Harraton Surgery

Quality Report

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

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Summary of findings

Overall summary

Harraton Surgery is located in the village of Harraton in the Washington area of Sunderland. Dr Inder Jeet Singh is the registered manager for Harraton Surgery.

At this inspection we found there was a lack of clear leadership and vision within the practice. Governance arrangements were unclear. Although staff told us about actions they had taken to improve the service, there was a lack of a documented audit trail to evidence this.

The practice could not demonstrate an understanding of what their key strengths were and what they had identified as areas for improvement. We found that practice was responsive in its approach to quality, rather than proactively planning for improvements. The provider was in breach of regulations relating to assessing and monitoring the quality of service; ensuring that premises were safe and accessible for patients, staff and visitors; and, having adequate processes in place to safeguard vulnerable children, young people and adults from abuse.

Patients told us they had no problems in accessing appointments and were usually able to get appointments quite quickly. Most patients also told us that staff treated them with dignity and were responsive to their needs.

We found care and treatment took account of recognised best practice standards and guidelines.

The majority of patients registered with the practice were of working age. There were approximately 200 patients registered with the practice over the age of 65, with a very small number of these living in a local care home. Of all patients, 51.1% were categorised as having a long term condition. Overall the practice made appropriate provision for each population group to ensure the practice was caring. However, further improvements were required to make sure the practice was safe, effective, responsive and well-led.

Regulated activities

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that not all aspects of the practice were safe. We found that further improvements were required to ensure that patients were safeguarded against poor care and treatment. We found that Harraton Surgery did not adopt a learning approach to reviewing safety incidents.

Staff demonstrated an understanding of safeguarding patients from abuse, however not all staff were aware of what the practice's own policies and procedures were in relation to this.

We found there were appropriate arrangements in place for managing medicines.

We found the practice had processes in place to maintain a clean environment.

Are services effective?

We found that not all aspects of the practice were effective as there were areas where improvements should be made. We found care and treatment took account of recognised best practice standards and guidelines. We saw that staff carried out assessments which covered health care needs.

Arrangements were in place to review and help patients manage their long term conditions. The practice had performed well on clinical indicators in the Quality and Outcomes Framework (QOF). The practice used these indicators as part of their audit schedule.

We found some staff were supported to continually update and refresh their skills. However this was not the case for all staff. The practice manager confirmed that she had not undertaken appraisals with non-clinical staff for over two years.

The practice had arrangements in place to communicate and work well with other services.

Are services caring?

We found the practice was caring. Most patients reported that staff were caring and responsive to their needs. However some reported that they were kept waiting past their appointed time.

Data from the National GP patient survey demonstrated that patients overall were satisfied with the practice, particularly in getting in touch with the surgery and making appointments.

Summary of findings

The practice had arrangements in place to ensure continuity of care with those who are receiving end of life care with the out of hours providers.

We found that before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Where people did not have the capacity to consent, the practice acted in accordance with legal requirements.

Are services responsive to people's needs?

We found that not all aspects of the practice were responsive to people's needs. Patients told us they had no problems in accessing appointments and were usually able to get appointments quite quickly. The practice offered online booking of appointments, and email access to repeat prescriptions and medical advice. However only a small number of patients used these facilities. Arrangements were in place to offer patients alternative access to medical support, including telephone appointments and home visits, where appropriate.

The practice had not robustly planned how those patients with physical disabilities could access the building.

Appointments were offered at various times during the day to meet patients' needs.

The practice had not received any formal complaints over the last two years. We found evidence that patients had raised some informal, verbal complaints with the practice about being kept waiting beyond their appointed time. There was no clear evidence that the practice had taken action to address these concerns.

Are services well-led?

We found that not all aspects of the practice were well-led. There was a lack of clear leadership and vision within the practice. The practice did not plan for reviewing quality and governance arrangements were unclear.

The practice did not have a patient participation or reference group to help contribute the patient voice to quality improvement. A patient survey had been undertaken at the end of 2013. However there was no clear evidence that this led to improvements.

We found a lack of arrangements to actively encourage learning and improvement across the practice.

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 made appropriate provision across the practice to ensure the service for older people was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led.

Although arrangements were in place to identify and take action where older patients were at risk of abuse, some staff were unclear about what these arrangements were.

Regular meetings took place with healthcare professionals from other agencies, to ensure information was shared for those most at risk and vulnerable older patients. Care plans were in place for those at risk of quickly deteriorating health.

People with long-term conditions

The practice made appropriate provision to ensure the service for people with long term conditions was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led.

There were regular chronic disease clinics in place to monitor the health and wellbeing of patients with long term conditions. Care plans were in place for those who were at most risk of deteriorating health and whose conditions were less well controlled.

There were mechanisms for communicating with other community healthcare professionals to ensure important information about patients care and treatment was shared.

Mothers, babies, children and young people

The practice made appropriate provision to ensure the service for mothers, babies, children and young people was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led.

Although arrangements were in place to identify and take action where babies, children and young people were at risk of abuse, staff were unclear about what these arrangements were.

Vaccinations and health checks were available to ensure the health and progress of babies, young children, expectant and new mothers. There were arrangements in place to support good sexual health awareness for young people.

