

# Care Quality Commission

## Inspection Evidence Table

### Fiveways Health Centre (1-3833238553)

Date of inspection: 8 November 2018

## Well-led

## Rating: Inadequate

At our first announced comprehensive inspection on 9 January 2018, we rated the practice as Inadequate for well-led services Breaches were found of Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the unannounced inspection on 6 June 2018, we followed up on the actions and processes the practice told us they had implemented to mitigate the risks previously identified. Due to the significant concerns we identified under Section 31 of the Health and Social Care Act 2008 an immediate temporary suspension of four months was imposed on the registration of the provider and registered manager.

At the announced inspection on 20 and 25 September 2018, the provider had failed to address the issues we had highlighted as being necessary for the suspension to be lifted. Due to the continued risks, an extended suspension took effect from Monday 8 October 2018 for a period of 28 days.

At this inspection on 8 November 2018 we were not assured that the provider had appropriately addressed the continuous issues. Following this inspection, the suspension finished on 12 November 2018, we served a Notice of Decision under Section 31 of the Health and Social Care Act 2008 to immediately impose urgent conditions on the registration of the service provider in relation to the regulated activities as we believe a person will or may be exposed to the risk of harm if we do not do so.

### Leadership capacity and capability

**Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>On the day of the inspection we were told that the evening before, a decision had been made that the current practice manager was stepping down from the role whilst they completed practice management training. The administrator was to become the duty manager, a role which would replace the practice manager, however the administrator was unable to demonstrate they</li></ul>	

had knowledge of what was expected within the new role of duty manager. We found that no clear leadership with defined roles and responsibilities had been considered or formalised to support the operational oversight and management whilst the duty manager was learning her role. In addition, there was no oversight with regards to experienced management and leadership to drive improvement.

- We found since the suspension the practice had commissioned the services of a management consultancy group to support them with the implementation of systems and processes. We were unable to gain assurances that effective management was in place and the current leaders had the capability to lead and drive improvement. For example: We were told by the lead GP on the day of inspection that they had implemented a system to review the safeguarding register on a weekly basis, however on further investigation we found no evidence that reviews had been completed and the GP then confirmed he had not commenced the reviews. Furthermore, we had received conflicting information with regards to this aspect of the practices safeguarding systems and processes.
- Since the last inspection in September 2018, the practice nurse had left the practice and we were told a new nurse had been recruited to the practice. We were also told that due to the demographics of the local population a female GP would be offering two clinical sessions per week. The practice plan was to have the new staff in place when the suspension had finished.
- The delivery of high-quality care was not assured by the leadership, governance or culture at the practice. We found that the practice took a reactive approach to service improvement. For example: The practice had not appropriately or effectively addressed all the actions we said it must and should take to make improvements identified at our previous inspections including the management of safety alerts and the safeguarding registers.

## Vision and strategy

**The practice had a clear vision but it was not supported by a 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.	N
There was a realistic strategy in place to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us they had a vision to be flexible and versatile to meet the needs of their patients, be a learning organisation with a no blame culture. However, the evidence provided as part of our inspection process did not reflect or align with this vision. For example, we found:</p> <ul style="list-style-type: none"> <li>• The practice were unable to demonstrate they had considered the impact the change in management would have on the overall leadership and governance arrangements. The need</li> </ul>	

for experienced leadership was not part of the business strategy whilst the administrator was learning her new role as duty manager.

- The new duty manager was unable to demonstrate they understood how their role would impact on the vision and strategy in the development of the practice.
- The practice had a strategy to improve clinical leadership, with two new GP partners joining the practice. However, the strategy was not supported due to the continuous lack of understanding of the management team to deliver high quality, sustainable care. Managerial leadership at the practice were unable to demonstrate how they were embedding a strategy to improve outcomes for all patients.

## Culture

**The practice culture did not effectively support high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
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.	N
The practice's speaking up policies were in line with the NHSI National Raising Issues Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice did not have a culture of high-quality sustainable care. Their approach to risk and learning identified a reactive culture. Since the last inspection in September 2018, the practice had written 36 significant events since October 2018. We found that these events had been written up retrospectively as the significant events were for patients identified as at risk in the previous inspection of June 2018. We found no evidence that learning had been shared for the 10,000 letters previously identified as not being actioned.</li> <li>• The practice was unable to demonstrate they focused on the needs of patients. Reports from the Clinical Commissioning Group (CCG) had shown that the practice had delayed sending clinical correspondence received to the caretaking practice where patients are being cared for during the suspension. For example: 48 letters received at Fiveways Health Centre between 2 November 2018 to 8 November 2018 were not received by the caretaking practice until the 13 November 2018. This presented a risk that potentially, the health and care needs of patients had not been reviewed or actioned in an appropriate or timely manner.</li> <li>• The provider was unable to demonstrate openness, honesty and transparency as we were told on the day of inspection by the lead GP that they had implemented a system to ensure all patients on the safeguarding register were reviewed every week. However, on further investigation we found no evidence to support reviews had taken place or the safeguarding register had been reviewed. On speaking again with the GP, we found they had provided conflicting information to a member of the inspection team and had not completed any reviews.</li> </ul>	

- The wellbeing of staff had not been considered as we found due to the rapid changes made before the inspection, staff who had been promoted to a managerial role were unsure of their responsibilities.

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

Source	Feedback
Staff	Staff told us that they had done a range of training during the suspension period. Time had been used to improve notices at the practice and to understand the new systems that had been implemented.

## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• During the inspection process it was clear that the practice had received a considerable amount of external support and guidance during the period of suspension to develop governance and leadership. Despite this and the fact that the partners were not responsible for carrying on the regulated activities during the suspension period the practice was unable to demonstrate sustained improvement, or that the systems, policies and processes for the management of safeguarding and safety alerts were understood, effective or embedded.</li> <li>• As part of the external support and guidance received, the practice had commissioned the services of a management consultancy group to support them in moving forward and implementing new ways of working. We were told by the practice and the consultancy group that they would be supporting the practice in the forthcoming months and training the duty manager in her new role. We have now been informed by the consultancy group that these plans have now changed and they are no longer supporting the practice.</li> <li>• On speaking with the duty manager, we found they were unsure of their role and responsibilities and the level of authority they held within the practice. On further investigation it was apparent that as the decision had been made the night before the inspection to change the management structure, no discussions had been held to confirm the responsibilities the duty manager would have within her role.</li> <li>• The safeguarding lead was unaware if the practice used the local reporting system of the CCG to share incidents, safeguarding concerns or significant events.</li> <li>• The practice had implemented a new management system so all staff had access to policies, procedures, safety alerts and minutes of meetings. The lead GP for safety alerts was unable to demonstrate where alerts were stored and confirmed he was unsure where alerts were kept.</li> </ul>	

- One of the GP partners was unable to demonstrate effective use of the GP management system that had been implemented. The GP had difficulty in accessing policies and information.

## Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N
There were processes in place to manage performance.	N
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The lead GP failed to acknowledge the risks associated with the lack of appropriate management in place to support the delivery of quality, sustainable services.</li> <li>• The systems for identifying and managing risk continued to be ineffective. On reviewing safety alerts issued by the Medicines Healthcare Regulatory Authority (MHRA), we found the practice had completed no searches prior to July 2018 to identify if any patients were at risk. We found some alerts had not been received or actioned. For example: An alert issued in October 2018 concerning the interaction of a medicine used to treat HIV and thyroid medicine had not been received by the practice. Another alert issued in October 2018 concerning patients who had undergone heart surgery and the contra-indications with an anticoagulation medicine was not on the practice's management system. On speaking with one of the GPs he was aware of the alert, however he thought the alert was not relevant. We found some alerts had been actioned, however on further investigation, we found an MHRA alert for a medicine used in the treatment of neuropathic pain had not been actioned fully. The alert advised clinicians of the potential severity of respiratory problems for certain groups of vulnerable patients. We were told that two searches are carried out each month to ensure the practice is up to date with the latest alerts, however on further investigation we found the practice were a month in arrears in checking alerts.</li> </ul>	

## Appropriate and accurate information

**The practice did not always act on appropriate and accurate information.**

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N

Our inspection indicated that information was accurate, valid, reliable and timely.	N
Staff whose responsibilities include making statutory notifications understand what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection, the practice had implemented a new management system to support staff in their role and to ensure staff had access to policies and procedures. The practice at the time were utilizing on average 50-60% of the system, however at this inspection we were told that the practice is now using the system fully. Some staff were unable to access the system appropriately, which could cause a delay in obtaining information. Safety alerts including those issued by the MHRA were also incomplete and the practice lead for safety alerts had difficulty in accessing the alerts and searches that had taken place.</li> <li>During the inspection the safeguarding lead told us he reviewed the child protection register weekly and the child safeguarding register every month. We found inaccuracies in the registers, and overall concerns regarding safeguarding systems and processes. There were some children on the child protection register that should not have been included, there were other children with child protection plans in place but were not listed on the register and there were also some alerts missing from patient records. We found that some of the cases on the safeguarding register did not have any safeguarding concerns documented. There was also no evidence of meetings with multi-disciplinary teams. The lead GP when asked why the list was not up to date confirmed he had not looked at the list.</li> <li>The child safeguarding register showed 25 patients. Review of a random sample of records identified four patients on the register had no record of safeguarding concerns in their medical records. The lead GP confirmed he had not reviewed the list.</li> <li>The last report for adult safeguarding showed four patients on the register. On reviewing the patients' records, we found three out of four patients had no alerts on their records to identify them as vulnerable adults.</li> <li>The last report for vulnerable patients with FGM showed 16 patients on the register. On reviewing a sample of records, we found the clinical search was not accurate as it included patients who had a family history of FGM.</li> <li></li> </ul>	

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

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	N/A
Staff views were reflected in the planning and delivery of services.	Y
The provider worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had received a range of external support during the suspension period, including the CCG and LMC. The practice told us they had been updating the caretaking practice of any concerns they found to mitigate further risks to patient care.</li> </ul>	



- Staff told us they had been involved in writing the standard operating procedures for reception, so all staff who worked in this area were aware of the correct processes to follow.

#### Feedback from Patient Participation Group

#### Feedback

No feedback as the practice was suspended.

#### Continuous improvement and innovation

**There was little evidence of systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement	N
Learning was shared effectively and used to make improvements.	Y*
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Some processes that had been introduced since our previous inspections had not been implemented adequately to bring about improvements. For example: the management of safety alerts and safeguarding.</li> <li>• The GP partners had commenced clinical audits to monitor patients care and treatment. For example: the GPs had done an audit on 6 November 2018 to review patients on high risk medicines were up to date with their blood tests. The audit demonstrated all patients had received the appropriate monitoring by the caretaking practice</li> <li>• *Since the previous inspections, the GP partners had recognised the inadequate management of clinical test results received at the practice. The partners have written a protocol to manage patient results, with clear actions and comments.</li> </ul>	

#### Examples of continuous learning and improvement

The practice had commissioned the services of a management consultancy group to support them in the implementation of policies and procedures to mitigate further risk. The practice was unable to demonstrate how sustainability would be achieved once the management consultancy group had finished at the practice and what leadership would be in place to ensure all implemented procedures continued to be effective. We now know the management consultancy group are not providing the required support.

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>