

# Cramlington Medical Group

## Quality Report

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Date of inspection visit: 12 May 2015  
Date of publication: 13/08/2015

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.

### Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cramlington Medical Group on 12 May 2015. Overall, the practice is rated as inadequate. Specifically, we found the practice to be inadequate for providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services. There were aspects of the practice which were 'inadequate' and that related to all population groups.

Our key findings across all the areas we inspected were as follows:

- The practice was going through a period of major upheaval. The senior GP partner was absent from the practice, and key members of staff, including the practice manager, who had tendered their resignation at the end of 2014 and vacated their post the day before our inspection. This had impacted upon staff morale and their capacity to provide patients with safe, good quality care and treatment;
- Effective leadership and governance arrangements were not in place. We found risks to patient safety that had not been identified by staff, consequently there were no plans to address these;
- Nationally reported data for 2013/14 showed the practice performed well in providing clinical care and treatment to patients with most of the long-term conditions and public health indicators covered by the Quality and Outcomes Framework (QOF). However, QOF data for 2014/15 indicated the practice had not performed as well as it had previously done with regards to the delivery of healthcare reviews for patients with long-term conditions. Although staff provided a range of services to meet the needs of patients with long-term conditions, the practice did not have an effective mechanism in place for identifying and monitoring patients who were unresponsive to 'recall' telephone contact or letters;
- We were unable to confirm that patients' needs were assessed, and care was planned and delivered in line with current legislation and best practice guidance. This was because, for example, the practice had no

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system in place for reviewing and, where necessary, updating their clinical guidelines in light of changes to national and local CCG guidelines. Also, clinical staff had failed to carry out a structured programme of clinical audits;

- Most patients told us they were treated well and received a good service. Findings from the National GP Patient Survey of the practice, published in 2015, showed variable levels of satisfaction with the quality of services provided by the practice. Some of the results were better than or in line with the local CCG and national averages, whilst others clearly fell below both averages;
- Effective arrangements were not in place to ensure that locum GPs working at the practice had undergone the required pre-employment recruitment checks, to make sure they were suitable to work with children and vulnerable adults;
- Although there was a system in place for identifying, reporting on and learning from significant events, this did not always work effectively. The quality of the recording of significant events was not satisfactory and did not always demonstrate the steps taken by the practice to prevent their reoccurrence and safeguard patients;
- The practice was clean and hygienic throughout, and patients said they were satisfied with the levels of cleanliness;
- The practice had good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvements are:

- Ensure required pre-employment checks for locum GP staff are carried out;
- Ensure suitable governance arrangements are in place to assess, monitor and improve the quality and safety of the services provided. In particular: undertake a structured programme of clinical audits to demonstrate improvements in patient care; review and update clinical guidelines to ensure patients receive the most effective care and treatment available; ensure clinical staff follow the practice's clinical guidelines;
- Take action to ensure the safe management of medicines;

- Evaluate and improve the systems in place for identifying and monitoring patients who are unresponsive to 'recall' telephone contact or letters;
- Review the availability of appointments to ensure the numbers offered per patient per week are in line with current guidance;
- Ensure all staff, including the regular locum GPs who work at the practice, have completed all of the training they need to keep patients safe.

The areas where the provider should make improvements are:

- Make sure an effective system is in place for dealing with safety alerts, including those concerning the management of medicines;
- Take account of the advice contained in the Significant Event Analysis GP Mythbuster which can be found on the Care Quality Commission's website;
- Carry out a recorded risk assessment to determine which emergency medicines GPs should carry with them during routine visits, for use in an acute situation. When doing this, take account of the guidance issued by the CQC;
- Provide all staff who carry out lead clinical and non-clinical roles with clear guidance about their roles and responsibilities and how they should implement these;
- Improve the recording of complaints to ensure that it is clear what lessons have been learnt and how they should carry these out.

CQC has taken the decision not to put the practice into Special Measures for the following reasons: the Provider that was registered for this service at the time of the inspection, and who was rated as Inadequate, is no longer carrying on the Regulated Activities but has yet to cancel their registration with CQC. A new provider is carrying on the regulated activities at the location and is applying for the location to be added to their existing registration. CQC has confidence that the incoming provider will address the issues contained within the report, and that based on their track record as a Provider they do not need the support that would usually be provided to a practice in Special Measures. We believe that because of the unique circumstances surrounding this practice and the arrangements that have already been put in place to support them to improve, the same outcome will be achieved as if it had gone into Special

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Measures. As with any practice rated as inadequate CQC will inspect again in a shorter time frame and consider its findings on that inspection and take any necessary action.

**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 inadequate for providing safe services.

The arrangements for assessing, monitoring and mitigating risks relating to the health, safety and welfare of patients were not satisfactory. There was evidence of a failure in the systems that had been put in place to ensure the safe management of medicines and recruitment of suitable locum GP staff. These concerns had not been identified by practice staff. The arrangements for identifying, analysing and learning from significant events did not always provide opportunities for all staff to reflect on what had happened and why, how things could have been different, what lessons needed to be learnt and what needed to change to improve patient outcomes. Arrangements for responding to safety alerts were not safe. Effective infection control arrangements were in place and the practice was clean and hygienic throughout. The premises were maintained in a safe condition, as was the equipment used by staff.

Inadequate



### Are services effective?

The practice is rated as inadequate for providing effective services.

Most of the nationally reported data for 2013/14 showed the practice had performed well in providing recommended care and treatment to patients. However, we also identified a range of concerns that had the potential to affect the quality of care and treatment patients received. For example, some clinical staff were not familiar with, and did not refer to, the practice's clinical guidelines when making judgements about how to meet patients' needs. Also, we found there were no arrangements in place to ensure that the practice's clinical guidelines were reviewed and, where necessary, updated to reflect changes to local and national clinical guidelines. There was no evidence to demonstrate clinical staff were carrying out a structured programme of clinical audits in order to assess, measure and improve outcomes for patients. We also found evidence of other system failures. Patients' records were not being summarised promptly, and the recording of READ codes to indicate what care and treatment had been provided was not consistently carried out. An effective system was not in place to ensure the maintenance of good quality recording in patients' medical records.

Inadequate



### Are services caring?

The practice is rated as requires improvement for providing caring services.

Requires improvement



# Summary of findings

Most patients told us they were treated with dignity and respect, and that staff were professional, compassionate and understanding. The feedback we received indicated the majority of patients were satisfied with the care and treatment they received. The practice had completed their own survey of patients in 2014/15. This showed most patients were satisfied with the services provided. For example, the scores for patient satisfaction with the quality of the clinical consultation they received, and the confidence and trust they had in their GP or nurse, were in excess of 80%. Evidence from this survey showed there had been an improvement in patient satisfaction levels compared to the previous year. However, findings from the National GP Patient Survey of the practice, published in January in 2015, showed variable levels of satisfaction with the quality of services provided. Some of the results were better than or in line with the local CCG and national averages, whilst others clearly fell below them.

## Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services.

Services had been effectively planned to meet the needs of most of the key population groups registered with the practice. For example, pregnant women were able to access a weekly antenatal clinic provided by a midwife. Nationally reported QOF data showed that child development checks were offered at intervals consistent with national guidelines. The QOF data also showed the practice had obtained 100% of the total points available to them for providing palliative care to patients. (This was the same as the local CCG average and 3.3 percentage points above the England average). However, although the practice provided a range of services to meet the needs of patients with long-term conditions, the practice did not have a robust mechanism in place for identifying and monitoring patients who were unresponsive to 'recall' telephone contact or letters. Patient feedback about appointments was on the whole positive. However, we found the practice was not providing the number of appointments that would normally be expected for a practice of this size. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints procedure, and evidence demonstrating the practice did respond to the complaints they received. However, complaints were poorly recorded and it was difficult to identify what lessons had been learned as a consequence of those that had been received.

Requires improvement



## Are services well-led?

The practice is rated as inadequate for being well-led.

