Care Quality Commission

Inspection Evidence Table

Cramlington Medical Group (1-2138647930)

Inspection date: 16 July 2019

Date of data download: 01 July 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/2018.

Effective Rating: Good

Following our previous inspection in November 2017, the practice was rated as requires improvement for providing effective services because:

- Outcomes for patients were lower than the local clinical commissioning group (CCG) and national averages.
- A rigorous system was not in place for recording and monitoring the training staff required to carry out their role.

During this inspection, we found the practice:

- Introduced a rigorous system for recording and monitoring staff training.
- Improved their overall Quality and Outcomes Framework (QOF) achievement from a low baseline of 84%, for 2015/16, when Northumbria Primary Care Limited became the service provider in 2015, to 100% for, 2017/18. However, the practice's overall exception reporting rate, for the 2017/18 QOF year, was higher than both the local CCG and national averages. Unverified, unpublished QOF data, for 2018/19, indicated exception reporting levels for the majority of clinical indicators which were previously twice the national average, had reduced, in some cases significantly, whilst patient register numbers had remained similar over both QOF years.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up	Y

in a timely and appropriate way.	
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	0.22	0.55	0.77	Variation (positive)

Older people

Population group rating: Good

Findings

- The practice used a risk profiling tool, to help them identify those patients at greatest risk.
- The practice held regular multidisciplinary meetings in line with their meetings programme. Staff used these meetings to review the needs of older patients and patients with complex needs.
- Arrangements had been put in place to support effective care planning. Emergency health care plans had been completed for those patients considered to be most at risk.
- 15-minute appointment slots were available for patients with the most complex needs.
- Older patients were offered opportunities for immunisations as part of the practice's vaccination programme.
- The practice followed up older patients discharged from hospital. The provider's frailty nurse ensured care plans and prescriptions were updated to reflect any extra or changed needs.
- Health checks were offered to patients over 75 years of age who had not had one during the previous four years.
- Influenza, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Staff had appropriate knowledge of treating older people, including their psychological, mental and communication needs.
- The link GP for the local care home held a weekly ward round and worked collaboratively with other health professionals such as the local care of the elderly consultant and the provider's specialist frailty nurse, to review the needs of the patients living there. Clinical staff used a best practice tool, to help them communicate effectively with their patients.

People with long-term conditions Population group rating: Good

Findings

- Housebound patients could have an influenza vaccination in their own home.
- Practice leads had been identified for the key long-term conditions, to help promote leadership and expertise.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation (AF) and hypertension.
- Weekly meetings, involving a GP and a nurse, took place to review the needs of patients with diabetes.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.
- GPs followed up patients who had received treatment for an acute exacerbation of asthma at hospital or the local out-of-hours service.
- Clinical staff actively collaborated with other health and care professionals, to deliver a coordinated package of care to patients with the most complex needs.
- Staff who were responsible for reviews of patients with long-term conditions had received, or plans were in place for them to receive, relevant training.
- The practice's QOF achievement, for 2017/18, demonstrated how they had improved patient outcomes overall. However, the overall exception reporting rate, for the 2017/18 QOF year, was higher than both the local CCG and national averages. Unverified, unpublished QOF data, for 2018/19, indicated exception reporting levels for the majority of clinical indicators which were previously twice the national average, had reduced, in some cases significantly, whilst patient register numbers had remained similar over both QOF years.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	87.4%	83.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	29.6% (107)	16.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	79.3%	80.1%	77.7%	No statistical variation
Exception rate (number of exceptions).	35.7% (129)	12.0%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on	82.4%	80.6%	80.1%	No statistical

the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)				variation
Exception rate (number of exceptions).	27.4% (99)	17.4%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	82.4%	75.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	16.8% (62)	8.5%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.1%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	24.5% (40)	13.5%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	83.5%	83.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	13.5% (121)	4.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	90.9%	85.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	15.4% (16)	7.1%	6.7%	N/A

Any additional evidence or comments

- The Quality and Outcomes Framework (QOF) is a programme for GP surgeries focussed on incentivising and tracking good practice in a number of areas, called indicators. Exception reporting is the exclusion of some patients from particular indicators, where the practice has appropriate reasons to do so. For example, due to the patient's personal circumstances or choice. Prior to the inspection, we noted that exception reporting against the following indicators was higher than we would expect: asthma review; COPD review; stroke prevention; high blood

pressure management; diabetes - blood pressure reading; diabetes – cholesterol; diabetes - managing blood glucose level; mental health care planning.

