

# Care Quality Commission

## Inspection Evidence Table

### Fiveways Health Centre (1-3833238553)

Inspection date: **20 and 25 September 2018**

Date of data download: 16 September 2018

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

## Well-led

### Leadership capacity and capability

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

We found there was no clear leadership with defined roles and responsibilities with regards to practice management. Most practice management tasks had been delegated to the administration staff with the management lead having minimal knowledge or oversight.

- Since the suspension the practice had recruited two new GP partners to the practice, whose registration with the CQC was pending, to lead the clinical team to ensure patients received appropriate care and treatment. The provider told us that they had a younger population with a large ethnic minority group within the local area and they were planning on recruiting a female GP to work at the practice for two sessions a week.
- We found since the suspension managerial leadership had not improved and the practice were unable to demonstrate effective management and the capability to lead effectively and drive improvement. For example:
- The clinical leads were in the process of making improvements to patient care by the introduction of clinical templates to support them in decision making and to ensure patients' care was reviewed effectively. However, we found the clinical staff were using dummy patient records to trial the new templates as they were unaware they had access to patient's clinical records. On speaking with the CCG we were told that the management team were aware that staff had access to review clinical records, this was confirmed by the practice manager but had not been shared with the GPs. This had caused a delay in the review and implementation of the templates and demonstrated a lack of communication between the team.
- The practice was unable to demonstrate that they had ensured that persons providing care and treatment to patients had the appropriate experience. The practice had not carried out appropriate staff checks at the time of recruitment and on an ongoing basis. Since the previous inspection the practice had recruited a nurse as a permanent member of staff. We found the appropriate checks had not been completed prior to their recruitment. On reviewing the nurses file, we found missing employment history and references.

## Vision and strategy

### Practice Vision and values

The practice had commenced a strategy to improve clinical leadership, however this was not supported due to the lack of understanding of the management team to deliver high quality, sustainable care. We continued to find managerial leadership at the practice had not been supportive in embedding a strategy to improve patient outcomes.

## Culture

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

The practice did not have a culture of high-quality sustainable care. Their approach to risk and learning identified a reactive culture which at times focused on blame rather than learning.

- The practice was unable to demonstrate they focused on the needs of patients. A lack of communication between the manager and GPs had resulted in no patients' records being reviewed during the suspension to share learning from the previous inspections and mitigate future risks.
- Templates had been devised by the new GP partners, but had not been tested thoroughly as the GPs were unaware they could access the clinical system to carry out audits and review the appropriateness of the templates against patients' records. During the inspection we were told by the CCG that the practice had read access to the clinical system, which was confirmed by the management team, however this was not shared with the clinical team and therefore the practice was unable to demonstrate the newly implemented processes were effective and would contribute to the management of patients' care and treatment.
- The minutes of the meeting dated 11 June 2018 to discuss the patients which were referred to in the Notice of decision to suspend the practice dated June 2018 were minimal and did not include all patients identified in the notice. We noted that approximately half of these patients had been discussed. The meetings recorded that a further meeting would be scheduled to ensure all identified issues were discussed. The next meeting minutes were dated 27 June 2018 and showed no discussion of the remaining patients had taken place. Practice staff confirmed during the inspection that no further meetings had taken place. As a result, the practice continued to demonstrate a culture of lack of recognition of risk in assessments and discussion of the health and safety of service users receiving care and treatment, or that they were doing all that was reasonably practicable to mitigate such risks.
- The management of significant events at Fiveways Health Centre do not ensure safe care and treatment was provided to patients.
- The practice was unable to demonstrate that all the clinical team were aware of the patient demographics and their associated needs. For example, a member of the clinical team was unaware the practice had patients in a care home.
- The practice demonstrated a blame culture with a lack of awareness and a failed system for the purchasing of flu vaccines. There had been no consideration of what needed to be done to prevent a re-occurrence and no evidence of lessons learnt being shared with the team.

- The provider was unable to demonstrate openness, honesty and transparency as we found evidence of a false declaration had been made on two application forms to the CQC and due to the non-payment of fees the CQC had had to use enforcement actions to recover monies owed.

