

# Care Quality Commission

## Inspection Evidence Table

### Fiveways Health Centre (1-3833238553)

Inspection date: 06 June 2018

Date of data download: 07 June 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

## Safe

### Safety systems and processes

Safeguarding	Y/N
There was a lead member(s) of staff for safeguarding processes and procedures.	Y*
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y*
Policies were in place covering adult and child safeguarding.	Y*
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	N
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y*
Disclosure and Barring Service checks were undertaken where required	Y
Explanation of any 'No' answers:	
<ul style="list-style-type: none"><li>*There was a lead member of staff for safeguarding, however we were advised by the safeguarding lead that there were currently no active concerns regarding patients on the safeguarding register.</li><li>* There were systems and processes in place, but these had not become developed or embedded in the practice.</li><li>* Policies were in place covering adult and child safeguarding, however these had not been implemented appropriately.</li><li>There were no joint working arrangements in place with the health visiting service.</li><li>The practice had a system in place to highlight vulnerable patients, but on reviewing a sample of patients' records we found three safeguarding concerns that had not been acted on putting these patients at risk of harm.</li></ul>	

## Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	N
Comprehensive risk assessments were carried out for patients.	N
Risk management plans were developed in line with national guidance.	N
Staff knew how to respond to emergency situations.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
<p>Explanation of any answers:</p> <p>Some arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, but the practice relied heavily on long term locums including a locum practice nurse and the administration team to complete clinical administration tasks.</p> <p>The practice was unable to demonstrate that risk management plans and comprehensive risk assessments had been carried out for patients. The practice did not have an effective system to ensure all patients were adequately investigated, abnormal results were responded to and patients were prescribed the appropriate treatment. This placed patients at risk of having undiagnosed disease, untreated conditions and inadequate treatment. For example:</p> <ul style="list-style-type: none"> <li>On reviewing a sample of patients records we found two patients with longstanding medical conditions and we could find no evidence to support that the patients had received the appropriate treatment, investigations and medicines. The evidence highlighted that in August 2017 patients presenting with specific symptoms had not been investigated.</li> <li>Further evidence showed inadequate treatment had been identified for vitamin deficiency in December 2017 and evidence showed that national guidance had not been followed for the appropriate management of this condition.</li> </ul>	

## Information to deliver safe care and treatment

Questionsy	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	N
Referral letters contained specific information to allow appropriate and timely referrals.	N
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N

Explanation of any answers:

- We reviewed six patients' medical records and found a lack contemporaneous documentation during consultation to support delivery of the appropriate care and treatment and mitigate risk to patients. This included a lack of detail in the recording of history, examination, investigation and follow up of results and did not provide assurance that adequate care and treatment had been provided.
- We reviewed a total of 33 letters received by the practice between the 30 May 2018 and 01 June 2018 and found 13 had not been actioned appropriately. The system for ensuring full and accurate contemporaneous records was not effective, as clinicians did not have access to up to date medical history and accurate medicine records. From the 13 letters we reviewed we found three had not been clinically coded, therefore no information was available on the patients' records and one had been inappropriately coded giving inaccurate information.
- From two patients' records we reviewed we found failure to adequately investigate, respond to abnormal results and prescribe appropriate treatment for patients, putting them at risk of having undiagnosed disease, untreated conditions and inadequate treatment.
- On reviewing another two patients' records we found significant concerns in the lack of systems to ensure referrals had been made. The practice was unable to demonstrate a process to ensure all referrals were made in a timely manner, putting patients at risk of harm.
- We found patients with long term conditions had not received regular monitoring and follow up to ensure they were receiving the appropriate care and treatment. We reviewed three patient records and found significant failings in the management of their conditions to ensure the treatment they were receiving was still suitable.