- As a result of the practice's higher than average exception reporting rates, leaders continued to take steps to improve and strengthen their patient recall and QOF monitoring systems and processes. The practice operated a 'Year of Care' patient recall system for patients with long-term conditions (LTCs), with patients being sent three letters inviting them to attend for an appointment. Patients with learning disabilities, and/or sensory impairments, were sent invitations in a large print format, and/or they were contacted by telephone. The practice's weekly team meeting included a QOF agenda item, to help monitor ongoing progress against targets. Leaders used an internal IT tool to monitor their QOF performance on a weekly basis. Arrangements were in place to closely monitor clinical indicators which had to be met within specific timescales. Designated staff were responsible for making sure non-attenders were followed up. A standard operating procedure had been set up, to help provide staff with clear guidance about how to manage patients with LTCs who declined to be monitored.
- Following the inspection, the provider sent us audit information which demonstrated that staff had recorded the reasons why patients had been excepted. They also confirmed that patients were only excepted by a clinician who was familiar with their health needs.
- The provider shared unverified, unpublished QOF data, for 2018/19, which indicated there had been a reduction in the numbers of patients excepted for most of the clinical indicators where exception reporting rates had been higher than the national averages. For example:

  - The number of patients excepted for the diabetes – managing blood glucose level clinical indicator had reduced from 107 patients (2017/18 QOF year), to 65 patients (2018/19 OQF year).

  - The numbers of patients excepted for the high blood pressure management clinical indicator had reduced from 121 patients (2017/18 QOF year), to 61 patients (2018/19 QOF year).

  Leaders assured us that the number of patients with the above clinical conditions were broadly the same for each of the QOF years, i.e. 2017/18 and 2018/19. Leaders also said the number of patients with the following clinical conditions were also similar for both QOF years: COPD review; stroke prevention; diabetes - blood pressure reading; diabetes – cholesterol; mental health care planning.

Families, children and young people Population group rating: Good

Findings

The practice:

- Had a designated safeguarding lead who provided expertise and leadership, to help ensure there was a co-ordinated response to concerns about vulnerable patients at risk of harm. Monthly safeguarding meetings, involving health visitor staff, were held to share information about vulnerable children and adults who were at risk.
- Was working on a project to help identify younger patients who were also carers. They had also carried out a survey to obtain feedback regarding the needs of this particular group of patients.

- Carried out childhood immunisations in line with the national childhood vaccination programme. The childhood immunisation indicators, for vaccines given to children aged two and under, referred to in this evidence table, show the practice's uptake rates were above the World Health Organisation targets.
- Provided weekly ante-natal clinics at the surgery and clinicians also completed the post-natal six-week check for new mothers.
- Had arrangements to identify and review the treatment of women who were on long-term medicines. These included carrying out an initial audit in response to the original safety alert, to make sure women of child-bearing age who were taking a medicine associated with a significant risk of birth defects, had a pregnancy programme in place. A follow up audit was carried out in 2018. Subsequently, the provider introduced a rigorous quality checking system, to alert staff of the need to monitor patients taking a medicine that could cause birth defects.
- Had arrangements for following up children who failed to attend appointments.
- Offered family planning services, and clinical staff were able to refer patients to the local family planning clinic. These arrangements helped ensure young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	44	44	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	32	32	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	32	32	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	32	32	100.0%	Met 95% WHO based target (significant variation positive)

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice's uptake rate for breast screening was above the local CCG and the national averages. The uptake rate for bowel cancer screening was above the national average, but below the local CCG average.
- The practice had arrangements in place for informing eligible patients, such as students attending university for the first time, to have a meningitis vaccination.
- Patients had access to appropriate health assessments and checks, including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcomes, where abnormalities or risk factors were identified.
- Patients could book or cancel appointments and order repeat medication online.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	73.2%	77.9%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	79.8%	78.1%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	56.8%	64.7%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	65.6%	66.1%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	47.2%	46.6%	51.9%	No statistical variation