Inadequate



## Summary of findings

The practice was not well-led. The senior GP partner had had a clear vision about how they wanted Cramlington Medical Group to develop, and they had taken steps in the past to deliver this. However, their absence from the practice meant they were no longer in a position to influence how the service was delivered. An up-to-date business development plan was not made available to us. The inspection team was only able to identify one strategy for the practice, and that was one of making sure that the new GPs, who would be carrying on the regulated activities the week following our inspection, received a good handover. Effective governance arrangements were not in place.

# 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 inadequate for the care of older patients. This is because the practice is rated as inadequate for safe, effective and well led, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data, for 2013/14, showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local Clinical Commissioning Group (CCG) and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing patients with heart failure with the recommended care and treatment. This was 0.1 percentage points above the local CCG average and 2.9 points above the England average. Staff continued to meet the day-to-day needs of most older patients. However, the recent absence of the senior GP partner, and the short-term use of locum GPs to provide all medical cover, made it more difficult for the staff to provide continuity of care and proactive, personalised care to this group of patients.

Inadequate



### People with long term conditions

The practice is rated as inadequate for the care of patients with long term conditions. This is because the practice is rated as inadequate for safe, effective and well led, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data, for 2013/14, showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local CCG and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing patients who have asthma with the recommended care and treatment. This was 0.4 percentage points above the local CCG average and 2.8 points above the England average. The practice nurse we spoke with had received the training they needed to provide good outcomes for patients with long-term conditions. Emergency care plans had been put in place for patients at risk of an unplanned hospital admission. However, QOF data for 2014/15 indicated the practice had not performed as well as it had previously done with regards to the delivery of healthcare reviews for patients with long-term conditions. Although staff provided a range of services to meet the

Inadequate





# Summary of findings

needs of patients with long-term conditions, the practice did not have a robust mechanism in place for identifying and monitoring patients who were unresponsive to 'recall' telephone contact or letters.

## Families, children and young people

The practice is rated as inadequate for the care of families, children and young people. This is because the practice is rated as inadequate for safe, effective and well led, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These were above the England averages (i.e. by 0.9 and 1.2 percentage points respectively), and in line with the local CCG averages. Pregnant women were able to access a weekly antenatal clinic provided by a midwife. This also provided mothers with access to a post-natal check performed by the senior GP partner. Mothers-to-be were able to access a primary care mental health nurse for both ante-natal and post-natal support. The practice nurse provided a fortnightly immunisation clinic and supported a family planning clinic, operated by the health centre in which the practice was located. Appointments were available outside of school hours and the premises were suitable for children and babies. However, on the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of most childhood immunisations was lower, in comparison to the overall percentages for children receiving the same immunisations within the local CCG area. For example, the numbers of children who were given six of the eight childhood immunisations that should be given to children aged five years were below each local CCG average.

Inadequate



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

The practice is rated as inadequate for the care of working age patients. This is because the practice is rated as inadequate for safe, effective and well led, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data, for 2013/14, showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local CCG and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing care and

Inadequate



# Summary of findings

treatment for patients with cardiovascular disease. This was 7.9 percentage points above the local CCG average and 12 points above the England average. The needs of this group of patients had been identified and steps taken in the past to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients, such as being able to order repeat prescriptions and book appointments on-line. Health promotion information was available in the waiting area. The practice provided additional services such as Well Woman and Well Men and travel clinics. However, the provision of extended hours appointments had recently ended due to circumstances within the practice.

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

The practice is rated as inadequate for the population group of patients whose circumstances may make them vulnerable. This is because the practice is rated as inadequate for safe, effective and well led, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment for patients with learning disabilities. This was 8.7 percentage points above the local CCG average and 15.9 points above the England average. However, QOF data for 2014/15 indicated the practice had not performed as well as it had previously done with regards to the delivery of healthcare reviews for patients with learning disabilities. We saw evidence confirming that a significant number of the patients on the practice's register for this group of patients had not received their annual healthcare review.

Staff worked with members of the multi-disciplinary team to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. However, some staff had not received appropriate safeguarding training and this meant they might not be confident about recognising the signs of abuse and know what action to take to safeguard patients.

Inadequate



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

The practice is rated as inadequate for the care of patients experiencing poor mental health. This is because the practice is rated as inadequate for safe, effective and well led, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Inadequate



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Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment for patients experiencing poor mental health. This was 3.8 percentage points above the local CCG average and 9.6 points above the England average. The data also showed that, where appropriate, care plans had been completed for 92.2% of patients who were on the practice's mental health register, in agreement with the patients. However, QOF data for 2014/15 indicated the practice had not performed as well as it had previously done with regards to the delivery of healthcare reviews for patients experiencing poor mental health. We saw evidence confirming that a significant number of the patients on the practice's register for this group of patients had not received their annual healthcare review.

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## What people who use the service say

During the inspection we spoke with five patients and reviewed 14 Care Quality Commission (CQC) comment cards completed by patients. The majority of these patients said they were treated well and received a good service. This was confirmed by the practice's own survey, carried out in 2014/15, which indicated most patients either had a 'good' or 'reasonable' level of satisfaction with the care and treatment they received. Findings from the National GP Patient Survey of the practice, published in January 2015, showed variable levels of satisfaction with the quality of services provided by the practice. Some of the results were better than or in line with the local CCG and national averages, whilst others clearly fell below both averages. For example, of the patients who responded to the survey:

- 91% said they found the receptionists helpful, (this was above the local CCG average of 88% and the national average of 87%);
- 92% said they had confidence and trust in the last GP they saw or spoke to, (this was below the local CCG average of 94% and the national average of 93%);

- 90% said they had confidence and trust in the last nurse they saw or spoke to, (this was in line with the local CCG average and above the national average of 86%);
- 77% said the last GP they saw, or spoke to, was good at listening to them, (this was below the local CCG average of 89% and national average of 88%);
- 77% said they were satisfied with the practice's opening hours, (this was in line with the local CCG average and above the national average of 76%);
- 79% said they were able to get an appointment to see or speak with someone, (this was below the local CCG of 86% and the national average of 86%);
- 75% said they found it 'easy' to get through on the telephone to someone at the practice, (this was in line with the local CCG average and above the national average of 71%).

These results were based on 103 surveys that were returned from a total of 261 sent out. The response rate was 39%.

## Areas for improvement

### Action the service MUST take to improve

- Ensure required pre-employment checks for locum GP staff are carried out;
- Ensure suitable arrangements are in place to assess, monitor and improve the quality and safety of the services provided. In particular: undertake a structured programme of clinical audits to demonstrate improvements in patient care; review and update clinical guidelines to ensure patients receive the most effective care and treatment available; ensure clinical staff follow the practice's clinical guidelines;
- Take action to ensure the safe management of medicines;
- Ensure all staff, including the regular locum GPs who work at the practice, have completed all of the training they need to keep patients safe;
- Evaluate and improve the systems in place for identifying and monitoring patients who are unresponsive to 'recall' telephone contact or letters;

- Review the availability of appointments to ensure the numbers offered per patient per week are in line with current guidance.

### Action the service SHOULD take to improve

- Make sure an effective system is in place for dealing with safety alerts, including those concerning the management of medicines;
- Take account of the advice contained in the Significant Event Analysis GP Mythbuster which can be found on the Care Quality Commission's (CQC) website;
- Carry out a recorded risk assessment to determine which emergency medicines GPs should carry with them during routine visits, for use in an acute situation. When doing this, take account of the Emergency Drugs for GP Practices Mythbuster which can be found on the CQC website;

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- Provide all staff who carry out lead clinical and non-clinical roles with clear guidance about their roles and responsibilities and how they should implement these;
- Improve the recording of complaints to ensure that it is clear what lessons have been learnt and how any improvements required have been implemented and reviewed.

# Cramlington Medical Group

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP, a specialist adviser with a background in practice management and a CQC pharmacist inspector.

