taking part in an extended hours pilot. Patients from those surgeries were able to access services at a local health centre between 6:00pm and 8:00pm weekdays and between 9:00am and 5:00pm at weekends.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made available every day.

The practice had undertaken a significant amount of work in relation to access to the service. Separate systems were in place for patients to book planned (routine) and urgent appointments. There were daily clinics which were run by the nurse practitioner. Patients did not have to book these in advance. If the nurse practitioner deemed the patient needed to be seen by a doctor then this was arranged. There was a doctor designated as 'on-call' each day. This doctor triaged any requests for same day appointments. Patients were either given a telephone appointment or advised to attend the surgery for a face to face appointment with the on-call doctor. Patients we spoke with during the inspection commented that this system worked well. Many spoke positively of the daily open access nurse practitioner clinics.

Reception staff had been trained to take note of any urgent problems any urgent problems and notify the doctor, of an unwell child or parental concern. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day.

The most recent National GP Patient Survey (January 2015) showed 72% (compared to 73% nationally) of respondents were able to get an appointment or speak to someone when necessary. The practice scored very highly on the ease of getting through on the telephone to make an appointment (94% of patients said this was easy or very easy compared to the national average of 71%). Patients we spoke with confirmed they were able to get an urgent appointment at short notice.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was



# Are services responsive to people's needs?

(for example, to feedback?)

closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The local out of hour's provider was Primecare.

We found the practice had an up to date booklet which provided information about the services provided, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

## Listening and learning from 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. The complaints policy was outlined in the practice leaflet and was available on the practice's website.

None of the 14 patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the practice. None of the 49 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy and had attended 'Customer Care' training. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

The practice actively reviewed complaints and had recently reviewed its arrangements for managing and responding to complaints. The revised approach demonstrated the people who use services were involved in the review of complaints. A decision had been taken to share (anonymised) details of all complaints with the PRG, to promote openness and transparency. The PRG members we spoke with confirmed these arrangements were in place and told us they welcomed the opportunity to be involved in the process.

The practice had received five formal complaints in the 12 months prior to our inspection and these had been reviewed as part of the practice's formal annual review of complaints. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. Staff we spoke with felt involved in the process.

We looked at some of the complaints the practice had received. We saw these had all been thoroughly investigated. The complainant had been communicated with throughout the process and the practice apologised when they did not do as well as they should have done. We saw the clinicians involved had reviewed what had happened and what could be learnt to prevent a reoccurrence. For example, conflict resolution training had been arranged for all staff, to support them to deal with difficult conversations.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision; this was 'to offer the highest standard of health care and advice to our patients, with the resources available to us'. The vision also referred to team working, training and meeting standards of excellence. In addition to the practice vision, the practice was committed to the Clinical Commissioning Group (CCG) vision; this was 'Better health for Sunderland'.

The lead GP and practice manager told us that the practice had a culture of continuous improvement. They told us that the service the practice provided had taken many years to build up.

When we spoke with staff it was evident they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. They all told us they put the patients first and aimed to provide person-centred care.

Practice development sessions were held annually and were attended by the GP partner, the practice manager and the practice team. These meetings were used to review any changes that needed to be made to take account of contractual changes in the GP contract, to reaffirm what the practice did well, what its priorities were for the year ahead, and what changes needed to be made to make further improvements to patient outcomes. A further GP partner and a nurse practitioner had recently been employed by the practice. The practice had considered this essential for succession planning.

### Governance arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on any computer within the practice. The policies and procedures had been reviewed regularly and were up-to-date.

There was a management team in place to oversee the practice. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The practice had achieved an overall QOF score of 97.8% of the maximum points available in 2013/2014; this

achievement was above both the local Clinical Commissioning Group (CCG) and the national averages (94.5% and 93.5% respectively). This confirmed the practice had delivered care and treatment in line with expected national standards.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected.

We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The practice participated in an external peer review with other practices in Sunderland CCG, in order to compare data and identify areas for improvement (peer review enables practices to access feedback from colleagues about how well they are performing against each other and national standards).

### Leadership, openness and transparency

There was a well-established management team with clear allocation of responsibilities. For example, one of the GP partners was the lead for minor surgery, and another was the safeguarding lead. We spoke with staff from different teams; they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. The lead GP partner told us they considered the culture of the practice to be one of openness and team work. They had an open door policy and said they encouraged all staff to ask questions.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the managers were visible and accessible. Records showed that regular meetings took place for all staff groups.

The practice manager told us that they met with the GPs every month and information from these meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

# Are services well-led?

Good 

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

A decision had recently been taken to share information about complaints with the Patient Reference Group (PRG). This process encouraged openness and transparency.

We found the practice learned from incidents and near misses. Significant events meetings were held where such issues were discussed. Lessons learned from these discussions were shared with the relevant team members.

## **Practice seeks and acts on feedback from its patients, the public and staff**

The practice had made arrangements to seek and act on feedback from patients and staff. The practice manager told us they had been proactive in seeking feedback. There was a section on the website where patients could submit comments or suggestions and suggestion boxes in the waiting rooms.

There was an active PRG open to all patients. The PRG contained representatives from some of the key population groups. Regular meetings were held; the practice manager and a GP from the practice always attended to support the group. We spoke with two members of the PRG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised. The practice manager told us they were continuing to build on the work of the PRG. Complaints had been shared and the practice was considering inviting PRG members to attend future staff interviews.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices).

We saw the practice had recently introduced the FFT, there were questionnaires available in the waiting rooms and instructions for patients on how to give feedback. The practice manager told us the first set of comments and feedback had just been analysed. The results were published within the practice and on their website. Initial results showed that 75% of patients said they would be extremely likely to recommend this GP practice to their friends or family, 25% would be likely to recommend. There were no patients that were unlikely or extremely unlikely to recommend the practice.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice.

The practice had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

## **Management lead through learning and improvement**

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was very supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place. Staff from the practice also attended the monthly CCG protected learning time (Time In, Time Out) initiative. This provided the team with dedicated time for learning and development.

All of the staff we spoke to said their personal development was encouraged and supported. Some staff were undertaking professional qualifications, including the nurse practitioner who was completing their prescriber training. Administrative staff were offered the opportunity to study for NVQs in Customer Service.

The management team met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

GPs met with colleagues at CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice. The practice manager met with other practice managers in the Sunderland area and was part of the local 'Informatics Group' which had been involved in the development of the use of patient records during the pilot extended hours project.