Any additional evidence or comments

The practice's uptake of cervical screening was 73.2%, which was below the 80% target of the national screening programme (Public Health England). The practice was aware their cervical screening performance was below the target and had implemented a range of initiatives to help improve their performance. These included:

- The introduction of an internal system to monitor attendance levels. A designated member of the

administrative team carried out regular searches of the national database, to identify patients who had failed to respond to requests to make an appointment, to undergo cervical screening. All these patients received a personal telephone invitation to contact the surgery to make an appointment. Where contact had been unsuccessful, patients were then sent a 'pink' paper recall letter, encouraging them to attend for cervical screening.

- The setting up of a computer prompt to remind reception staff to opportunistically encourage women to book a cervical screening appointment.
- The practice seeking advice from the Jo's Cervical Cancer Trust, about how to improve patient attendance levels. In response, staff had recently held a coffee morning to raise patient awareness.

Leaders told us checks of the national cervical screening system indicated that the practice's approach was beginning to reduce the number of patients failing to attend their cervical screening appointments.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End-of-life care was delivered in a coordinated way, which took account of the needs of those whose circumstances may make them vulnerable.
- The practice offered annual health checks to patients with a learning disability. Arrangements were in place to minimise the use of psychotropic medicines, this included the use of a template prompt encouraging clinical staff to do this.
- The practice had arrangements in place for vaccinating patients who had an underlying medical condition, in line with the recommended schedule. As part of the practice's preparation for the influenza season, searches were carried out to identify and target 'at-risk' patients.
- The practice demonstrated they had a system to identify people who misused substances.
- Patients identified as being vulnerable had been targeted, as part of the practice's clinical summarising project, to make sure their medical record summary was accurate and up-to-date. The practice operated a system which enabled staff to add vulnerable patients to a 'waiting list', resulting in them being highlighted as a priority for the clinical summarising project.
- Patients identified as being vulnerable were able to benefit from access to 15-minute appointments.
- As part of the practice's winter planning arrangements, where resources allowed, the nurse practitioner carried out earlier home visits to vulnerable patients on their register.
- Arrangements for reviewing the needs of palliative care patients had been improved. Clinical staff had carried out a preferred place of death audit, to help ensure patients' wishes had been documented. Patients had access to a surgery by-pass number to provide them with easier access to clinical advice and support.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice's performance, in relation to two of the mental health indicators (mental health care planning and recording of alcohol consumption), was better than the local CCG and national averages. In relation to care planning for patients with dementia, their performance was comparable with the local CCG and national averages.
- The practice provided annual mental health reviews for patients who had a mental illness and clinicians used these to assess and monitor their physical health.
- Patients could access smoking cessation advice at the practice. Patients identified as smokers were offered nicotine replacement therapy products as well as a referral for ongoing support.
- Patients at risk of dementia were identified and offered an assessment, to detect possible signs of dementia. The practice used the Dementia Quality Toolkit in their clinical system, to help support the identification of patients with a potential missed dementia diagnosis. When dementia was suspected, there was an appropriate referral for diagnosis. The practice's emergency health care plan template had recently been updated, to include a prompt to consider carrying out a Mental Capacity Act assessment.
- A local community service provider followed up patients who failed to attend for the administration of long-term medication, and patients who were misusing substances.
- All staff had received dementia awareness training.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.1%	89.5%	Variation (positive)
Exception rate (number of exceptions).	41.1% (23)	17.8%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.8%	90.0%	Variation (positive)
Exception rate (number of exceptions).	12.5% (7)	12.4%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	89.6%	81.9%	83.0%	No statistical variation

Exception rate (number of exceptions).	11.8% (9)	7.0%	6.6%	N/A

Any additional evidence or comments

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	549.9	537.5
Overall QOF score (as a percentage of maximum)	100.0%	98.4%	96.2%
Overall QOF exception reporting (all domains)	13.7%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.1&2	Y
Quality improvement activity was targeted at the areas where there were concerns.3	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. 4	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice had an extensive library of clinical audits and quality improvement activities, consisting of 'core' provider audits, we well as those that had been carried out in response to internal incidents, events and areas identified as requiring improvement. For example:

1. The practice had taken action to reduce the numbers of patients prescribed high-risk benzodiazepines, opiates and gabapentinoids medicines. As part of the initial audit, clinicians had collaborated with Northumberland Recovery Partnership, to help plan how proposed changes would be implemented. Improvements made as a result of this initial audit included:

    - Drawing up of a set of 'difficult drugs rules' to help clinical staff prescribe in line with the updated prescribing policy.
    - Providing all practice staff with updates to the prescribing policy as well as training on how to manage challenging behaviours and difficult consultations.
    - Updating the locum GP pack to reflect the practice's revised prescribing policy.
    - The setting up of internal systems to help identify and monitor patients prescribed such medicines.
    - Implementing tighter medicine review recall systems.
    - The introduction of clinical templates and medicine agreements, to help clinical staff work

more effectively with patients.

The outcome of the second audit indicated that, following the improvements made by the practice, the overall number of acute and repeat prescriptions for these high-risk medicines had fallen. Improvements made by the practice are reflected in statistical data included in this evidence table. This indicates the practice's prescribing of hypnotics (drugs that can be used to treat insomnia) was well below the national average.

2. The practice had taken steps to improve their antibiotic stewardship systems and processes. Clinical staff had completed a sepsis recognition and action audit. This involved auditing the practice's systems and processes against the 'Ten Top Tips' in the Royal College General Practitioners' sepsis toolkit. As a result of the audit, improvements introduced included: the provision of training for clinical staff; the introduction of a sepsis template and use of an 'App' to support clinicians when making decisions about the prescribing of antibiotics; displaying visual prompts in the reception area; provision of additional equipment for the emergency boxes. A subsequent audit showed that improvements had been made in the use of the sepsis tool adopted by the practice. Leaders told us they planned to make further improvements in this area.

3. Following a serious untoward incident at the practice, clinical staff were concerned that patient records had not been accurately summarised by the previous provider. As a result, a sample of 50 sets of patient medical records were audited. This showed concerns regarding the quality of summarising in 40 of the 50 records examined. As a consequence, the provider updated their risk register and, in April 2018, the practice embarked on a Quality Summarising Project, employing and training two staff to carry out the role of clinical summariser. To date, out of approximately 5000+ medical records, 28% (1544) had been re-summarised. The records of patients considered to be the most vulnerable were initially prioritised, following a risk stratification exercise. To date, of those records re-summarised, no further concerns have been identified. [3]

4. The practice was concerned that they had higher than average hospital referral rates. In response, they introduced referral review meetings in November 2018. Leaders told us the practice's referral rates had dropped by a third.

5. The provider employed a specialist frailty nurse in August 2018, to undertake discharge reviews and carry out care planning, for patients admitted into secondary care across all their sites. The frailty nurse reviewed all of the practice's hospital discharges to ensure appropriate care plans had been put in place. As a result of the provider identifying acute kidney injury (AKI) as a major cause of admissions across all their sites, the frailty nurse had provided practice staff with training, to help reduce inappropriate hospital admissions.[4]

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample	Y

taking for the cervical screening programme.	
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. 1	Y
Staff had access to regular appraisals, mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.2	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses and pharmacists.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- During our previous inspection, in November 2016, we found the provider did not have a rigorous system in place for recording and monitoring the training staff required to carry out their role.
- During this inspection we found the practice was now using the NHS electronic staff record, to record and monitor when staff completed the provider's staff training programme. The practice team lead monitored the delivery of the staff training programme on a monthly basis, and provided feedback to the executive lead GP and the Northumbria Primary Care Limited executive team. Performance levels were closely monitored by the provider.
- The practice's recently recruited healthcare assistant was due to commence the Care Certificate training. They had already completed equivalent training in the army.1
- The provider was introducing arrangements to enable all of their GPs to receive in-house annual appraisals. All of the salaried GPs at the practice had undergone an annual appraisal with their responsible officer. The provider's nursing matron had developed and introduced a comprehensive nursing validation and competency tool, to help support the process of assessing the continuing competency of the practice's nursing staff. 2