## Background to Cramlington Medical Group

Cramlington Medical Group is a town centre practice which provides care and treatment to 5,529 patients of all ages, based on a Personal Medical Services (PMS) contract agreement for general practice. The practice is part of NHS Northumberland Clinical Commissioning Group (CCG). The practice serves an area that has:

- Higher levels of deprivation affecting children than the local CCG average, but lower levels than the England average;
- Higher levels of deprivation affecting people in the over 65 years of age than the local CCG and England averages.

The practice's population includes:

- Less patients aged under 18 years than the local CCG and England averages;
- Less patients aged over 65 years of age than the local CCG average, but more than the England average.

The practice provides services from the following address: Cramlington Medical Group, The Health Centre/Forum Way, Cramlington. NE236QN. We visited this address as part of the inspection.

The practice occupied a purpose built building which it shared with another GP practice and other social and healthcare services. The premises are fully accessible to patients with mobility needs. Staff provide a range of services and clinic appointments, including, for example, services and clinics for patients with diabetes and asthma. The practice consists of one senior GP partner (male), one long-term locum GP (male) and two other locum GP staff (one female and one male). The senior GP partner was absent from the practice at the time of our visit. The practice manager post was vacant as they had tendered their resignation in December 2014 and left their post the day before our inspection. The practice also had three practice nurses. One of these posts was vacant, and of the other two, one practice nurse worked 30 hours per week and the other worked four hours. A healthcare assistant was employed as were a range of administrative and reception staff.

When the practice is closed patients are directed to the out-of-hours service provided by Northern Doctors Urgent Care service.

## Why we carried out this inspection

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.

# Detailed findings

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

## How we carried out this inspection

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

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

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

- Older people

- People with long-term conditions
- 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 visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 12 May 2015. During this we spoke with a range of staff including: the senior GP partner; the long-term locum GP; the former practice manager; both practice nurses, and members of the administrative and reception team. We also spoke with three members of the practice's Patient Participation Group and two other patients. We reviewed 14 Care Quality Commission (CQC) comment cards that had been completed by patients. We observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We looked at records the practice maintained in relation to the provision of their services.

# Are services safe?

## Our findings

### Safe Track Record

The practice declared that they were fully compliant with the relevant regulations at the time of submitting their application to register with us in 2012. When we registered this practice, on 01 April 2013, we did not identify any safety concerns that related to how they operated.

The arrangements in place to manage safety alerts received by the practice were not fully satisfactory. The practice manager received all administrative safety alerts and then placed copies of these into a folder to which all staff had access to. Staff were expected to sign these to confirm they had read and understood them. When we checked the administrative safety alerts information made available to us, we found no recorded evidence to confirm that staff had read them. Safety alerts relating to clinical issues were stored in a separate folder and staff were expected to record their signature, at the end of each quarter, to confirm they had read all of the alerts for that period. However, we found evidence that a number of staff had actually signed the quarterly records before the three-month period had expired. The failure to have effective arrangements in place to ensure that all staff had read the relevant safety alerts meant some might not take appropriate action to reduce risks to patient safety. The practice did not have a nominated lead for dealing with safety alerts. This meant no one had been allocated the responsibility of checking to make sure that any actions that needed to be taken as a result of the safety alerts had actually been carried out.

Although staff had used the practice's significant event audit (SEA) process to identify potential risks to patient safety, we found it had not been effectively implemented. Our review of the practice's records identified that a number of incidents had occurred that should have been considered as significant events from which lessons could have been learnt. For example, we were told about a patient who had collapsed in the practice and had to be admitted to hospital. Also, the office areas of the practice had been flooded over a weekend and this had caused problems with their computer equipment. Neither of these events had been evaluated using the practice's SEA process.

During the inspection we found other evidence such as, for example, unsafe medicine arrangements, and unsatisfactory recruitment processes for GP locums, which indicated that patient safety had not been given a high enough priority, and because of this, we could not confirm the practice had a safe track record.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and learning from significant events and complaints. Staff had identified and reported on five significant events during the previous 12 months. The practice manager told us significant events were discussed at the end of practice meetings. They said these meetings were attended by as many members of the practice team as possible and that any necessary actions were agreed by the staff that were present. We saw evidence of good attendance at these meetings. However, we were concerned that the long-term locum GP did not know what the practice's system was for recording significant events and had received no information about the lessons that had been learned from the SEA meetings. Although there was a system in place which should have ensured all staff, including those who had not attended these meetings, signed a record to confirm they had read practice meeting minutes, this was not implemented effectively. In the sample of records we checked we found that only approximately 50% to 75% had actually signed the signature sheets to confirm they had read them. This indicated that the arrangements for disseminating information about lessons learned from SEA meetings were not satisfactory.

We also found evidence there were inappropriate delays between when significant events occurred and when SEA meetings were held to discuss them. For example, a SEA meeting had been held on 6 May 2015 to discuss an event which took place on 12 August 2014. The failure to review significant events promptly and learn from them could increase the risk of them happening again.

Staff had not kept sufficiently detailed records of significant events and the action taken to prevent their reoccurrence. It was difficult to identify from the SEA reports we looked at: why the significant event had been selected; what staff had learnt from the event; what changes needed to be introduced, how and by whom; how the impact of these changes would be monitored. Also, the SEA reports contained no evidence that consideration had been given to whether the significant event should be discussed with



## Are services safe?

other relevant agencies. In one of the SEA audit reports we looked at, it had been reported that a GP had prescribed an alternative antibiotic to a patient, following the return of a sputum culture which showed they had developed a resistance to the original antibiotic therapy. The practice manager had reported that the patient had, on checking their new prescription, informed staff they had an allergy to the second antibiotic prescribed. The patient's medical records were checked and contained no reference to their allergy. Staff had recorded that an audit would be undertaken to check whether important information from patient communications received into the practice was being added to their medical records. When we checked we found no evidence the proposed audit had been carried out. This increased the risk to patient safety because the practice did not have robust arrangements in place for following through on the actions documented in SEA reports.

### **Reliable safety systems and processes including safeguarding**

Staff told us there were established systems and processes to help prevent the abuse of children and vulnerable adults. The practice manager said safeguarding policies and procedures were in place, and that children and vulnerable adults who were assessed as being at risk were identified on the practice's IT clinical system using READ codes. (Clinicians use READ codes to record patient findings and any procedures carried out. These codes alert clinicians to the potential vulnerability of these patients.) They also told us staff had completed safeguarding training that was relevant to their roles and responsibilities.

The practice sent us their safeguarding policies and procedures shortly after the inspection. On reviewing this information, we found the practice's safeguarding policy and procedures only covered children and young people. There was no separate policy providing staff with guidance about how to protect vulnerable adults. The failure to provide staff with a suitable policy and procedures on how to protect vulnerable adults increased the risk that they may not take appropriate action to safeguard patients' welfare.

The practice's safeguarding children and young people policy identified the senior GP partner as the designated safeguarding lead, and the practice manager as the deputy lead. However, in the absence of the senior GP partner, there was no designated safeguarding lead for the practice.

The practice manager told us the long-term GP locum would address any safeguarding queries, but did not want to be named as the safeguarding lead. When we spoke to this GP they confirmed the practice did not have a safeguarding lead. However, they made no reference to having agreed to be responsible for addressing any safeguarding issues that might arise. Having a designated safeguarding lead, who is clear about their roles and responsibilities, helps to ensure staff implement the practice's policies and procedures in relation to safeguarding patients. Failing to provide a safeguarding lead could mean that patients are not effectively safeguarded.

We looked at the arrangements for providing staff with access to appropriate safeguarding training. The senior GP partner, practice manager and the long-term GP locum had completed Level 3 Safeguarding Children (SC) training. (This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns.) One of the practice nurses had completed SC training to Level 2. However, some staff had not completed safeguarding training relevant to their roles and responsibilities. For example, according to the training matrix we were provided with, four administrative staff had not completed Level 1 SC awareness training. One of the practice nurses had only completed the first part of the Level 2 SC training. Also, eight staff, including the healthcare assistant, had not completed safeguarding adults training. The failure to ensure all staff completed appropriate safeguarding training means some may not know what action to take to effectively safeguard children and vulnerable adults.