## Appropriate and safe use of medicines

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y
<p>Explanation of any answers:</p> <p>The practice did not have an effective process in place to ensure the appropriate management of patients' medicines including changes made by other services. For example: On reviewing three patients records we found no action had been taken in response to requests by secondary care for medicines to be prescribed, no system to ensure patients who required urgent medicines were followed up and the prescribing of medicines that were contraindicated as causing potential risk to a patient had been prescribed.</p> <p>We reviewed a sample of patients' records that had prescriptions awaiting collection. This identified significant issues regarding the management of long term conditions and medicine reviews. The practice were unable to demonstrate an effective system to ensure prescribing and prescriptions were managed appropriately for the delivery of safe care and treatment.</p> <p>We found staff did not have the appropriate authorisation in place to administer medicines. For example: the health care assistant had signed patient group directives (PGD) for the administration of vaccines, for which they did not have the appropriate clinical qualification to do so. The practice were unable to demonstrate that they had a senior person to ensure only competent, qualified and trained professionals oversaw and followed the directions of the PGD.</p>	

## Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y*
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	N
<ul style="list-style-type: none"> <li>*The practice told us they had a system for recording and acting on significant events, however this was not embedded within the practice. On the day of inspection we were advised that not all significant events had been documented or discussed.</li> <li>We found evidence of a clinical significant event that had not been discussed with the team to ensure actions and learning were shared to mitigate future risk.</li> </ul>	

Example(s) of significant events recorded and actions by the practice;

Event	Specific action taken
Recorded significant event described how a diagnosis of diabetes had been delayed since 2010. The person concerned had attended for other appointments which showed further concerns that had not been acted on. This included requests from specialist services for the commencement of medicines.	<p><u>Action taken</u></p> <p>In April 2018 the practice had recorded the significant event and had spoken with the person concerned and advised what had happened with the delayed diagnosis of diabetes since 2010.</p> <p><u>Action not taken</u></p> <p>On further review of the patients' record we found no evidence of specific action that had taken place to ensure the patient had received the appropriate care and treatment. For example:</p> <ul style="list-style-type: none"> <li>From a consultation in April 2018 we were unable to find a record of specific details, including history and examination.</li> <li>Further reviews of the clinical records showed blood tests that had been taken where diabetic abnormalities had been identified, but no action had been taken. Failure to diagnose diabetes in a timely manner placed this patient at risk of complications associated with diabetes.</li> <li>Other blood tests highlighted further concerns, we found no evidence that these had been acted on.</li> <li>A request from a secondary care consultant to repeat blood tests and prescribe medicines had not been acted on. This placed the patient at risk of complications which could have a significant impact on their health.</li> </ul>

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y*
Staff understand how to deal with alerts	Y*
<p>At the previous inspection we highlighted concerns regarding the ineffective processes for the managing of safety alerts including MHRA alerts. At this inspection, we performed searches on the clinical system of two medicines that had recently been highlighted as causing issues requiring action and review. The register of alerts kept by the practice did not include these medicine alerts. We found the following:</p> <ul style="list-style-type: none"> <li>• A drug safety alert issued during the last 12 months for a medicine used to treat epilepsy and chronic pain, which highlighted that ‘it could be associated with respiratory depression particularly for certain at risk groups. We identified three patients who had been prescribed this medicine and also had underlying respiratory disease. We could find no evidence recorded in the patients’ records to suggest that the patients had been warned of the risks of respiratory depression associated with taking this medicine. In addition, the practice were unaware of this alert.</li> <li>• Another alert issued in the last 12 months highlighted a risk of depression and increased suicidal ideation associated with a medicine used for enlarged prostate or hair loss. When asked the practice were unaware of this alert and we could no evidence that searches had been done to identify affected patients. We undertook a search and six patients were identified. A sample of these records, four in total showed that the risks had not been discussed with the patient.</li> </ul>	

# Effective

## Effective needs assessment, care and treatment

Prescribing				
Indicator	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). <b>(01/07/2016 to 30/06/2017)</b> (NHSBSA)	1.48	No Data	0.90	Comparison not available

Diabetes Indicators				
Indicator	Practice performance	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 <b>(01/04/2016 to 31/03/2017)</b> (QOF)	79.4%	79.3%	79.5%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	24.9% (53)	11.1%	12.4%	
Indicator	Practice performance	CCG average	England average	England comparison
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 <b>(01/04/2016 to 31/03/2017)</b> (QOF)	83.5%	78.1%	78.1%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	11.7% (25)	8.8%	9.3%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less <b>(01/04/2016 to 31/03/2017)</b> (QOF)	71.9%	78.5%	80.1%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	21.6% (46)	11.4%	13.3%	