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or	Y

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.[1]	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: • A new care plan template was being piloted at a local care home, to help clinicians improve how they recorded discussions with patients about their end-of-life needs, wishes and preferences. [1]	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	99.2%	95.2%	95.1%	Variation (positive)
Exception rate (number of exceptions).	2.1% (31)	0.7%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	N/A
Explanation of any answers and additional evidence:	

Well-led Rating: Outstanding

The practice was rated as outstanding for Well-Led because there was an embedded and systematic approach to improvement, which was improving patient safety. Leaders used improvement methods to deliver change, and to support development and innovation. Staff felt empowered to lead and deliver change.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.[1]	Y
Explanation of any answers and additional evidence: • The provider had arrangements in place to develop leadership at the practice. The executive GP had recently completed a strategic leadership course. There were plans in place for the other GPs to also complete leadership training. There was evidence other practice staff were encouraged and supported to develop. For example, administrative staff had received training to take on additional roles and responsibilities. Although we were not shown a specific succession plan for the practice, we were reassured that they now had stable leadership and a full complement of GPs in place. The provider told us they had in rigorous plans in place to ensure sufficient numbers of GPs at the practice. [1]	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities. [1]	Y
The vision, values and strategy were developed in collaboration with staff and patients.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.[2]	Y
Explanation of any answers and additional evidence: • The provider had a strong development plan in place, called 'You Said, We Did' which reflected	

the complex and challenging environments in which their practices operated. The provider was one of the finalists for the General Practice Awards in 2018, where they were recognised for the work they had undertaken with patients and staff, to deliver a five-year strategy designed to improve services. 1

- The practice had recently devised their own SMART action plan which clearly set out their priorities for the next two years. There was evidence of clear objectives as well as details of how progress would be measured. 1
- Strong arrangements were in place to monitor the practice's progress against the plan, and to identify areas for continual quality improvement. These included a full away-day for the provider's executive team and two half-day sessions for practice staff. The practice had also recently reviewed their team action plan at an education meeting.2

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.1	Partial
The practice had access to a Freedom to Speak Up Guardian.2	Partial
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

- The provider had a detailed whistleblowing policy, which provided their staff with clear guidance on how, and with whom, to raise concerns. The policy included information about how to access the local governance team and the NHS National Whistleblowing helpline. However, it made no reference to the NHS Improvement Raising Concerns (Whistleblowing) Policy, or how to access a Freedom to Speak Up Guardian. 1&2

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Non-clinical staff	Staff told us:

feedback	• When everyone was at work, there were enough staff on duty to provide safe, high-quality care. • They were required to complete mandatory training and that this was monitored by the practice team lead. • They had a good understanding of how to manage emergencies. • They received protected time to undertake learning. • They underwent a regular annual appraisal. • The provider took concerns raised by patients seriously. • The practice had a clear vision for the future. Most staff told us they had been involved in a planning event and had attended team meetings where they were encouraged to have their say. • There were clear roles and responsibilities, and they were aware of their expected contribution. • Their immediate manager: encouraged them at work; gave them clear feedback on the quality of their work; valued their work and communicated with them effectively about any incidents or changes affecting their work. • Staff worked well together and were supported by their manager, the GPs and the provider. Staff provided details of events they had supported that had helped to improve patient outcomes. For example, health awareness days and charity fundraising events. • The provider had an 'employee of the month' scheme, where a nominated member of staff would receive recognition via a certificate. (There were a number of such certificates in the administrative area at the time of the inspection.) • An exercise-bike in the administrative office provided staff with an opportunity to manage their stress levels.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	N/A
Explanation of any answers and additional evidence: • The practice had a structured meetings programme, which gave staff opportunities to reflect on and maximise learning, share experiences, bond as a team, manage patient risk and focus on quality improvement. • The provider had a full suite of policies and procedures, which staff were able to access via their desktop**.**	