The practice had a chaperone policy. Information about this was displayed in the reception area and the consultation rooms. All staff who had agreed to carry out chaperone duties had completed training to allow them to do this. Staff undertaking this role had undergone a Disclosure and Barring Service (DBS) check. (DBS checks help identify whether a person is suitable to work with children and vulnerable adults.)

### **Medicines Management**

The arrangements for ensuring the practice complied fully with NHS Protect Security of Prescription Forms guidance were not effective. The practice had good arrangements for protecting the security of prescription forms received into the practice, and staff recorded prescription serial numbers

## Are services safe?

to provide evidence of an audit trail. However, we found that unused prescription pads had been left on top of a filing cabinet in the main administrative office, instead of in a secure filing cabinet as described in the practice's repeat prescribing policy. This increased the risk that prescriptions might be stolen and used illegally.

The practice had a policy which provided staff with guidance about how to maintain the cold-chain for medicines requiring cool storage, such as vaccines. The policy stated that staff should monitor refrigerator temperatures and keep a log of the checks they carried out. (A cold-chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature). The records we looked at showed staff had not consistently carried out daily temperature checks of the refrigerators. The failure to maintain an unbroken 'cold-chain' increased the risk to patient safety because they might not receive effective vaccines.

The arrangements in place for monitoring the expiry dates of emergency medicines and medical gases, including those carried by locum GPs working at the practice were not effective. For example, although the practice had a policy which stated that emergency medicines should be checked monthly, we found no evidence this was being done. When we checked the 'doctor's bag' belonging to one of the locum GPs we found it contained one item of medicine and this was significantly out-of-date. This indicated that there was not an effective system in place for confirming that the medicines carried by locum GPs were within their expiry date and would therefore be effective if administered. Staff had usually carried out fortnightly monitoring checks on medical gases to make sure they were within their expiry dates. However, there was no record that these checks had been carried out since December 2014.

The practice carried a small supply of controlled drugs (CDs). On checking the arrangements in place for securely storing CDs, we found that the key to the CDs cupboard was not kept secure. This meant that unauthorised persons might be able to access the medicines stored within it. All of the CDs stored at the practice were out-of-date. Staff had not made any arrangements to ensure they were destroyed in line with the CDs regulations. Staff were unable to locate the practice's CDs register. This had not been found by the time we left the premises. We shared this information with

NHS England so that appropriate action could be taken. Shortly following the inspection, NHS England confirmed the CDs had been destroyed in the presence of their CDs Accountable Officer. Because we were unable to check the CDs register, we were unable to confirm the dates on which supplies had been obtained and from whom, and the quantity purchased. This meant we were unable to confirm that the required records had been kept or that staff had complied with the relevant regulations.

Emergency medicines were stored securely. They included, for example, medicines for the treatment of a life-threatening allergic reaction, emergency oxygen and a defibrillator. All emergency medicines were within their expiry date and suitable for use. A recorded risk assessment confirming the senior GP partner had considered which emergency medicines were not required for use in acute situations, when they carried out home visits, was not in place. This failure to carry out a suitable recorded assessment of the emergency medicines the GPs should take with them on a home visit meant they might not be able to respond appropriately in an acute situation and this could place patients at risk.

Patients were able to order repeat prescriptions using a variety of ways, such as by telephone, online, and by post. The practice website provided patients with advice about ordering repeat prescriptions. There were policies and procedures in place covering repeat prescribing and the carrying out of medicine reviews. However, these were not always being followed in practice. Whilst we saw evidence of good practice, for example, the practice's clinical system identified which medicines could not be added to a patient's repeat medicines list, we also identified concerns. We found evidence that repeat prescriptions were being issued after the number of authorised repeat prescriptions had been exceeded. Five of the eight prescriptions we looked at that had been signed and were ready for collection by patients, had been marked with a note that a medicine review was overdue. This meant there was an increased risk to patients that they might continue to take medicines which were no longer required, or that might no longer be the most effective therapy for them given their current clinical condition.

### Cleanliness & Infection Control

The premises were clean and hygienic throughout. The patients we spoke with, and those who had commented on this in the CQC comment cards, told us the practice was

## Are services safe?

always clean. Notices reminding patients and staff of the importance of hand washing were on display. Cleaning services were provided by the local NHS primary care trust. The practice's infection control lead told us that any concerns they had about the standard of cleanliness, or a failure to follow the agreed cleaning specification, would immediately be raised with the local Trust's domestic supervisor to ensure any concerns were promptly addressed. They also told us the domestic supervisor carried out their own audits to make sure the practice received a good service.

Up-to-date infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. They covered a range of key areas such as hand hygiene, cleaning and decontamination, and the collection and handling of specimens.

Arrangements had been made to monitor the measures the practice had put in place to prevent and control the spread of infection. The infection control lead nurse had produced an annual infection control statement in line with the Department of Health's Hygiene Code of Practice. This provided an overview of the controls in place to reduce infection control risks, as well as details of what steps needed to be taken to make further improvements during the year ahead. For example, the infection control lead had identified that the arrangements for completing hand hygiene audits with the locum GPs needed to be more robust.

Audits were carried out to make sure staff were following the practice's infection control policies, procedures and guidelines. We saw an infection control audit had recently been carried out. In addition to this, a cleanliness and maintenance audit had been completed in March 2015. An action plan had been put in place to address the shortfalls found.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be regularly changed or cleaned. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. A member of the reception team was able to tell us where the kits were kept, how these would be used and by whom. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had

been appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, a contract was in place for the safe disposal of clinical waste. All the waste bins we saw were visibly clean and in good working order. A legionella risk assessment had been carried out by NHS Property Services, and staff could access this. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). The infection control lead nurse told us NHS Property Services carried out regular checks of the premise's water systems to help ensure they were maintained free of Legionella.

### Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We also saw records confirming, where appropriate, the calibration of equipment had been carried out regularly. Staff monitored the safety of the premises and equipment and took action to ensure patients were not put at risk. We checked the building and found it to be safe and hazard free. None of the patients we spoke to, or received feedback from, had any concerns about their safety when visiting the practice.

### Staffing & Recruitment

The provider had not always carried out appropriate pre-employment checks to make sure that all staff were suitable to work with children and vulnerable patients. The practice had a staff recruitment policy which provided guidance about the pre-employment checks that must be carried out on new partners and staff. These included obtaining written references and a Disclosure and Barring Service (DBS) check. However, the policy contained no reference to the need to obtain a full employment history from applicants.

We looked at the records that had been kept for a non-clinical member of staff who had recently been appointed. The records demonstrated that the required pre-employment checks had been carried out. We saw evidence confirming some of the required pre-employment checks had also been carried out for the long-term GP locum. For example, a DBS check had been carried out as

## Are services safe?

well as a check confirming they were licensed by the General Medical Council (GMC) to practice. A copy of their medical indemnity insurance certificate had also been obtained. However, this was not a copy of their most up-to-date insurance certificate. Obtaining a copy of clinical staff's current indemnity certificates helps to ensure they have appropriate medical insurance cover in place for the role they are carrying out. In addition, we found the insurance certificate for another GP who had worked at the practice had been photocopied in error onto the back of the copy of the long-term locum GP's certificate. Staff agreed to address this error following the inspection. The recruitment file for this GP contained no evidence that other required pre-employment checks had been carried out.

We asked to see to evidence to confirm the other GP locums who worked at the practice had undergone relevant pre-employment checks before they started. The practice manager told us they had not carried out any pre-employment checks on these locum GPs either or obtained evidence from the agency who had supplied them to confirm these had been carried out. This meant there was no evidence to confirm that appropriate medical indemnity arrangements were in place, or that the DBS checks for these locum GPs were clear. These failures increased risk to patient safety because appropriate measures had not been taken to ensure these locum GPs were suitable to provide care and treatment to patients.