Summary of findings

The working-age population and those recently retired

The practice made appropriate provision to ensure the service for the working-age population and those recently retired was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led.

Patients told us they had no problems in accessing appointments and were usually able to get appointments quite quickly. We found a range of appointment times and types were available to meet patients' needs.

Information was available within the practice to inform patients about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

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

The practice made appropriate provision to ensure the service for people in vulnerable circumstances who may have poor access to primary care was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led.

The practice told us that they offered the same service to all patients, irrespective of social or lifestyle choices.

We found the practice had not sufficiently considered the needs of people with disabilities who might have problems accessing the building.

People experiencing poor mental health

The practice made appropriate provision to ensure the service for people experiencing poor mental health was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led.

The practice enabled other healthcare professionals to use consulting rooms within the practice so patients could access services close to home. The practice developed care plans for those patients with enduring mental health conditions most at risk of relapse.

Summary of findings

What people who use the service say

We spoke with nine patients on the day of the inspection. Before the inspection CQC comment cards were also left in the reception waiting rooms for patients to feedback to us their experience of the surgery. We received 13 responses.

The majority of patients told us they were satisfied with the care and treatment they received at the practice and most reported that staff were caring and responsive to their needs. However, some patients told us they were kept waiting for an unacceptable amount of time past the appointment time they were given, this was sometimes in excess of 40 minutes. The practice had also identified this feedback through its own patient survey.

A small number of patients also fed back that sometimes they felt the doctor did not listen to them and they felt rushed through a consultation.

Areas for improvement

Action the service MUST take to improve

- The practice must improve its approach to leadership and quality improvement. Also it must strengthen its approach to improve the quality and learning from risk management, audits, analysis of incidents and events, complaints and feedback from patients and staff.
- The practice must improve the arrangements for ensuring that premises are safe and accessible for patients, staff and visitors.
- The practice must strengthen its approach and put in place appropriate arrangements to safeguard children and vulnerable adults from the risks of abuse. Where staff provide a chaperone service, they must be supported to understand this role and have appropriate background checks carried out.

Action the service SHOULD take to improve

- The practice should improve its approach to checking at appropriate intervals whether healthcare professionals, such as doctors and nurses, are registered with the appropriate professional bodies.

Harraton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included two specialist advisers; a GP and a practice manager.

Background to Harraton Surgery

Harraton Surgery is located in Harraton Village in the Washington area of Sunderland. The surgery is based in a two storey converted house. On the ground floor there is a reception area, a treatment room and a consultation room. There is an additional consultation room on the first floor.

Dr Inder Jeet Singh is the sole registered provider for the practice. Working alongside him is a female locum GP, a practice nurse, a healthcare assistant, a practice manager and secretarial and administration staff. Most staff work part time hours.

Surgery opening times are between 8:00am and 6.00pm Monday to Friday. An extended surgery is provided on a Wednesday evening between 6:00pm to 7:00pm. In addition to the practice there are three minor injuries and illness units in the Washington and Sunderland area, where patients can access services between 8:00am to 8:00pm everyday. The practice is supported with out-of-hours provision from the 111 service between 8pm and 8am and all day at weekends and on bank holidays.

The patient list size for Harraton Surgery is 2148 (as at 30 June 2014). The majority of patients are between the ages of 18 and 65. Approximately 200 patients are over the age of 65, with only a very small number living in a local care home. The majority of patients come from the villages of Harraton, Crowther, High Rickleton and Lambton Park in the Washington area. However some patients are registered from the surrounding areas following the closure of a previously linked practice.

This was the first time the practice had been inspected by the Care Quality Commission (CQC). At the point of registration the practice declared it was fully compliant with the regulations.

Dr Singh has only one registered location as part of this registration. Dr Singh also has two other GP practices, which were registered separately. All three practices have separate patients lists. Only Harraton Surgery was visited as part of this inspection. Dr Singh was reviewing how all three practices were registered with CQC.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting the practice, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

We carried out an announced inspection visit on 26 and 27 August 2014.

During our inspection we spoke with a range of staff including GPs, practice nurses, administration and reception staff and the practice manager. We spoke with nine patients on the day of the inspection.

We observed how people were being cared for in communal areas and talked with carers and/or family members. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe patient care

Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, indicated that in 2012-2013 the practice was appropriately identifying and reporting incidents.

The practice used an electronic system to record serious incidents. We asked the GP if any serious incidents had occurred within the practice, he was unable to recall any during his four years at the practice. A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

We discussed significant events with both the GP and the locum GP. Significant events are any event thought by any staff member to be significant in the care of patients or the conduct of the practice. This can include critical incidents, errors, near misses or any event where the practice can learn about the quality of care and indicate any changes that might lead to future improvements. They told us that they thought the practice had some prescribing errors, which were picked up prior to dispensing, either by themselves or by the community dispensing pharmacist. They were unable to provide specific details during the inspection of any significant events. Other staff told us they were unaware if any significant events had taken place over recent years.