Other long term conditions				
Indicator	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. <b>(01/04/2016 to 31/03/2017)</b> (QOF)	77.8%	77.5%	76.4%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	3.6% (6)	5.1%	7.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months <b>(01/04/2016 to 31/03/2017)</b> (QOF)	93.5%	90.3%	90.4%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	17.9% (10)	12.0%	11.4%	
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 150/90 mmHg or less <b>(01/04/2016 to 31/03/2017)</b> (QOF)	81.3%	81.9%	83.4%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	8.3% (34)	3.9%	4.0%	
Indicator	Practice	CCG average	England average	England comparison
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. <b>(01/04/2016 to 31/03/2017)</b> (QOF)	86.7%	88.7%	88.4%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	0 (0)	5.6%	8.2%	



Child Immunisation		
Indicator	Practice %	Comparison to WHO target
Percentage of children aged 1 with completed primary course of 5:1 vaccine. <b>(01/04/2016 to 31/03/2017)</b> (NHS England)	85.5%	Below 90% Minimum (variation negative)
The percentage children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) <b>(01/04/2016 to 31/03/2017)</b> (NHS England)	71.1%	Below 90% Minimum (variation negative)
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) <b>(01/04/2016 to 31/03/2017)</b> (NHS England)	73.3%	Below 90% Minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (first dose of MMR) <b>(01/04/2016 to 31/03/2017)</b> (NHS England)	73.3%	Below 90% Minimum (variation negative)

Cancer Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening who were screened adequately within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64 <b>(01/04/2016 to 31/03/2017)</b> (Public Health England)	50.6%	66.3%	72.1%	Comparison not available
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	52.5%	66.9%	72.5%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	31.6%	44.5%	57.4%	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. (PHE)	33.3%	68.0%	70.3%	N/A

Mental Health Indicators				
Indicator	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 <b>(01/04/2016 to 31/03/2017)</b> (QOF)	91.8%	90.7%	90.3%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	11.6% (8)	13.6%	12.5%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months <b>(01/04/2016 to 31/03/2017)</b> (QOF)	94.7%	92.3%	90.7%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	17.4% (12)	10.1%	10.3%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months <b>(01/04/2016 to 31/03/2017)</b> (QOF)	81.8%	85.1%	83.7%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	4.3% (2)	5.7%	6.8%	

### Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543	528	534
Overall QOF exception reporting	9.5%	6.2%	5.7%

## Effective staffing

Question	Y/N
The registered person provided assurances that 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 taking for the cervical screening programme.	Y*
The learning and development needs of staff were assessed	N
The provider had a programme of learning and development.	N
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
Staff had access to appraisals, one to one, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y*
<p>If no please explain below:</p> <ul style="list-style-type: none"> <li>*We found specific training for the nurse to carry out her role had been completed, however the provider had not assured themselves or provided support to staff to ensure they had the skills and knowledge to carry out their roles. For example, clinical staff were unaware of the appropriate process and clinical codes to use for medical conditions and there was an over reliance on the administration staff to carry out managerial roles and clinical administration tasks.</li> <li>We identified on the day of inspection a significant lack of assessment had been completed by the provider to ensure staff development needs were being addressed. We found there was no programme of learning and development in place to ensure staff were competent in the roles they were carrying out. For example: The coding of medical conditions was being completed by administration staff who had no clinical training in this area and there was no clinical oversight to ensure the appropriate codes were being used. On reviewing a sample of patients records we found three records where surgery had not been coded in the patients' medical record and one record where the wrong clinical code had been used. This placed patients at risk of harm as clinicians would not have access to up to date medical history and accurate records.</li> <li>We were told that the health care assistant had planned to complete the Care Certificate, but we found no evidence to confirm that this had been completed.</li> <li>*We were unable to confirm how the role of the health care assistant was supervised by clinical staff to ensure patients received suitable care and the health care assistant had the appropriate support in place to carry out their role.</li> </ul>	

## Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed <b>(01/04/2016 to 31/03/2017)</b> (QOF)	Y

## Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months <b>(01/04/2016 to 31/03/2017)</b> (QOF)	93.5%	95.9%	95.3%	Comparison not available
QOF Exceptions	Practice Exception rate	CCG Exception rate	England Exception rate	
	0.6% (4)	0.8%	0.8%	
Indicator	Practice	CCG average	England average	England comparison
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) <b>(01/04/2016 to 31/03/2017)</b> (PHE)	46.7%	50.4%	51.0%	Comparison not available

## Description of how the practice monitors that consent is sought appropriately

From the records we viewed we found consent had been sought, however the practice were unable to evidence that they reviewed patients records on a regular basis to ensure consent had been sought appropriately.