### Monitoring Safety & Responding to Risk

The practice had a health and safety folder which contained a range of risk assessments covering, for example, lone working. However, seven of those we looked at were incomplete, and one had not been signed off. We also found no evidence arrangements were in place to review, and where necessary, update these risk assessments.

There was evidence that some systems were in place to manage and monitor risks to patients and staff. For example, the practice manager told us staff used a risk assessment screening tool to identify patients at risk of an unplanned admission to hospital. They also said the needs of these patients were regularly reviewed and emergency care plans had been completed to help prevent them from experiencing unnecessary admissions into hospital.

The arrangements for ensuring staff and patients' safety in the event of a fire were mostly satisfactory. NHS Property Services were responsible for carrying out the required fire safety checks and there were records available that demonstrated that checks were being carried out appropriately. For example, checks on the practice's fire extinguishers had been carried out within the previous three months. The practice manager told us a recorded fire risk assessment had been completed by NHS Property Services. Some staff had completed Fire Warden training to help ensure the safe evacuation of their colleagues and patients in the event of a fire. However, the most up-to-date training matrix we were given showed some staff had not completed basic fire awareness training. Also, we were unable to confirm whether the locum GPs who regularly worked at the practice had completed this training, as their names had not been added to the staff training matrix.

### Arrangements to deal with emergencies and major incidents

We found the risks associated with major incidents and emergency situations had been recognised, assessed and managed. The practice had a business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. The plan covered the actions to be taken to reduce and manage a range of potential risks, and had successfully been implemented following a recent major flood at the practice.

Emergency equipment was available, including an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment and we were able to confirm it was regularly serviced and well maintained. An emergency medicines kit was also available within the practice. This included a supply of oxygen. The most up-to-date training matrix we were given indicated some staff had completed training in cardio-pulmonary resuscitation (CPR). Failure to ensure all staff have completed CPR training increases risk to patient safety because staff who have not had this training may not know how to respond appropriately when a patient requires resuscitation.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice had systems in place to help ensure patients received evidence-based care and treatment. However, we found these systems were not being implemented effectively. For example, the practice had developed clinical guidelines but we were unable to confirm staff consistently followed these when carrying out assessments and planning care and treatment for patients. The long-term locum GP we spoke with told us he knew there were clinical guidelines for the practice, but he said he had not read them. Also, the practice nurse we spoke with was unable to tell us how she would access the practice's clinical guidelines for nurses. They said they had developed their own. Clinical guidelines help GPs and nurses to make the best decisions about what care and treatment is required for a particular condition and, if clinical staff are not familiar with these guidelines, it could place patients at risk of receiving inappropriate care and treatment. We also found there were no arrangements in place to ensure the practice's clinical guidelines were regularly reviewed, and where necessary updated, to reflect changes in local and national clinical guidelines. This placed patients' health and wellbeing at risk because they may not receive the most up-to-date and effective care and treatment.

As a consequence of the senior GP's absence from the practice, lead responsibilities for particular areas of clinical practice had been shared between them and the practice nurses. (Clinical lead roles are important because clinicians undertaking them should be able to provide leadership and direction, and support colleagues to improve the quality of the services they provide). The senior GP partner had held lead responsibilities for most of the clinical conditions covered by the Quality and Outcomes Framework (QOF), but this was no longer possible. At the time of the inspection, there was no-one who was providing the clinical leadership previously provided by the senior GP partner. The long-term locum GP told us they felt the practice was 'rudderless'. In addition to this, the practice manager had left their post the day before the inspection and this only left the Business Manager, who had only been in post for a few weeks, to oversee the day-to-day running of the practice.

In the absence of the senior GP partner, the practice manager had allocated the responsibility of dealing with

patient communications, and actioning clinical tasks on the practice's IT system, to the long-term locum GP. We were told this GP had been allocated specific time to carry out these tasks. However, these arrangements did not appear to be working effectively and there were delays in actioning clinical tasks. In addition to this, we also identified that a lead role had been inappropriately allocated to a member of the non-clinical team. We found evidence that they had been tasked with arranging the completion of Part 2 Cremation Forms. (This is a task that must always be completed on a doctor-to-doctor basis). Nursing staff who had lead clinical roles continued to carry these out appropriately. For example, one of the practice nurses led on infection control issues and another practice nurse was responsible for overseeing chronic disease management.

### Management, monitoring and improving outcomes for people

Nationally reported QOF data, for 2013/14, showed the practice had achieved 97% of the total points available to them for providing recommended treatments to patients with the commonly found health conditions covered by the scheme. (This was 0.2 percentage points below the local Clinical Commissioning Group (CCG) average but 3.5 points above the England average). There were also other examples of good QOF performance where the practice had obtained all of the points available to them. This included providing care and treatment for patients with cancer, asthma, dementia and heart failure.

Whilst the practice had achieved a high overall QOF score for 2013/14, the data we looked at showed they had performed less well in providing recommended care and treatment to patients with diabetes, epilepsy and peripheral arterial disease. QOF data for 2014/15, indicated that some patients on the practice's long-term conditions (LTCs) disease registers had not received a healthcare review. At the time of our inspection, there was one practice nurse vacancy. This meant that the delivery of the chronic disease programme was mostly being provided by a practice nurse working 30 hours over a three day week. In addition, this practice nurse also had other responsibilities, such as providing baby and travel immunisations. This practice nurse told us that, when they took leave, their hours were not covered. The inspection team concluded that in light of the number of patients registered at the practice and the range of responsibilities currently



# Are services effective?

(for example, treatment is effective)

allocated to this practice nurse, this could account for the reduction in the numbers of patients on some of the practice's LTCs disease registers receiving healthcare reviews during 2014/15, when compared to 2013/14.

Members of the administrative team had been allocated roles which involved them monitoring how well the practice was performing in key QOF areas. Staff undertook searches of the practice's LTCs disease registers to make sure that patients who had not yet received the recommended care and treatment were offered appointments. However, the minutes of a recent staff meeting indicated that the eagerness of staff to maximise the practice's QOF performance had resulted in patients being invited to attend for appointments only to be told there were none available. This had resulted in these patients receiving a poor service from the practice.

There was no evidence to demonstrate clinical staff were carrying out a structured programme of clinical audits in order to assess, measure and improve outcomes for patients. We asked the provider to send us a summary of the clinical audit activity carried out by the practice during the previous two years. We did not receive this information. During our visit, the senior GP partner told us they had carried out 'small' audits on diabetes and asthma care. However, we were not provided with any details of these. The long-term GP locum told us they had completed full cycle audits on hypertension and the use of calcium channel blockers (medicines used to treat high blood pressure) in preparation for their appraisal. However, we were not shown any documentary evidence to confirm this. The inspection team felt that the failure to carry out a planned programme of clinical audits was a missed opportunity to review and improve outcomes for patients.

## Effective staffing

There were sufficient numbers of reception and administrative staff to carry out the roles and responsibilities that had been allocated to them. Administrative staff were rotated to ensure they could effectively complete all reception and administrative duties. All of these staff were willing to do extra hours as and when needed.

Because the senior GP partner had been absent from the practice since March 2015, the practice manager had ensured that, on most occasions, the level of GP medical cover provided was in line with NHS England's expectation.

The locum GPs had worked at the practice on a regular basis. However, the reliance on locum GP cover, even in the short-term and when there is no other choice, has the potential to impact on patient safety. The long-term locum GP we spoke with told us they had felt obliged, in the circumstances, to increase their hours and complete extra duties. They said they were unhappy about having to do this. As well as concerns about the practice's reliance on locum GPs to provide all medical cover, we were also concerned that the practice did not have a GP locum induction pack. Having such a pack helps to safeguard the quality of patient care by ensuring locum GPs are able to use practice protocols and procedures effectively and safely.