However, following the inspection they sent us details of four significant events that had occurred relating to patients from the practice. These included; an error with medication made by a community pharmacy, a data protection issue by the community midwifery team, a failure to pass on a message leading to a medication error and a failure of a medication delivery device. Although there was some learning identified from these events, we found that systems were not in place to ensure the robust identification, evaluation and learning from serious incidents and significant events. Learning was not effectively communicated across the practice.

The practice had policies and procedures setting out how staff could carry out their work effectively and safely. However, many of these had not been reviewed for number of years. We found there were duplicate policies where previous documents had not been removed or withdrawn. This made it confusing for staff to know what the practice's policies and procedures were and to be confident that they were following the correct ones. We spoke with the practice manager about this. They told us that they were aware that the policies and procedures had not been kept up to date and organised effectively. They told us that this was on their 'to do' list, but because of working pressures had been unable to address this.

Learning from incidents

We found the practice's approach to identifying and investigating incidents was unclear and the practice had not adopted a learning approach when reviewing safety incidents. There was a lack of clarity as to how significant and serious events were identified, what staff responsibilities were within the practice and how learning would be disseminated. This increased the risk of significant events being repeated.

We asked how learning was disseminated to staff. Staff told us that messages were communicated on an ad hoc basis, to take into account the part time working patterns of staff. The practice manager told us it was difficult to arrange meetings when all staff were available. The practice manager told us that clinical team and staff meetings were arranged on an ad hoc basis and no notes were taken of these meetings. They also told us there was a communications book in the reception area which was used to pass on messages to staff. However, we saw there were no records in the book to show whether these messages had been seen, noted and acted on by all staff.

Safeguarding

The practice told us they had adopted the local Clinical Commissioning Group (CCG) policies for the safeguarding of vulnerable adults and children. Also that the GP was the safeguarding lead. We looked at the policies and procedures for the practice to locate the one relating to safeguarding. We found that there were several safeguarding policies in the file, including the one from the local commissioning group. We found it confusing to know which policy was current and used by the practice. This was because there were a number of policies that had not been archived when they had been superseded and example policies from other areas in the country.

Staff we spoke with demonstrated an understanding of safeguarding patients from abuse and the actions to take should they suspect anyone was at risk of harm. However, some staff were unaware of what the practices own policies

Are services safe?

and procedures were in relation to safeguarding, and were unaware that the practice had a lead in this area. We were concerned that this could lead to suspicions of abuse not being identified and passed onto the relevant authorities.

We spoke with the GP about the level of training he had undertaken in the safeguarding of children. He told us that he had received training to level two in safeguarding children, and planned to undertake level three training this year. It is a requirement of Local Children Safeguarding Boards, based on a statutory requirement in the Children Act 2004, that a lead GP in safeguarding is trained to level three.

The GP told us that he cascaded training on safeguarding to all staff within the practice. We found that although clinical staff had attended training, not all administrative staff had received training in this area.

We asked practice staff about how the role of chaperone was fulfilled within the practice. They told us that normally the practice nurse or healthcare assistant undertook this role. However other staff would undertake this role if both of these staff members were unavailable. We asked administrative staff who had previously acted as a chaperone to describe this role. These staff were not clear about the role of a chaperone. They told us they had not received any specific training prior to acting as a chaperone. Staff told us they were there to help the doctor, but were unsure as to how they could safeguard people. There was no evidence that appropriate checks, such as a disclosure and barring service (DBS) checks, had been carried out to ensure staff members were suitable to undertake this role.

Staff told us that there was an alert on the clinical system to record and alert staff to patients within the safeguarding system. This ensured staff were aware of this information when providing care and treatment to such patients.

Staff talked to us about how they shared information with other relevant healthcare professionals in relation to safeguarding and concerns about abuse. They told us they had previously been able to inform the health visitor of any safeguarding concerns relating to children. This would also be discussed at a quarterly meeting with other health professionals. However, the practice did not currently have a linked health visitor. They told us that the loss of this linked health visitor had made communication more difficult.

Monitoring safety and responding to risk

The practice used a system called 'script switch' which alerted GPs to up to date guidance and protocols for the drugs they prescribed. This system allowed them to review the medication at the time to ensure the safest and most effective medication was given to the patient. Similarly the clinical IT system, EMIS web, supported the practice to provide health and care within nationally recognised best practice guidelines.

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

Medicines management

We found that there were appropriate arrangements in place for managing medicines. National safety alerts regarding medicines were acted on by the surgery.

We checked storage of medicines, including emergency medicines and vaccines. The practice manager managed stock ordering and rotation of stock to ensure medicines were used in the order of age.

We found medicines were kept safely, within an appropriate temperature range. Vaccines were stored in two fridges, both of which had temperature gauges on the front and independent thermometers inside to ensure the accuracy of temperature recording and to insure against failure of the inbuilt thermometer. The fridges were cleaned on a monthly basis or as needed if there was a spillage. The fridge was adequately maintained by the manufacturer and the staff were aware of the actions to take if the fridge was out of temperature range.

The practice held emergency medicines on site, including those for anaphylaxis and injectable antibiotics. We saw checks had been made to ensure these medicines remained in date and were safe to use. This was audited by the practice manager annually to confirm that regular checks had taken place.