## Any additional evidence

### Older people

### Patients with Long term conditions

On reviewing a sample of patients records we found patients a failure to monitor patients with long term conditions to ensure the patients' needs were being met and current treatment was still appropriate. For example: we found three patients who had significant histories of long term chronic conditions who had not been seen since 2016. There was no history of any relevant examinations having been completed to ensure patients were receiving the appropriate care and treatment. On further investigation we found further examples of a patient with a significant chronic impairment who had not been referred as requested by a specialist consultant in 2017 and had also not received the appropriate monitoring. This placed these patients at severe risk of harm.

We also found that your records showed medication review without patient had been added, but we could find no evidence that a review had taken place.

#### Families, children and young people

On reviewing a sample of patients' records we found the practice had failed to follow up on children that had attended hospital. For example: We saw evidence of three children who had attended the accident and emergency department and there was no record of any follow up having been completed by the practice on discharge from hospital. We also found that medicine requests made by the hospital had also not been acted on, placing the children at risk of harm.

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

On reviewing a sample of patients' records we found the practice had not acted on presenting symptoms of patients to ensure they received the appropriate care. For example: we found three patients records where the practice had not adequately investigated and prescribed the appropriate treatment which placed these patients at risk of having undiagnosed disease, untreated conditions and inadequate treatment.

#### People whose circumstances make them vulnerable

On reviewing a sample of patients' records we found two patients had been seen by the emergency services, but we found no record of assessment having been completed by the practice on discharge from hospital. This placed the patients at risk of harm.

On further investigation we found medicines had been prescribed to a patient with severe learning disabilities without the appropriate review having taken place.

We found evidence to confirm that concerns had been raised about the health of a patient with learning disabilities. Your records demonstrated that some examination had taken place, however no further tests had been requested to identify the concerns raised to ensure the appropriate care and treatment was being provided.

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

On reviewing a sample of patients' records we found the three patients with poor mental who had not received the appropriate care. This included lack of examination to assess and arrange the appropriate investigations and treatment, inadequate reviews to ensure patients care and medicines were being monitored regularly. This placed these patients at the risk of harm as the practice were unable to provide assurances that these patients had received the appropriate care.

# Well-led

## Leadership capacity and capability

### Examples of how leadership, capacity and capability were demonstrated by the practice

The practice were unable to demonstrate effective leadership. Systems in place were putting patients at risk and the GP lead did not have the capability to lead effectively and drive improvement. For examples:

- We found staff working within the practice did not have the appropriate competencies to carry out specific roles. For example, During the inspection, the inspection team were provided with conflicting information regarding the tasks and duties undertaken by the health care assistant. We saw a template setting out the duties the health care assistant could undertake, which included some areas for which they had not received the appropriate training. The practice were unable to demonstrate that all staff working within the practice had the necessary skills, knowledge and where appropriate training to work within their specific role.
- The clinical lead lacked capacity to effectively manage the practice and oversee all clinical areas of the practice adequately. At the previous inspection we found administration staff were exception reporting patients on the clinical registers with no clinical input or support, we were told this had improved, however we found administration staff were still carrying out clinical administration roles with the coding of medical conditions with no clinical oversight or supervision.
- The management team demonstrated a lack of capability and knowledge to ensure effective processes were embedded to drive efficiency in the practice. This included the management of risk, staff development and ineffective governance processes. For example: Significant events were not documented and discussed with the team to share learning and mitigate future risk.

### Any additional evidence

We identified significant failings in the care of patients, this included: safeguarding concerns not being addressed, patient medicine reviews not being completed, overall management of patients with long term conditions and a lack of clinical oversight to ensure patients were receiving adequate care and treatment.

## Vision and strategy

### Practice Vision and values

The practice were unable to provide evidence of a vision and credible strategy to deliver high quality, sustainable care. We found due to the lack of clinical and managerial leadership the practice had been unable to embed a strategy to improve patient outcomes. The practice had limited systems in place to monitor progress and were unable to demonstrate how they planned services to meet the needs of their practice population.