We saw evidence that some staff had completed further learning which helped to ensure they had the skills and competence required to carry out their roles. For example, one of the practice nurses had completed a degree in infection control training and had substantial experience in carrying out infection control audits and delivering infection control training to primary care staff. The other practice nurse had completed training that enabled them to meet the needs of patients with long-term conditions, such as, for example, a diploma in diabetes. They had also completed cervical smears and immunisation training updates. All of the staff who undertook chaperone duties had completed relevant training.

Because the senior GP partner was absent from the practice we did not check whether they were up-to-date with their annual continuing professional development requirements. The long-term GP locum we spoke with indicated they were aware of the General Medical Council (GMC) re-validation requirements, and said they were in the process of completing a clinical audit in preparation for this. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.) The sample of records we looked at confirmed all other staff had received an annual appraisal.

## Working with colleagues and other services

The practice held regular multi-disciplinary meetings to discuss patients with complex and end-of-life needs. These meetings were usually attended by the senior GP partner, the practice manager, practice nursing staff and local

# Are services effective?

(for example, treatment is effective)

healthcare professionals, such as health visitors. The senior GP partner told us these meetings were used to share important information about patients' needs and how they were being managed.

The senior GP partner told us that, over the years, they had striven to develop and build effective working relationships with staff in the local care homes. They said clinical staff responded to patients' needs as and when they arose. As part of our preparation for this inspection, we sought the views of local care home staff about the practice. We received mixed feedback about the quality of care and treatment people living at one of these homes had received. Most of the care home staff we contacted spoke positively about the practice and their staff. However, the staff at one particular care home told us they had been so disappointed with the quality of the care and treatment people living in their care home received they had raised their concerns with the appropriate regulatory body.

Practice staff had developed systems to handle incoming and outgoing patient information. However, these did not always work effectively. For example, the administrative team was responsible for summarising patient records. There was evidence of a backlog of several weeks in relation to the completion of summaries of patient information letters and new patient records. The long-term GP locum told us they had identified delays of several months in some clinical tasks and patient information letters being READ coded and actioned. The failure to have a sufficiently robust system in place to ensure patients' records are appropriately READ coded, and are summarised promptly, could mean that the clinical staff do not have access to the information they need to enable them to provide effective continuity of care.

## Information Sharing

The practice had a clinical IT system which enabled staff to coordinate, document and manage patients' care, and to scan paper communications, such as those from hospital, on to the system for future reference. Staff used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours service provider. This ensured the practice received information about contact the service had had with any of their patients. Staff used a secure system to share information about patients with complex care and treatment needs with out-of-hours and urgent care providers. This helped to ensure this type

of patient data was shared in a timely manner so that patients could receive prompt and appropriate care and treatment. Systems were in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.)

## Consent to care and treatment

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. During our interviews with the senior GP partner, and the long-term GP locum, we identified no concerns about how they handled consent issues. The practice nurse we spoke to was also very clear about when consent was needed and for what purposes. Good awareness was shown by both. However, the training matrix we were provided with contained no evidence that any of the locum GPs or nurses had completed training on the Mental Capacity Act (MCA) (2005) and their responsibilities as clinicians in implementing this legislation. The practice manager confirmed that the matrix was up-to-date.

## Health Promotion & Prevention

The practice offered all new patients a health check with a member of the nursing team. These checks covered a range of areas including height, weight and blood pressure. The practice also offered the NHS Health Checks enhanced service to all patients aged between 40 and 75 years of age.

Nationally reported QOF data for 2013/14 showed the practice had obtained 95.8% of the total points available to them for providing recommended care and treatment for patients who smoked. (This was 0.4 percentage points above the local CCG average and 2.1 points above the England average.) The data also confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. Practice staff had recorded the smoking status of 91.7% of eligible patients aged over 15 in the preceding 24 months, in order to help them identify patients at risk and to target the care and treatment they provided.

The QOF data included other examples of how well the practice had done in providing recommended care and treatment to patients in relation to the other public health

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

indicators. For example, the practice had obtained 100% of the total points available to them for treating patients diagnosed with obesity. (This was the same as the local CCG and England averages.) The practice had also obtained 97.9% of the points available to them for providing cervical screening to women. (This was 1.7 percentage points below the local CCG average but 0.4 points above the England average.) The QOF data for 2013/14 showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening and for informing women of the results of this test. The practice's performance in providing contraceptive services was 2.2 percentage points above the local CCG average and 4.8 points above the England average.

Staff had identified patients who needed additional support. The QOF data confirmed the practice maintained a register of all patients with dementia, in order to target the care and treatment they provided. QOF data showed the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to dementia patients. (This was 3.1 percentage points above the local CCG average and 6.6 points above the England average).



# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We interviewed three members of the practice's Patient Participation Group (PPG). Without exception, they told us the practice offered a good service and staff were caring and helpful. They also confirmed they were treated with dignity and respect, and that staff were professional, compassionate and understanding. Fourteen patients had completed Care Quality Commission (CQC) comment cards. The feedback we received indicated the majority of these patients were satisfied with the care and treatment they received. Most of them told us they received a good service which met their needs.

The practice had completed their own survey of patients in 2014/15. This showed most patients were satisfied with the services provided. For example, the scores for patient satisfaction with the quality of the clinical consultation they received, and the confidence and trust they had in their GP or nurse, were in excess of 80%. Evidence from this survey showed there had been an improvement in patient satisfaction levels compared to the previous year. However, findings from the National GP Patient Survey of the practice, published in 2015, showed variable levels of satisfaction with the quality of services provided. Some of the results were better than or in line with the local CCG and national averages, whilst others clearly fell below them. For example, of the patients who responded to the survey:

- 91% said they were satisfied with the helpfulness of the receptionists, (this was above the local CCG average of 88% and the national average of 87%);
- 90% said they had confidence in the last nurse they saw or spoke to, (this was in line with local CCG average and above the national average of 86%);
- 83% said the last nurse they saw, or spoke to, was good at giving them enough time, (this was in line with the local CCG average but below the national average of 81%);
- 77% said the last GP they saw, or spoke to, was good at listening to them, (this was below the local CCG average of 89% and national average of 88%);
- 76% said the last GP they saw or spoke to was good at giving them enough time, (this was below the local CCG average of 88% and the national average of 86%);

- 73% said the last GP they saw or spoke to was good at treating them with care and concern, (this was below the local CCG average of 86% and the national average 82%);
- 73% said they had confidence and trust in the last GP they saw or spoke to, (this was below the local CCG average of 86% and the national average of 82%).

Patients' privacy and dignity was respected. The reception desk opened directly onto the patient waiting area. We saw that staff who worked in this area made every effort to maintain patients' privacy and confidentiality. A notice reminded patients of the importance of standing back from the reception desk to allow the patient in front to speak privately with staff. However, in the practice's own survey of patients, 25% indicated that their conversations could be overheard by others and they were not happy with this. In response to this, the practice had displayed a notice explaining that patients could speak to a receptionist in private if they preferred to do so.

During the inspection all consultations and treatments were carried out in the privacy of a consulting or treatment room. There were screens in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. A member of the reception team told us a private room would be made available should a patient indicate they wished to speak confidentially. We observed staff as they greeted and interacted with patients. We saw their approach was considerate and caring, while remaining respectful and professional.

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

Findings from the National GP Patient Survey of the practice, published in 2015, showed variable levels of satisfaction regarding the involvement of patients in decisions about their care and treatment. Some of the results were better than, or in line with, the local CCG and national averages, whilst others fell below them. For example, of the patients who responded to the survey:

- 78% said the last GP they saw or spoke to was good at explaining tests and treatments, (this was below the local CCG average of 84% and the national average 82%);

## Are services caring?

- 62% said the GP they visited had been 'good' at involving them in decisions about their care, (this was below the local CCG average of 78% and the national average of 74%);
- 80% said the last nurse they saw, or spoke to, was good at explaining tests and treatments, (this was in line with the local CCG average and above the national average of 77%);
- 68% said the last nurse they saw, or spoke to, had been 'good' at involving them in decisions about their care, (this was below the local CCG average of 89% but above the national average of 67%).