- A strong governance system was in place to monitor the practice's QOF performance. This included: producing a daily performance report during the last six months of the QOF year, to help identify potential areas of concern and target resources; administrative staff telephoning vulnerable patients to personally invite them to attend for care and treatment; close monitoring of time-bound QOF clinical indicators, to ensure relevant timescales were met; requesting patients, via a poster in reception, to tell staff of any changes to their address or telephone numbers. However, although the level of exception reporting for some of the QOF clinical indicators was higher than the local CCG and national averages, leaders were taking steps to improve their patient recall and monitoring systems and processes.
- The practice made use of the local Safeguarding and Incident Risk Management System (SIRMS), to share information about incidents affecting the quality of care experienced by their patients.
- The practice had undergone an auditing process carried out by Northumbria Healthcare NHS Foundation Trust internal auditors, to review their complaints and incident processes. The practice was awarded a good rating and was found to have performed very well.
- A rigorous system was in place for responding to safety alerts.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.1	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.2	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place. 3	Y
Staff were trained in preparation for major incidents.3	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

- The practice had systems and processes for reporting on, and managing significant events, and for responding to complaints and, where necessary, learning from these to improve patient care. Complaint outcomes were monitored by the provider's executive board, and an annual complaints review was undertaken for all of the provider's practices to identify common themes and concerns, and review areas for learning and improvement. This system had been in operation for three years, and the provider had identified a reduction in the overall number of complaints they received. 1
- Practice management staff used the NHS Electronic Staff Record app, to help them manage staff safety more effectively. 1
- A rigorous recruitment process was in place, with all checks and monitoring being undertaken by Northumbria Healthcare NHS Foundation Trust.1

- Rigorous systems and quality control processes were in place to manage infection control.[1]
- The provider operated a 'Whats App' group, providing access at executive and management level. The 'app' enabled the practice management team to access advice and support, about issues affecting their daily performance and areas of risk that required prompt action. [3]
- The provider operated a group-wide risk register, to help manage the risks they faced as an organisation. The Cramlington team were able to contribute to discussions held at a provider level concerning risk issues affecting their practice.
- The provider implemented an annual Northumbria Primary Care Limited group-wide audit programme, which had been developed as a result of learning events across their seven practices. In addition to the practice's involvement in these audits, a range of local needs based clinical audits were also carried out each year.[3]
- The provider had a business continuity plan that covered all of their sites. Specialist emergency training was being provided to staff during 2019. [2&3]

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

- The provider held structured executive meetings, which included the lead GP from each practice. This enabled the lead GP at Cramlington to provide feedback on a range of performance issues, to help drive improvements such as: the practice's performance on the provider's risk dashboard; the GP survey results; training; and learning from significant events across the provider's locations.

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y

Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.[1]	Y

Explanation of any answers and additional evidence:

- GP and management representatives attended local clinical commissioning group (CCG) meetings and 'Resilience' sessions. (The General Practice Resilience Programme provides funding to support GP practices and builds resilience into the system).

- Staff were engaging with:

  - External organisations through their social prescribing project, to help provide their patients with better access to non-medical care. For example, an Asylum and Resettlement Officer had visited the practice, to help staff consider what extra resources they could provide to this group of patients. [1]

  - Their peers and other stakeholders to help develop their local Primary Care Network and provide patients with access to a wider range of primary care services. [1]

- The provider operated an 'Employee of the Month' initiative. Certificates confirming this were available in the administrative office.

Feedback from Patient Participation Group.

Feedback

Members of the patient participation group (PPG) told us:

- Plans were in place for them to meet regularly and the new (PPG) group included a good cross-section of patients, usually between eight and ten. Members told us their meetings were well chaired and that everybody was able to speak, ask questions and make suggestions. They said the practice kept them well informed and that there had been discussions about sharing complaints and incident information with members in the future.
- They were listened to as a group, and changes were made following their feedback. For example, members said that a large television screen had been placed in the reception area, to deliver important patient messages. They also said the privacy line at the reception desk had been re-painted, to help remind patients where to stand so those in front of them had privacy.
- The practice had a well-balanced group of staff, so they were able to meet patients' needs across the whole spectrum of ages. They told us they were very happy with the continuity of doctors, and pleased with the introduction of the nurse practitioner role.
- Staff were friendly and helpful.
- The appointment system worked well and staff were very responsive.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous

improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

- The provider, in collaboration with staff from their practices, had set up a clinical support unit, consisting of a clinical pharmacist and a medicines technician team. The leadership team at Cramlington Medical Group told us this had impacted greatly on patient safety. Improvements at the practice included: the provision of a dedicated group of staff to oversee and support the safety of the practice's prescribing systems; the introduction of a standardised template to support the work of the practice's healthcare assistant when taking blood samples; the setting up of a more effective system for monitoring patients prescribed high-risk medicines, including the checking of pathology results before re-prescribing took place. Audit activity confirmed that these initiatives had resulted in safer care and treatment.
- A health and well-being champion had been appointed, to make it easier to link with Northumbria Healthcare NHS Foundation Trust initiatives of benefit to the practice.
- Regular educational sessions were held, in response to internal and external events, covering topics such as: frailty; care planning; a screening toolkit to support better medicine reviews; admissions avoidance for patients with acute kidney injury, NICE chronic disease guidelines and emergency medicines.
- The practice operated a system of external clinical peer review, to help improve the quality of the services they delivered. Examples of reviews carried out to date included: palliative and diabetic care; quality care planning; referral management and safeguarding children. The practice was able to demonstrate improvements had been made as a result of these reviews.
- The practice had changed how they managed the needs of patients with diabetes. In particular, they had introduced weekly, GP supported, practice nurse meetings, where patients who were due to attend the practice that week, had their needs reviewed.
- The practice had improved their care planning arrangements, especially in relation to supporting vulnerable patients.
- The new leadership team had introduced a referral management system, to help them improve the effectiveness of their referrals and provide improved peer support.
- The practice had started a minor surgery service from the site, to help improve the care and treatment they provided to their patients. Improvements included the triaging of all musculoskeletal (MSK) referrals during the practice's weekly referral management meetings, and the development and implementation of a new MSK assessment/care planning template. Leaders told us they now had a GP who was a specialist in this area, who could administer steroid injections and provide clinical staff with a second opinion for any MSK issues.
- The practice identified that they needed to improve how they responded to the extra demands and challenges they faced during the winter period. As a result, they met with representatives of the local emergency hospital to identify shared issues and possible solutions. Subsequent

improvements included: the nursing team carrying out earlier home visits; collaborating with the provider's frailty nurse to carry out weekly reviews of all discharges; an improved emergency healthcare plan template; targeted use of 15-minute appointments for vulnerable patients using the local emergency department; taking steps to maximise use of locally available extended access appointments.

- The practice participated in, and led on, a local pilot to develop systems and processes to help protect children at risk of harm due to domestic abuse, mental ill-health and substance misuse.
- The provider supported the operation of a closed Facebook group, to deliver educational sessions, to help promote staff learning and skill development.
- Leadership staff have attended a 'Masterclass' appraisal training session, to help them deliver better quality appraisals.
- The practice has continued to develop and improve their children's safeguarding systems and processes. Following an external peer review, improvements and changes made included: an improved safeguarding team meeting format; holding separate meetings to review safeguarding issues for children aged under five; more collaborative work with the school nurse; the introduction of an internal waiting list for children under 5, to which any member of staff can add a concern; the introduction of an annual recall for 'looked-after' children; the implementation of an internal 'I have a concern' button, which allows clinicians to immediately document any potential safeguarding concerns they have, and forward them to the practice's safeguarding lead, for review and discussion; improved systems and processes for following up children who fail to attend planned appointments; better use of community services.
- The practice had participated in a local safeguarding pilot, to develop a process to help share information regarding fathers of unborn babies, who were not registered at the same practice as the mother.
- The practice had initiated an in-house, safe prescribing project, to help reduce the prescribing of a certain group of medicines that can result in dependence, misuse and opioid-related deaths. A specialist clinician, from a local recovery project, helped staff to develop an action plan which was being implemented at the time of the inspection. Staff have received training to help them manage patients who challenged the new approach to prescribing these medicines. Systems had been set up, to support clinicians to prescribe in line with the practice's action plan. Audits had been carried out to review progress. These demonstrated progress had been made in reducing opiate, gabapentinoid and benzodiazepine prescribing, which had previously been very high. Statistical data included in this evidence table indicated the practice's prescribing of hypnotics (drugs that can be used to treat insomnia) was well below the national average.
- The practice had taken action to ensure their historical patient record summaries were accurate by setting up a Quality Summarising Project. To date, out of approximately 5000+ medical records, 28% (1544) had been re-summarised.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.