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

Source	Feedback
Staff	Administration staff we spoke with told us how they had used their time during the suspension. This included: further training and learning of new systems within the practice, especially around the management of correspondence and an information sharing system. The practice had installed these systems to ensure all staff were kept up to date of any changes and to have access to policies, minutes and any other information that the management team wanted to share with the team.

## Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	A review of practice policies had been commenced during the inspection and this was being overseen by the GP clinical lead. We found that the safeguarding policy required further details to ensure it contained all the necessary information for the safety of patients. For example, the child safeguarding policy did not have details on the actions staff had to take if patients did not attend appointments and the patient records did not contain the names of the parents or guardians of children on the risk register.
Other examples	The practice had reviewed their policy on the management of medicine alerts received from the Medicines Health Regulatory Authority (MHRA), however on speaking with a member of the clinical team they were unable to demonstrate how the safety alert system worked effectively. For example, the staff member was unable to find information concerning the latest alert on coagulation checks and therefore would be unable to ensure they had the most appropriate and up to date information for the safe delivery of care and treatment. The management of medicine alerts was included in the Warning Notice issued to the provider on 28 February 2018. The practice was unable to demonstrate they had acted effectively to protect persons from exposure to the risk of harm.
	Y/N
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	N

Any additional evidence
<p>The practice demonstrated a lack of governance and understanding in effective governance arrangements. We found the systems the practice had implemented offered little assurance that systems and processes were embedded.</p> <ul style="list-style-type: none"> <li>• As identified at our previous two inspections, the practice was unable to demonstrate effective</li> </ul>

processes for the recording, actioning and learning from significant events to mitigate future risk.

- The practice was unable to demonstrate that they had taken action to ensure safe care and treatment was provided to patients including the appropriate assessment of all the health and safety risks to patients and learning from significant events to mitigate future risks. At this inspection we found the significant event process was difficult to navigate and there were duplicate entries which caused confusion. On reviewing a sample of significant events, we found the practice had missed opportunities for learning and sharing with the team to ensure future risks were mitigated. For example, since the suspension in June 2018, the practice had only considered eight of the 23 risks identified in the Notice of Decision we issued on 8 June 2018 as significant events. These had been discussed at staff meetings.
- Where significant events had been recorded there had been no action to complete audits of clinical records to identify patients who may also be at risk. This was discussed with the GPs during the inspection, who told us they were unaware that the practice had access to patient information on the clinical system and therefore audits were achievable. It was confirmed by the CCG during the inspection that the manager had been made aware of the 'read only access' and this was confirmed by the manager at the inspection. This demonstrated a lack of communication between the team and due to the lack of comprehensive audits the practice was unable to demonstrate quality improvements had been made during the suspension period.
- The practice was 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. For example, we were unable to ascertain what the practice nurse's roles and responsibilities were. We were told by a member of the administration staff that the nurse was the infection control lead for the practice, however the nurse had limited knowledge of her responsibilities within this role. At the first inspection in January 2018, infection control management was highlighted as a risk and also detailed in the Warning Notice issued in February 2018. The practice continued to be unable to demonstrate the appropriate management for assessing and preventing the spread of infections.
- The practice was not in line with health and social care priorities across the region. During the inspection the practice was unable to demonstrate a proactive approach to assessing, monitoring and mitigating risks relating to the health, safety and welfare of patients. For example, the practice had not ordered flu vaccines, which were required in February 2018 (prior to the suspension period) to ensure there was sufficient stock in place for the start of the flu vaccination season. We were told on the day of inspection that the practice manager had a system for this however they were unable to demonstrate this system and we received no appropriate explanation as to why this incident had occurred. The practice had not demonstrated they had recognised the potential risk to patients or that they had considered how a reoccurrence would be avoided. We found no evidence that this incident had been recorded or discussed with the team. The management of risks was highlighted during the inspection in January 2018 and also included in the warning notice issued in February 2018.
- We found staff carrying out advanced roles, were unaware of their responsibilities. For example, a member of the clinical team was unable to demonstrate their experience and role in line with their job description, this included the long-term management of patients' conditions. We were also unable to identify who in the practice had the overall responsibility for the management of patients' with long term conditions.