## Culture

### Examples that demonstrate that the practice has a culture of high-quality sustainable care

The practice was unable to demonstrate a culture of high quality sustainable care. For example:

- Due to capacity issues the lead GP was unable to demonstrate effective clinical leadership and oversight of patient care.
- We found a lack of processes to ensure patient care was managed appropriately and the practice's systems had not become embedded within the team to ensure sustainable care was achieved.
- The practice were unable to demonstrate how they prioritised care and how clinical work was evaluated to ensure patients had received appropriate investigations, treatment and management of their health needs.
- The clinical staff and management team relied heavily on administration staff to carry out the roles of clinical administration and practice management.
- We found evidence that the practice nurse had completed the relevant training required for her role. However, the practice was unable to demonstrate that staff carrying out advanced roles had received the appropriate training and support. This included the health care assistant, clinical staff medical coding of patients' correspondence and administration staff who were completing clinical administration tasks and other advanced roles.

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

Source	Feedback
Staff	<p>We were told by the administration staff that they were no longer carrying out clinical administration roles within the practice as all exception reporting was being done by the clinical team. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)</p> <p>We found on the day of inspection that staff were still doing clinical administration tasks with the coding of medical conditions. Staff told us how GPs highlighted the condition that required coding in the clinical correspondence and the administration staff would then use a directory of clinical codes to decide which one would be the best one to use without any clinical support or oversight. On reviewing a sample of patients records we found three patients who had undergone surgery and this had not been coded on their medical records. Another example was of the wrong code having been used for a test that had been completed.</p> <p>On further review we found a patient who had undergone surgery and on speaking with the clinical team we were told they were unsure which code to use, so this had not been sent to the administration staff to act on and it had not been coded at all. This highlighted a significant failing in ensuring patients' medical records were up to date.</p>



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### Any additional evidence

We were told that the Lead GP had been given administration time for the clinical review of correspondence and clinical indicators. On the day of inspection, we found one of the locum GPs was employed to do clinical administrative duties. There was no effective leadership from the management team to monitor quality and ensure patients' care and treatment was being reviewed and actioned appropriately. From a sample of patients' records we viewed we found clinical conditions had not been coded, medicine requests had not been actioned and referrals to other services had not been made causing potential harm to patients.

## Governance arrangements

### Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.

Practice specific policies	The practice had a range of policies in place, but we found these were not adhered too and evidence demonstrated these policies were not embedded in the team. For example: we saw a safeguarding policy and exception reporting policy.
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	Y/N
Staff were able to describe the governance arrangements	Y*
Staff were clear on their roles and responsibilities	N

### Any additional evidence

\*Staff were able to describe some of the governance arrangements, but on investigation we found these had not become embedded.

There were no clear responsibilities, roles and systems of accountability to support good governance and management. This included the management of risk. For example:

- A review of consultation notes was carried out on the morning of 4 June 2018. This identified concerns regarding the documentation of the care and treatment of patients and action of potential safeguarding concerns. We reviewed six patients' records and found ineffective recording of history and examination findings at consultations, investigations or referrals had not been completed appropriately and safeguarding concerns had not been addressed, placing patients at risk of potential harm.
- Administration staff added clinical codes to patients' medical records, however there was no system in place to monitor accuracy of information and to ensure the appropriate codes had been used by a suitably qualified clinician.
- We found ineffective processes were in place for the monitoring of uncollected prescriptions and the monitoring of prescriptions that had not been collected with significantly overdue review dates.
- On reviewing a sample of patients' records, we found medication reviews codes had been added onto patient records, but there was no evidence of a review having taken place.
- Your records demonstrated that patients had not received treatment for newly diagnosed



conditions and patients with chronic and/or long term conditions had not received regular reviews.

- The management of safety alerts including alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were not being acted on or shared with the clinical team.
- Staff working within the practice had not had the appropriate to work within the competencies of their specific role.
- There was limited evidence of effective auditing systems in place to drive improvements including clinical audits.