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

Patients we spoke with expressed no concerns about the support they were given to cope emotionally with their care and treatment. Similarly, of those patients who had

completed CQC comment cards, all who made comments were positive about the support they received from the practice. The majority of patients confirmed the clinical staff were compassionate, sympathetic, considerate and understanding.

Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. The practice website provided patients with links to support organisations such as the Sunderland Carers' Association and the local Alzheimer's Society.

The practice's IT system alerted clinicians if a patient was also a carer, so this could be taken into consideration when they assessed their need for care and treatment. The practice manager told us clinical staff referred patients struggling with loss and bereavement to an appropriate support group, where this was appropriate.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice manager told us arrangements had been put in place to meet the needs of older patients, and those with long-term conditions. The practice had used a risk assessment tool to profile patients according to the risks associated with their conditions. This enabled staff to identify patients at risk of, for example, an unplanned admission into hospital. Staff had taken action to prepare emergency care plans for this group of patients. We were told these patients were also discussed at the monthly multi-disciplinary team (MDT) meetings. Arrangements had previously been made to provide patients aged over 75 years with a named GP. However, because of the absence of the senior GP partner, this was no longer the case. The inspection team recognised that this situation was only short-term, and these patients would be allocated another named GP once the new doctors started working at the practice.

We found the practice did not have an effective mechanism in place to identify and monitor patients who were unresponsive to 'recall'. ('Recall' is an important process where staff follow up patients who have received clinically significant tests and results, or who have failed to attend their chronic disease healthcare review.) The practice nursing team was mostly responsible for the delivery of chronic disease management, and for providing advice and support to patients with long-term conditions (LTCs), such as asthma and Chronic Obstructive Pulmonary Disease (COPD). (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.) The practice nurse told us they were working on developing an effective patient 'recall' system. They said a member of the administrative team would, when they had time, carry out a search to identify all patients with LTCs, requiring a review. They would then telephone or write to these patients inviting them in for a review. We were told that no further contact would be made with the patient to remind them of the seriousness of not attending their healthcare review. The failure to ensure that an effective system was in place for following up patients with LTCs who failed to attend their healthcare review increased the risk to their safety and wellbeing. This is because they might not understand the significance of any changes in their health and how these should be managed.

At the time of our inspection we identified there was no system in place for checking whether urgent two-week referrals had actually been sent to the appropriate hospital department. The monitoring of these referrals had previously been undertaken by one of the secretarial staff who had recently resigned. This increased risks to patient safety, in that there was no 'safety net' in place to make sure that these referrals had actually been sent, or received by secondary care health professionals.

Nationally reported QOF data showed the practice had obtained 100% of the total points available to them for providing palliative care to patients. (This was the same as the local Clinical Commissioning Group (CCG) average and 3.3 percentage points above the England 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. The QOF data also showed that MDT meetings took place at least every three months, to discuss and review the needs of each patient on this register. The senior GP partner told us these meetings included relevant healthcare professionals involved in supporting these patients, such as community nursing staff 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 a weekly antenatal clinic provided at the practice by a midwife. This provided mothers with access to a post-natal check performed by the senior GP partner. Information in the practice's brochure informed mothers-to-be that they could access a primary care mental health nurse for ante-natal and post-natal support. QOF data for 2013/14 showed ante-natal 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 had obtained 100% of the total points available to them for providing child health surveillance. (This was in line with the local CCG average and 1.2 points above the England average).

The practice nurse provided a fortnightly immunisation clinic and supported a family planning clinic operated by the health centre in which the practice was located. However, on the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of most childhood immunisations was lower, in comparison to the

# Are services responsive to people's needs?

(for example, to feedback?)

overall percentages for children receiving the same immunisations within the local CCG area. For example, the numbers of children who were given six of the eight childhood immunisations that should be given to children aged five years were below each local CCG average.

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. Working patients had, until very recently, been able to access appointments outside of normal working hours. This option was no longer available which made it more difficult for them to access suitable appointments. Patients were able to book their appointments on-line which offered them more flexibility. Patients received recommended treatments for the health conditions common to working age patients, such as heart disease and hypertension. For example, QOF data for 2013/14 showed that 86.5% of patients aged between 16 and 75 years who had hypertension, had had an assessment of their physical activity during the previous 12 months. (This was 7.3 percentage points above the local CCG average and 7.9 points above the England average.)

The practice had taken steps to identify patients with mental health needs and had taken steps to meet their needs. Patients with mental health needs were able to access counselling at the practice as well as support from the community mental health team, where this was appropriate. The practice maintained a register of all patients diagnosed with the mental health conditions specifically covered by the QOF. Maintaining such a register helps practices to target care, treatment and advice to this vulnerable group of patients. The QOF data showed that, where appropriate, care plans had been completed for 92.2% of patients who were on the practice's mental health register, in agreement with the patients. However, the arrangements for supporting patients with mental health needs to attend their annual healthcare reviews were not fully satisfactory. We saw evidence that many of the patients on the practice's register for this group of patients had not received their annual healthcare review.

## Tackle inequity and promote equality

The practice had recognised the needs of different groups of vulnerable patients when planning their services. The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. However, the practice manager

was aware there were a very small number of patients living in temporary accommodation. They told us these patients had been supported to register with the practice on a temporary basis.

Staff were also aware they had a large group of people with learning disabilities living in sheltered housing near to the practice. Nationally reported QOF data for 2013/14 showed the practice maintained a register of all of these patients to help them target the care and support they required. The data showed the practice had achieved 100% of the total points available to them for providing care and treatment for patients with learning disabilities. (This was 8.7 percentage points above the local CCG average and 15.9 points above the England average). However, QOF data for 2014/15 showed that out of a total of 48 patients on the practice's learning disability register, only 15 had received a healthcare review. The inspection team felt that much could be done to improve this group of patients' access to annual healthcare reviews.

Reasonable adjustments had been made which helped patients with disabilities and those whose first language was not English, to access the practice. The premises in which the practice was located had been purpose built to meet the needs of patients with disabilities. For example, the main doors into the health centre building opened automatically. There was a disabled toilet which had appropriate aids and adaptations. Disabled parking was available at the front of the building.

The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. The practice had a small number of patients whose first language was not English. Staff had access to a telephone translation service and interpreters should they be needed.

## Access to the service

Appointments were available from 8:00am to 6:30pm five days a week. Extended hours access to GP appointments had until very recently been provided, and had included the provision of a Saturday morning surgery and cover on some bank holidays. Providing extended hours makes it easier for working age patients and families to attend an appointment. However, the absence of the senior GP partner, and the practice's reliance on the use of locum GPs to provide all medical cover, had meant the practice was no

# Are services responsive to people's needs?

## (for example, to feedback?)

longer able to provide this service in the short-term. We noted that the practice website had not been updated to reflect the fact that extended hours were no longer being provided.

Patients were able to book appointments by telephone and on-line, or by visiting the practice. The appointment system offered pre-bookable and 'bookable on the day' appointments that were released at the beginning of the morning and afternoon surgery sessions. The practice manager told us that 50% of each GP's morning and afternoon appointments were reserved so that patients could book these on the day.

In the absence of the senior GP partner, practice staff had been providing NHS England with rotas demonstrating they were providing the necessary level of medical cover. We looked at the rotas for medical cover and saw that the level of cover needed in the absence of the senior GP partner, had mostly been provided. When we checked to see whether the required number of appointments had been offered, based on the size of the practice's patient list, we found this was less than what should have been provided. Current guidance states that a practice should be offering 66 appointments per 1000 patients per week. This meant the practice should have been offering 363 appointments each week. We found instead it was offering only 330 appointments.