We were unable to check the medicines held within the doctor's bag. This was because the GP was unable to stay for the duration of the inspection and did not bring his bag

with him when we returned on the second day of the inspection. He told us he checked that appropriate medication was available, in date and safe to use. However we were unable to verify if those checks took place.

The practice had processes in place to ensure the safety of prescriptions. For example, for patients who were substance misusers or elderly patients who could not pick up their own prescriptions, the practice had a log of all prescriptions signed. This provided a clear audit trail for those prescriptions picked up from the surgery by patients own community pharmacies'.

When changes had been requested to the prescription for medication for patients by other health professionals, such as NHS consultants and/or following hospital discharge, the practice had a system for ensuring these changes were carried out in a timely manner. The request was seen by the GP who identified the action needed and made the change on the clinical system.

Cleanliness and infection control

We found the practice had processes in place to maintain a clean environment and they had taken action to reduce the risk of the spread of infections.

The practice manager and the GP were the named infection control leads for the practice, and were supported by the practice nurse on this. The practice had in place policies and procedures for infection control and hand hygiene, but these had not been reviewed for a number of years.

There was a cleaning schedule in place, which set out when and how different parts of the building, fixtures, fittings and environment should be cleaned. However this did not detail any periodic deep cleaning needed of the environment to ensure it remained clean and fit for purpose.

We found the environment was clean, free from odour and there was no visible staining to furniture or fittings. The practice manager told us the curtains in treatment room were taken down and washed at 60 degrees every six months. However there was no documentary evidence to support this.

The cleaner attended three times per week. On the days the cleaner did not attend any additional cleaning required was carried out by other staff such as the practice nurse, healthcare assistant or practice manager.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was impermeable, and easy to clean. There was a system for the disposal of clinical waste; this was collected by a contractor on a weekly basis. There were sharps disposal boxes in the clinical areas of the practice. It was noted that none of the sharps boxes within the practice had been dated or signed on construction. It is best practice that sharps boxes are signed on construction and disposal to provide an audit trail.

The practice manager provided us with a copy of their infection control audit following the inspection visit. This had taken place on 27 July 2014.

Staffing and recruitment

We looked at four staff files. The majority of staff members had been employed by the practice for a number of years, and therefore a full record of their recruitment process was not available. The practice manager told us that if new staff were recruited they would be subject to the practice's recruitment policy and procedure and a full record would be kept. They told us that any new staff would be subject to a disclosure and barring check (DBS).

We saw that one staff member had been employed within the last six months. We saw that there was a curriculum vitae (CV) on file for this staff member. There was one referee noted on this CV. However there was no documentary evidence that the practice had contacted this referee to confirm the applicant's conduct in previous employment. There was no documentary evidence that gaps in employment had been explored as part of the recruitment process. We noted also there was no disclosure and barring (DBS) check on file for this staff member. We asked the practice manager about this. They told us as the staff member was recruited on a temporary contract they had not applied for a DBS check. To manage any risks to patients, this staff member was shadowed at all times and would not be expected to undertake chaperone duties. The practice manager told us that if the staff member was made permanent a DBS check would be applied for, in line with their policy.

We saw that appropriate checks had been undertaken for the locum GP. As part of their recruitment they had provided evidence to confirm appropriate registration with

their professional body, The General Medical Council (GMC), and confirmation of eligibility to practice general medicine via the NHS England Performers List for GPs. There was also evidence of a DBS check.

We noted that in the staff file for the nurse, there was evidence that registration with the NMC had been checked. However this had expired on 31 July 2014 and no up to date check had been made. The nurse told us that this was checked during appraisal; however there was no documentary evidence on site to confirm this. The practice manager told us that she relied on the nurse to tell her if there was a problem with the NMC registration. Similarly with the locum GP, the practice relied on information provided by the GP about registration. No separate check was made by the practice. This increased the risk of registration lapsing for those staff who could only provide care and treatment whilst registered with a professional body.

Dealing with Emergencies

We looked at the log book for emergency medicines maintained in the practice. We saw that these were checked to ensure they remained in date and suitable and safe to use.

We looked at the emergency disaster and contingency plan. We saw it identified alternative premises in the case of an emergency. However it did not contain any of the telephone numbers which might be needed in an emergency, such as, the utility providers for the practice, who to contact in case of a suspected escape of gas or flood or local non urgent emergency services. There was only one copy of the plan in existence and this was kept in the Practice Managers room. This increased the risk that staff would not know what to do in the event of an emergency, as the plan could be destroyed or otherwise unobtainable in the event of an emergency.

Equipment

All equipment was checked and calibrated on a yearly basis. We saw evidence that these checks took place. The practice manager had a forward planner to ensure equipment was checked at the correct frequency and time.

The practice manager told us she carried out an annual walk around the premises to assess whether it complied with health and safety requirements. However there was no documentary evidence available to confirm this.