## Managing risks, issues and performance

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

Any additional evidence
<ul style="list-style-type: none"><li>We viewed minutes of staff meetings dated 11 June 2018, 27 June 2018 and 26 July 2018 which we found lacked detail to support any action and decision making. The practice had not considered all the findings and risks from previous inspections and the minutes showed minimal evidence of learning. This demonstrated a lack of awareness of actions necessary for the practice to assess, monitor, improve and mitigate risks. The minutes demonstrated a lack of understanding of governance arrangements and effective leadership.</li><li>During the suspension period the Clinical Commissioning Group had completed a range of reviews and investigations following the outcomes of the previous CQC inspections and the risks identified. The investigations highlighted a range of concerns relating to the safe care and treatment of patients and the safeguarding of children and adults. For example:</li><li>The practice had not considered the lack of medicine reviews for over 800 patients found during the CCG investigation as a significant event to identify learning and to understand how this had happened. The practice were unable to demonstrate they had implemented systems and processes required to mitigate future risk.</li></ul>

## Appropriate and accurate information

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

Any additional evidence
During the suspension period the practice had not used the opportunity to evaluate patients records and review identified concerns to ensure further risks were mitigated.

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

### Feedback from Patient Participation Group;

Feedback
No feedback was available due to the suspension.

Any additional evidence
The practice had reviewed the results of the Friends and Family Test, however we found no evidence to support the practice had acted on any comments made by patients.

## Continuous improvement and innovation

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

Audit area	Improvement
None	<p>No audits had been completed during the suspension period by the practice, however the CCG had commissioned for a review and audit programme to be completed which showed:</p> <ul style="list-style-type: none"> <li>• Diabetic patients which showed a number of patients on the diabetic register had not had the relevant blood tests or follow up over a period of months and in some cases years.</li> <li>• A medication review audit identified over 800 medication reviews that required urgent action as there were inappropriate prescriptions issued, this included lack of monitoring and lack of prescribing in long term conditions.</li> </ul>

Any additional evidence
Before the previous inspection in June 2018 where a Notice of Decision was issued to suspend the service, the practice submitted an action plan to address identified breaches identified in the January 2018 inspection report and the warning notices issued in February 2018. The action plan included:

Practice Action Plan	Improvement
A new policy and procedure for the management of safety alerts had been implemented and all alerts from 2017 had been reviewed to ensure patient safety had not been impacted.	Some of the clinical staff were unable to demonstrate how to access alerts and we found some alerts had not been reviewed.
The significant event policy had been reviewed. There was a new lead for significant events and all staff had received training to support the process.	We found the recording of significant events was not effective with minimal evidence of shared learning.
All Infection control policies had been reviewed and implemented. A new lead and support team had been appointed and face to face infection control training had also been completed.	The infection control lead at the practice had completed infection control training, but they were unable to demonstrate sufficient knowledge of the responsibilities that were involved in this role.
A yearly governance development plan had been implemented to ensure administrative and clinical areas were subject to continuous monitoring. Results and evaluations were recorded for reference, benchmarking for future audits and learning to be implemented.	The provider was still unable to demonstrate effective governance arrangements were in place to ensure the effective management and leadership within the practice and to mitigate risk. We found no audits had been completed during the suspension period to demonstrate learning.
Internal Surveys have been implemented with the yearly governance development plan quarterly.	The provider did not provide evidence to show internal surveys had been implemented.

Personal development plans were in place and training needs were being addressed. A number of training sessions had been completed. These training sessions were to ensure the systems were being used to their full potential with clear and unified understanding.	On speaking with staff they told us they had attended a range of training sessions during the suspension period. The practice had implemented a new information sharing system to keep staff up to date on any changes and for access to practice policies, we found some staff had difficulty navigating the system.
--	---

#### 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 practice's 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 comparable, 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 comparable 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$

3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.

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](#)).