Where patients who had completed Care Quality Commission (CQC) comment cards had commented on the practice's appointment system, most of these were positive. A small number expressed concerns that appointments were difficult to access. In addition, two of the five patients we spoke with on the day of the inspection also expressed concern and frustration about the lack of access to appointments. When we arrived at the practice, we observed a patient requesting an appointment. Whilst dealing with this patient's request, the receptionist left the reception area and did not return for almost 10 minutes. Our discussions with staff revealed that one of the GP locums had called in sick earlier that morning. We were told that, as well as meeting the needs of patients who were requesting appointments, the administrative team were also trying to make sure they could provide alternative appointments for those patients affected by the locum GP's absence. It was also evident that reception staff

were having to deal with the uncertainty over who would be providing medical cover the following week once the senior GP partner was no longer responsible for the practice.

Overall, with regards to access to the service, the results from the National GP Patient Survey of the practice, published in January 2015, were broadly in line with local CCG and national averages. Of those patients who responded to the National GP Patient Survey for the practice:

- 77% said they were satisfied with the practice's opening hours, (this was in line with the local CCG average but above the national average of 76%);
- 79% said they were able to get an appointment to see or speak with someone, (this was below the local CCG and national averages of 86%);
- 75% said they found it 'easy' to get through on the telephone to someone at the practice, (this was in line with the local CCG average but above the national average of 71%);
- 69% said they usually waited 15 minutes or less to be seen after arriving for their appointment, (this was below the local CCG average of 70% but above the national average of 65%).

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and the contractual obligations for GPs in England.

Information was available to help patients understand the complaints process. The practice website and an information leaflet provided patients with information about how to complain. The procedure informed patients that an apology would be offered where the practice had not got things right. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously.

From the information supplied by the practice, we were able to confirm they had received ten complaints during the previous 12 months. We found that complaints were poorly recorded. In particular, none of the entries made in the complaints record had been dated, and evidence indicating what learning had taken place was not clearly recorded. For example, one of the complaints had been

# Are services responsive to people's needs? (for example, to feedback?)

made by the relative of one of the patients. This involved a concern that the locum GP who saw this patient was unable to access copies of letters that were in their medical record. The 'Action Taken' section of the record of this complaint did not clearly identify exactly what difficulties the locum GPs encountered whilst trying to access copies

of the letters. The 'How Learning Was Implemented' section of this record only said 'consideration' would be given to how this issue could be addressed. The record of the complaint did not contain any information about the action taken to address the issue or whether it had led to improved outcomes for patients.



# Are services well-led?

Inadequate 

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

## Our findings

### Vision and Strategy

The practice website contained no information about the practice's vision and strategy for developing the service. However, it did include information about the planned changes to the management of the practice. It was clear the senior GP partner had previously had a clear vision about how they wanted Cramlington Medical Group to develop and that they had, in the past, taken steps to deliver this. However, their absence from the practice meant they were no longer in a position to influence how the service was delivered. The senior GP partner was unable to provide us with an up-to-date business development plan and they only had one clear objective at the time of our inspection. This was to make sure the new GPs, who would be responsible for the day-to-day running of the practice the week following our inspection, received a good handover. Because of these circumstances staff found it difficult to tell us what the plans were for the future development of the practice.

### Governance Arrangements

The senior GP partner and practice manager told us about the measures they had put in place to ensure patients received a safe service which met their needs. For example, they told us they actively promoted patient involvement and sought feedback from patients on the quality of the services they received. We thought the practice had performed well in this area. Members of the Patient Participation Group (PPG) told us the practice manager and the senior GP partner had 'good' arrangements for consulting them about the day-to-day functioning of the practice. However, we also saw evidence of failures in the practice's governance arrangements for delivering safe patient care. For example, staff provided us with limited evidence that regular clinical audits aimed at improving outcomes in patient care had been carried out. We also identified a range of concerns regarding the management of medicines at the practice. These concerns had not been identified by practice staff and, because of this, steps had not been taken to address them.

### Leadership, openness and transparency

The practice did not have effective leadership at the time of our inspection. The reasons for this included the absence of the senior GP partner (who was also the registered

manager), and the resignation of the practice manager, who had left their post on the day prior to the inspection. This had resulted in the business manager, who had only recently taken up their post, having to take on the overall responsibilities for the day-to-day running of the practice. However, it was evident that the senior GP partner had taken steps to make sure that the new doctors who would shortly be taking on the responsibility of carrying on the regulated activities knew about the practice's systems and processes. There was also evidence the senior GP partner had informed patients of the forthcoming changes, and staff had been made aware of some of the changes that were imminent.

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

The practice had sought and acted on feedback from patients and staff. For example, a patient survey had been carried out in 2014/15. The practice had both actual and virtual patient participation groups (PPG). Information about how to join these groups was available in the patient reception area, and on the practice website. Three members of the PPG told us practice staff actively encouraged their involvement and positively engaged with the group over issues such as the appointment and telephone systems. They also said they held weekly sessions at the practice where they asked patients for their views about the quality of services provided. We were told that, over the many months they had been doing this, the feedback they received was always positive. The PPG members were obviously very proud of the work they carried out for the practice, which included the completion of an annual report and action plan.

The most recently completed PPG patient survey report showed patients were satisfied with most aspects of the service provided. The survey report included actions to address issues raised by patients, such as the difficulties they had getting through to the practice on the telephone. However, we thought the action plan could be improved by providing more specific actions. This would enable a fuller evaluation of the successes achieved by the practice at the end of each 12 month period.

The practice website encouraged patients to complete a Friends and Family Test survey (FFT) following their consultation. (The FFT survey provides patients with an opportunity to leave feedback on the quality of services they have received.) A receptacle was available at the

# Are services well-led?

Inadequate 

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

reception desk for patients wishing to leave their completed survey forms. There was no feedback on the outcome of the FFT survey, either on the practice website or within the reception area.

The practice held monthly practice meetings where patients' needs, and matters affecting the day-to-day operation of the practice, were discussed. These meetings provided opportunities for staff to raise issues and concerns with the management team. We looked at a sample of the minutes of these meetings and noted that the long-term locum GP had not attended any of them. The practice's appraisal system provided opportunities for staff

to comment more formally about day-to-day operational issues, and their needs as a member of the practice team. We noted that some staff had not received an appraisal for over 15 months.

## **Management lead through learning & improvement**

The practice provided staff with opportunities for continuing professional development. However, according to the training records we were given, some staff had not received all the training they needed to enable them to carry out their roles and responsibilities effectively. Evidence referred to throughout this report indicates that effective systems were not in place to ensure improvement through learning and review.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

#### Regulated activity

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

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
The registered provider had not ensured that all staff, including locum GPs who regularly worked at the practice, had completed all of the training they needed to deliver safe care and treatment. All staff who obtain the consent of people who use the service must be familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005.  
This is a breach of Regulation 18 (1) and (2) (a) and (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Staffing

#### Regulated activity

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

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  
The registered provider had failed to ensure that they provided care and treatment in a safe way. In particular, the systems in place for ensuring the safe management of medicines were inadequate.  
This is a breach of Regulation 12 (1) and (2) (b), (g) and (f) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Safe Care and Treatment.

#### Regulated activity

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

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance  
The registered provider had not protected service users who may be at risk of inappropriate or unsafe care, by means of the effective operation of systems designed to-

This section is primarily information for the provider

## Requirement notices

- Regularly assess and monitor the quality of services provided in carrying on the regulated activity, and
- Identify, assess and manage risks relating to the health, welfare and safety of service users and others;
- Enable them to evaluate and improve their practice.

This is a breach of Regulation 17 (1) and (2) (a), (b), (c) and (f) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good Governance.

### Regulated activity

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

### Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered provider had failed to ensure that locum GPs working at the practice had been subject to relevant pre-employment recruitment checks and were safe to work with vulnerable patients.

This is a breach of Regulation 19 (1), (2) (a), (3) (a) and (b), and (4) (a) and (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Fit and Proper Persons Employed.