We looked at the arrangements in place to protect against the risks associated with fire. We were concerned that these did not meet best practice for fire detection and prevention. Therefore, we shared this information with the local fire and rescue service. Following our inspection, Tyne and Wear Fire and Rescue Service visited the practice to review the arrangements. They confirmed, after their visit, the practice had satisfactory arrangements in place and made some suggestions to the practice as to how they could improve. The practice had been unaware at the time of our visit they had a fire alarm installed. As part of the fire and rescue service visit, they confirmed the emergency lighting and sprinkler system incorporated a fire alarm system and made some suggestions about regular testing of this system.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

We found care and treatment took account of recognised best practice standards and guidelines. We saw that staff carried out assessments of patients which covered their health care needs.

Both doctors we spoke with told us the EMIS web software helped them adopt best practice guidelines, as the system incorporates National Institute for Health and Care Excellence (NICE) endorsed templates to guide diagnosis, care and treatment. The 'Script Switch' software, also provided in built guidance on prescription of medicines. This provided doctors with information from NICE on cost and effectiveness of drugs.

We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where patients were booked in for review appointments. This ensured patients had routine tests, such as blood or spirometry (lung function) tests to monitor their condition. The IT system used by the practice nurse allowed them to identify if a patient had multiple conditions. Therefore, all long term conditions could be reviewed at the same time, rather than needing separate reviews for each condition.

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

Management, monitoring and improving outcomes for people

Although the practice told us there were processes in place to monitor and improve outcomes for patients, we found no documentary evidence of completed audit cycles or evidence of where they had used available information to improve outcomes for patients. The practice offered smoking cessation sessions. However, the practice was ranked below average in relation smoking cessation advice within the General Practice Outcome Standards (GPOS). GPOS were developed by clinicians in collaboration with the London wide Local Medical Committees (LMCs), NHS London, and Commissioners as an agreed approach to improve quality. The practice also performed worse than other practices in relation to asthma diagnosis and had lower levels of dementia and cancer diagnosis. The GP was unaware of much of this data and was unable to give a reason why the practice was an outlier for these indicators.

Although the practice had higher than average nonsteroidal anti-inflammatory drug (NSAID) prescribing rates, the GP told us this was being addressed. He told us this was based on historic data from 2012-13 and the latest data demonstrated that the practice had significantly improved their prescribing rates. Spend on NSAID within the year was £144.36 per 1000 patients. This was well above average for the local Clinical Commissioning Group (CCG) and was also the highest in the North East. However due to lack of documented evidence, it was unclear whether the improvements that had been achieved were a consequence of action taken by the practice.

The practice nurse and health care assistant reviewed QOF and used this as an audit of their practice. However, there was no documentary evidence to confirm this. They told us patients who did not attend for vaccination, inoculations and cervical cytology were contacted three times to encourage patient attendance.

Staffing

We spoke with the GP about how he ensured that he kept his medical practice up to date. He told us he attended most of the clinical training sessions provided by Sunderland CCG, called 'Time In Time Out' (TITO). He gave us examples of topics covered during these sessions including ear, nose and throat (ENT), gastroenterology and a session on GP 'hot' topics.

The practice nurse told us that she had protected time for training. She said comprehensive practice nurse education was provided by the local CCG. This included accredited training, and three yearly updates on vaccination and immunisation, cervical cytology and ear care (syringing). There was also an update on smoking cessation, which the healthcare assistant also attended on a yearly basis. She told us she also attended a well-led practice nurse forum within the local area.

The practice nurse had been trained to level three in safeguarding for children and young people.

Are services effective?

(for example, treatment is effective)

The practice nurse told us she received yearly appraisals from the GP. However, the practice were unable to provide documentary evidence of this, as the appraisal documents were stored in another practice owned by the GP.

We spoke with the practice manager about regular appraisal sessions for other staff. She told us that appraisals had not occurred for the last two years, although this was something she planned to address. However there were no specific plans in place as to how the practice would address this shortfall.

There was mixed feedback from other staff in relation to the support given to attend training. Some staff told us they had been well supported to attend training relating to the new clinical IT system. Whereas other staff told us they had not received training for quite a while and felt that some training in some areas, such as safeguarding, had been neglected.

We looked at staff training records for four staff members and this confirmed that feedback given by staff. For some staff there was evidence that they had attended a number of training courses and had opportunities to keep their skills and experience up to date. However, for other staff there was little evidence to demonstrate they had attended training.

Working with other services

The GP and the practice manager told us that there were quarterly extended practice meetings with the multi-disciplinary team within the locality. Other health and social care professionals usually attended this, such as the attached district nurse and social worker. We saw notes of meetings, which confirmed these took place. This helped to share important information about patients including those who were most vulnerable and high risk.

Staff also told us how they engaged in regular meetings with other practice staff from across the locality to discuss issues and share good practice. However, we found no evidence to demonstrate where the practice had learnt from others in the local area and made improvements as a result. The practice did not take a reflective and learning approach to implementing best practice from other practices in the local area.

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

They told us that all patient letters from consultants and specialists were first seen by the doctor. Necessary actions from these were identified and carried out. The letters were then administratively coded and scanned onto the clinical records.

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

The practice manager told us that they had made their treatment and consultation rooms available to other health and care providers, such as Community Psychiatric Services and the mental health charity Mind. This ensured that patients could access other sources of support and help in their local community.