## Managing risks, issues and performance

Complaints	Y/N
Major incident plan in place	Y
Staff trained in preparation for major incident	Y

## Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Y*

### Any additional evidence

\* The information used to monitor performance and the delivery of quality care was inaccurate. We viewed a total of 23 clinical records. From these records there was insufficient evidence to demonstrate that an adequate assessment of the patient's condition had been undertaken. There was also inappropriate coding of conditions, failure to act on identified concerns and due to the lack of contemporaneous recording, there was potential risk of patients not receiving the appropriate care and treatment and further interventions. The practice were unable to evidence they had plans to address any identified weaknesses.

## Engagement with patients, the public, staff and external partners

### Feedback from Patient Participation Group;

Feedback
The practice were unable to demonstrate they had an active patient participation group.

### Any additional evidence

The practice had submitted an action plan to the CQC following the inspection in January 2018 which detailed plans to gather patient feedback through internal surveys. We found no evidence that the practice had implemented a questionnaire to gather patients' feedback. The practice had reviewed the results of the July 2017 National Patient Survey and discussed this as part of a team meeting. However we found no action plan in place resulting from this review to improve patients' satisfaction.

## Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
NSAIDS	One audit of a review of high risk patients taking NSAIDs had been completed since the previous inspection. The audit demonstrated the practice had completed a review of the prescribing of these medicines for patients to ensure they were receiving the appropriate care and treatment.
High Risk Medicines	Since the previous inspection in January 2018 the Lead GP had implemented a system to review and monitor patients on high risk medicines. We saw evidence to confirm that patients were monitored on a monthly basis.

### Any additional evidence

Since the previous inspection in January 2018, the practice submitted an action plan to address the identified breaches. The action plan included:

Practice Action Plan	Improvement
All incoming clinical documentation are being reviewed by clinical staff.	We found clinical documents were being reviewed by clinical staff, however the clinical coding of medical conditions was being carried out by administration staff.
All exception reporting is completed and inputted by the lead GP and the policy has been reviewed and implemented.	Administration staff confirmed that they were no longer carrying out this role, the clinical staff were exception reporting patients as required.
A new policy and procedure for the management of safety alerts had been implemented and all alerts from 2017 have been reviewed to ensure patient safety had not been impacted.	We found on the day of inspection two alerts that had not been received or any action taken to ensure patients safety was not at risk. We also found the sharing of alerts had not become embedded within the clinical team.
The practice had reviewed and updated their significant event policy and all staff had received training on data reporting system to share with external organisations.	We were told by staff on the day of inspection that some significant events had not been recorded or discussed and we also found that a clinical significant event had not been shared to monitor actions or mitigate future risk.
All Infection control policies had been reviewed and implemented. A new lead and support team had been appointed and infection control training had also been completed.	We found the practice had completed a review and updated their infection control policy. We saw evidence to confirm that staff had completed the appropriate training.
A yearly governance development plan has been implemented to ensure administrative and clinical areas were subject to continuous monitoring. Results and evaluations are to be recorded for reference, benchmarking for future audits and learning to be implemented.	We found significant failings in the governance arrangements at the practice. There was no monitoring of administrative and clinical areas to ensure they were effective and to mitigate risk. We found no evidence of benchmarking and learning to ensure improvements were implemented and embedded within the team.

The 2017 Patient survey feedback has been reviewed and communicated to the team with a discussion of the findings and learning's	We saw evidence to confirm the 2017 national patient survey was discussed with the team, however we saw no action plan to address the findings and implement learning.
Internal Surveys have been implemented with the yearly governance development plan on a quarterly basis.	The practice was unable to demonstrate internal surveys had been implemented.
Personal development plans are in place and training needs are being addressed. A number of training sessions have been completed, in the first three months. These included: repeat prescribing, infection control, computerised systems for sharing information and document management to ensure the practice's computer systems are being used to their full potential with clear and unified understanding.	We found some training sessions had been completed, however we found significant failings in the management of patients on long term conditions, ineffective processes for the monitoring of uncollected prescriptions and issues with significantly overdue review dates, inappropriate management of clinical correspondence and the failure to document, review and share learning of incidents and significant events.

#### DO NOT DELETE THE NOTES BELOW

##### 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, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

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

The following language is used for banding variation:

- Significant variation (positive)
- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95%.

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: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

##### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ( [See NHS Choices for more details](#)).