Health, promotion and prevention

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

We looked at the new patient registration process. We found the registration forms had questions about social needs and people who were at risk of abuse. This was followed up by the practice nurse as part of the new patient check. The new patient health check also included identification of smoking status and identified if a patient acted as a carer for anyone.

There was information available to support patients who planned to travel to help plan the healthcare they would need to keep them safe, such as travel vaccinations.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with nine patients on the day of the inspection. Before the inspection CQC comment cards were also left in the reception waiting rooms for patients to feedback to us their experience of the surgery. We received 13 responses. Most patients reported that staff were caring and responsive to their needs. However some patients did share with us that they were sometimes kept waiting for appointments for an unacceptable amount of time past the appointment time they were given, and this was sometimes in excess of 40 minutes. This feedback had also been identified in the practice's own patient survey. We asked the practice manager and the lead GP about this, but they were unable to demonstrate that an action plan had been put in place to address these concerns. A small number of patients also fed back that sometimes they felt the doctor did not listen to them and they felt rushed through a consultation.

We looked at data from the National GP Patient Survey data for January to September 2013. This demonstrated that patients were overall satisfied with the practice. In particular the practice performed better than comparators on the helpfulness of reception staff, the experience of making an appointment, how easy it was to get through to someone and being able to get an appointment with a GP or nurse. They performed slightly better than comparative practices on experience of treatment by the nurse and being listened to by the GP.

We saw the practice had processes in place to identify and record where someone was a carer.

We spoke with the lead GP about coordination and integration of care, in particular in relation to patients reaching the end of their life. The GP told us they made sure that patients experienced integrated care by recording notes about their care and treatment needs and by sharing this with the local out of hours provider. This ensured continuity of care.

We saw a number of leaflets were available in the reception area to signpost people receiving end of life care, their families and loved ones or the recently bereaved, to sources of support.

Involvement in decisions and consent

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

Patients reported being involved in decision making and being supported to make decisions. Where the GP carried out minor surgery within the practice, patients signed a form to indicate their consent to the treatment.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice manager and the GP oversaw the appointment system. The practice offered online booking of appointments; however they told us there had only been a small number of patients who had taken this up.

Staff told us they had access to an interpretation service via telephone or could arrange an interpreter to attend the premises with 24 hours' notice.

If a patient required a home visit, they were advised to contact the practice by 11:30 to request this. Where a patient was noted as receiving chemotherapy, palliative care or noted as at risk the practice told us that there was more flexibility in requesting home visits.

Patients could use email to request repeat prescriptions or ask medical queries. However, staff told us not many patients used this service. We found that patients were given choice in how they accessed primary medical services from the practice. A range of appointment times and types were available to meet patient need.

Staff told us they had not received training on equality and diversity. However, the practice manager believed that as the patient population was small staff understood the needs of the local population well and did their best to assist people.

We discussed with the practice manager how they complied with the Disability Discrimination Act. We also looked at the risk assessment and audit in place, and the adjustments made by the practice to ensure people with disabilities were able to access and use the service.

However, we found that arrangements in place to ensure easy access for those with physical disabilities were inadequate. Although a risk assessment had been carried out we found it failed to identify and address the barriers to some patient and visitors with disabilities being able to safely and easily access the building. The pathway up to the entrance of the building was uneven and caused a trip hazards for patients. The door way itself was narrow and we saw it was often blocked by cars parked around the surgery. The door to the practice was heavy and there was a tight right turn to reach the reception and waiting area. This could make the building difficult for those with mobility difficulties to access independently, particularly those patients who use wheelchairs. There was no bell or alert system to enable patients to let reception staff know when they were having difficulty accessing the building.

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

Access to the service

Patients told us they had no problems in accessing appointments and were usually able to get appointments quite quickly.

Staff told us for those patients who need urgent medical advice, two appointments were kept open every day to request. If these urgent appointments had been filled, staff told us the doctor would endeavour to see patients at the end of surgeries.

They also told us that routine appointments were normally available to book within 48 to 72 hours. Staff offered people the alternative of attending a walk in centre if they were unhappy with the length of time till they could get an appointment. The patients we spoke with and comment cards we received confirmed that patients were able to make appointments easily.

The out of hours service was advertised on the practice door and via a recorded message on the answer machine, which was switched on out of hours. There was also a walk in centre at the Galleries at Washington not far from the practice.

Patients accessed the results of tests by calling the surgery after 1.30pm or by calling into the surgery. Staff told us that the GP reviewed test results before they were given to the patient.

Concerns and complaints

The practice manager told us they had not received any complaints. We saw the practice had a policy in place as to how they would handle complaints. This stated that they would keep a record of all complaints whether verbal or

Are services responsive to people's needs?

(for example, to feedback?)

written. Staff told us that patients had made some verbal complaints about being kept waiting for appointments, but none had been willing to put their concerns in writing. We saw that none of these discussions had been recorded.

Patients also shared concerns with us about being kept waiting for appointments, both when we spoke with patients on the day of the inspection and also within the CQC comment cards. This was also a theme the practice had identified through their patient survey. However we saw no evidence to demonstrate the practice had taken steps to address this issue.

Are services well-led?

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

Our findings

Leadership and culture

We found the practice did not have a formal business plan in place.

We found that there was a lack of clear leadership and vision within the practice that was shared by all staff. There was no defined set of policies and procedures to define the way the practice operated. Similarly we found the practice did not plan to improve quality. We found the practice was unable to identify those areas it was good at and was unclear about the areas where it needed to improve. Although audits had been carried out, these were not documented and did not form part of a practice wide approach to quality.

Governance arrangements

There were no clear governance arrangements in place. There were no links between audits, incidents and learning leading to improved quality of service.

Staff told us that the lead GP and the practice nurse worked together and had regular meetings to discuss performance against QOF standards. However, there was no documentary evidence to support this. There were no systems in place to learn from significant events, complaints or clinical audit.

Systems to monitor and improve quality and improvement

The GP described to us the audit he had undertaken on hypothyroid patients in 2013. He described the audit process as three months review, suggested changes to the policy and a repeat cycle to assess change implementation. However he was unable to provide documentary evidence of this audit process. More up to date data was not available to confirm improvements. He told us that they had performed thyroid function test on 96 of 103 patients. The Locum GP had undertaken an audit of prescribing Citalopram, an anti-depressant, but confirmed that no practice wide audits had taken place

Patient experience and involvement

The practice did not have a patient participation group (PPG). The lead GP and practice manager told us that they had tried to encourage patients to be involved in a group, but none had come forward so far. We asked if the practice had considered whether a virtual group would encourage more patients to be involved. They told us they had not considered this.

The practice had undertaken a patient survey in November 2013. There were 80 questionnaires distributed and 74 completed questionnaires were returned. Feedback included that people wanted better arrangements for car parking, they wanted more than one night late surgery, they suggested the provision of tea/coffee facilities in the waiting room and for the doctor to start on time and not keep patient waiting. There was no evidence that the practice had used the results of this survey to improve the quality of service provided within the practice.

There was no patient comment box in place at the time of out inspection. The practice manager told us they had previously had one, but this had gone missing when the reception and waiting area was redecorated. They told us they planned to put one in place following our inspection.

Staff engagement and involvement

Staff told us that practice wide team meetings were infrequent, happened on an ad hoc basis, and no notes were taken. This led some staff to feel isolated and less informed about the practice as a whole.

The GP told us he had regular informal meetings on Mondays or Tuesdays with the part time locum GP, as these were the only occasions in the week that their practice attendances coincided.

The practice manager told us that there were regular weekly practice meetings with the GP, the practice nurse and practice manager. The practice manager also told us that she met with the GP on a weekly basis. There were no agendas or notes available of these meetings to determine that they took place and what areas of practice were discussed.

Staff told us a communication book was maintained at reception to facilitate the passing of message between staff. However there was no check made to ensure the relevant staff had read and taken action in relation to messages left in the book.

Staff reported to us that they felt able to raise concerns with the practice manager. However they were not always confident that something would be done to address any concerns they raised.

Are services well-led?

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

Learning and improvement

We found that because quality improvement and governance arrangements were unclear, the practice did not actively encourage learning and improvement from feedback, audits and significant events. The lead GP demonstrated a lack of knowledge about how high performing practices continually review and plan for quality improvements. We found staff did not have clear objectives focussed on the improvement of the surgery.

Some staff reported that they felt isolated and that there were problems with clear communication across the practice.

We found the practice did not use the information available to it to learn and improve the quality of care and service it offered. There was a lack of evidence as to how they had listened to patients and staff to identify and address areas for improvement.

Identification and management of risk

The practice's approach to identifying and managing risk was variable. We did see some evidence that risk assessments, audits and checks were used to identify risk. However there was evidence that some of these failed to pick up risks, such as access arrangements to the building. We also found no evidence of action planning to lead to improved quality of service

Older people

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

Our findings

The service made appropriate provision across the practice to ensure the service for older people was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led. This is because the areas that required improvements for safe, effective, responsive and well-led, also applied to all the population groups.

Safe

Although staff demonstrated that they had an understanding of the indicators of abuse and would take action if abuse was suspected, some staff were unclear about whether the practices had its own policies and procedures and the formal procedures to follow if abuse was suspected.

An audit trail was maintained of any prescriptions issued to older frail patients who were unable to pick up their own prescriptions from the surgery. This provided a clear audit where prescriptions were picked up from the surgery by the patients' own community pharmacies.

Effective

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

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

The GP told us that there was care planning in place for older people who were most at risk of deteriorating health. The practice told us they worked closely with the community matron and district nurses for elderly patients who were housebound, other vulnerable older patients and their carers.

Responsive

There was access to a range of appointments to meet the needs of this population group, for example home visits or telephone appointments as appropriate. Greater flexibility was shown for those most at risk, such as those receiving palliative care.

People with long term conditions

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

Our findings

The service made appropriate provision to ensure the service for people with long term conditions was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led. This was because the areas that required improvements for safe, effective, responsive and well-led overall, also applied to all the population groups.

Effective

The practice nurse held regular chronic disease management clinics to review and monitor patients with long term conditions and give relevant support where needed. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their conditions. There was care planning in place for those patients whose long term conditions for those who were most at risk of deteriorating health and whose conditions were less well controlled.

Where patients did not attend a review appointment for their long term conditions, the practice would contact them three times to arrange further appointments to give patients the opportunity to attend an appointment.

The IT system used by the practice allowed staff to identify if a patient had multiple long term conditions. This meant all such conditions could be reviewed at the same time, rather than needing a separate review for each one.

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

The practice reported that there was good access to secondary health services, such as a diabetes specialist nurse and a respiratory nurse specialist.

The practice was identified as having a lower level of diagnosis of asthma than comparator practices, and this had been identified as a trigger for further investigation. We spoke with the GP about this, but he was unaware of this data and was unable to give us a reason as to why they were performing differently to other practices.

Responsive

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

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

Staff told us for those patients who need urgent medical advice, two appointments are kept open every day to request. If these urgent appointments had been filled, staff told us the doctor would endeavour to see patients at the end of surgeries. They also told us that routine appointments were normally available to book within 48 to 72 hours.

Mothers, babies, children and young people

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

Our findings

The service made appropriate provision to ensure the service for mothers, babies, children and young people was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led. This was because the areas that required improvements for safe, effective, responsive and well-led overall, also applied to all the population groups.

Safe

Although staff demonstrated that they had an understanding of the indicators of abuse and would take action if abuse was suspected, some staff were unclear about whether the practices had its own policies and procedures and the formal procedures to follow if abuse was suspected. Staff had access to contact details for child protection teams.

Effective

Staff told us that due to the size of the patient population it would not be economical to provide midwifery services at the practice. Therefore any female patient who became pregnant would be referred to book in with the midwife at the nearest local service. For the practice this was normally at the Victoria Road Health Centre which is approximately three and a half miles from Harraton Surgery.

The GP told us that pregnant women were offered the pertussis or whooping cough vaccine. As babies who are too young to start their vaccinations are at greatest risk, this vaccine can help protect against the risk of very young babies getting this disease.

There were regular baby clinics held in the practice to give parents and their young children access to a vaccine service and advice as necessary. Six week baby checks were carried out and health and development checks were undertaken as appropriate. Women were offered six week post-natal health checks to ensure their health and wellbeing after giving birth.

Responsive

We found that the practice responded to the needs of parents, babies, children and young people. The appointments system meant that they were able to attend the practice at a time that suited them. Appointments were available outside school hours.

The practice offered access to advice and support with sexual health for young people. The GP told us that the practice promoted good sexual health by having condoms readily available in the practice and access to chlamydia testing.

Working age people (and those recently retired)

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

Our findings

The service made appropriate provision to ensure the service for the working-age population and those recently retired was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led. This was because the areas that required improvements for safe, effective, responsive and well-led overall, also applied to all the population groups.

Responsive

We found that the practice responded to the needs of working age patients. The appointments system meant that they were able to attend the practice at a time that suited them. Appointments were available from 8am and after 5pm. There was a late night surgery on a Wednesday to give additional options for attending an appointment outside normal working hours. Telephone appointments were also available for those who would find it difficult to attend an appointment in the surgery due to work commitments.

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

Effective

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

The practice offered smoking cessation sessions. However, the practice was identified as an outlier on smoking cessation advice on the General Practice Outcome Standards (GPOS). The practice was unable to give a reason why they were an outlier for this indicator.

There was information available to support patients who planned to travel to help plan the healthcare they would need to keep them safe, such as travel vaccinations. There were also general information leaflets available for patients who had recently retired to direct them to other sources of advice, support and information. For example there was information available from Age UK and Village Communities.

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

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

Our findings

The service made appropriate provision to ensure the service for people in vulnerable circumstances who may have poor access to primary care was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led. This was because the areas that required improvements for safe, effective, responsive and well-led overall, also applied to all the population groups.

Responsive

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

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

We found that the practice had not sufficiently considered the needs of those people with physical disabilities who might have problems in accessing the building.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The service made appropriate provision to ensure the service for people experiencing poor mental health was caring. However further improvements were required to make sure the practice was safe, effective, responsive and well-led. This was because the areas that required improvements for safe, effective, responsive and well-led overall, also applied to all the population groups.

Responsive

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

Similarly, a counsellor from the mental health organisation, Mind, used a consultation room in the practice to enable them to see patients closer to home. The GP told us that patients were able to self-refer themselves to Mind to access this service. We saw there was information available about this service within the GP surgery.

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

Effective

The practice reported that they had access to services provided by the local crisis team if a patient presented at the surgery with a mental health crisis.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have effective systems in place to effectively assess and monitor the quality of the service provided and the processes to identify assess and manage risks were not effective. The provider did not take regard of the complaints, comments and views of patients in assessing and improving the quality of service. Regulation 10 (1) (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider did not have suitable arrangements in place to ensure all staff responded appropriately to any safeguarding concern and reported any safeguarding concerns to the appropriate body.** **Regulation 11 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider did not protect staff, patients and visitors from the risks associated with unsafe or unsuitable premises.** **Regulation 15 (1)**