# Care Quality Commission

## Inspection Evidence Table

## Cleveland Surgery (1-560673438)

**Inspection date: 23 May 2019**

**Date of data download: 22 May 2019**

# Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

# Safe Rating: Inadequate

**Safety systems and processes**

### The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|---|---|
| There was a lead member of staff for safeguarding processes and procedures. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | No |
| There were policies covering adult and child safeguarding. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Policies were accessible to all staff. | Yes |
| Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs). | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| There were systems to identify vulnerable patients on record. | Partial |
| There was a risk register of specific patients. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |

| Safeguarding | Y/N/Partial |
|---|---|
| Explanation of any answers and additional evidence:<br>A GP partner was the safeguarding lead for the practice. However, there was no nominated deputy and as a result no-one to lead on safeguarding issues in their absence.<br>Systems identified children who were not brought to medical appointments in secondary care. However, there was no follow-up of these children to identify and mitigate any possible risk to them. Nurses we spoke with told us that they were not aware of any system to follow up children who were not brought for immunisations or appointments in secondary care.<br>Children at risk were identified on the practice medical records but parents were not annotated as such meaning that clinicians would not be alerted. | |

| Recruitment systems | Y/N/Partial |
|---|---|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | Yes |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Staff had any necessary medical indemnity insurance. | Yes |

| Safety systems and records | Y/N/Partial |
|---|---|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: | Yes<br>May 2018 |
| There was a record of equipment calibration.<br>Date of last calibration: | Yes<br>15 April 2019 |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks.<br>Date of last check: | Yes |
| There was a log of fire drills.<br>Date of last drill: | Yes |
| There was a record of fire alarm checks.<br>Date of last check: | Yes |
| There was a record of fire training for staff.<br>Date of last training: | Yes |
| There were fire marshals. | No |
| A fire risk assessment had been completed.<br>Date of completion: | Yes<br>25 Sep 2018 |
| Actions from fire risk assessment were identified and completed. | Yes |

| Health and safety | Y/N/Partial |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: | Yes |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: | Yes<br>6 Oct 2018 |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---|
| There was an infection risk assessment and policy. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence:<br>We noted that the privacy curtains in consultation rooms were recorded as having been installed on 17 July 2018. | |

**Risks to patients**

## There were adequate systems to assess, monitor and manage risks to patient safety.

| | Y/N/Partial |
|---|---|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans for patients were developed in line with national guidance. | Yes |
| Panic alarms were fitted, and administrative staff understood how to respond to the alarm and the location of emergency equipment. | Yes |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | Yes |
| 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. | Yes |
| There was a process in the practice for urgent clinical review of such patients. | Yes |
| There was equipment available to enable assessment of patients with presumed sepsis or another clinical emergency. | Yes |
| There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance. | Yes |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Yes |

**Information to deliver safe care and treatment**

## Staff did not have the information they needed to deliver safe care and treatment.

| | Y/N/Partial |
|---|---|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | No (1) |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | No (2) |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | No (3) |
| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
| Referrals to specialist services were documented. | Yes |
| There was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| 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. | Yes |

Explanation of any answers and additional evidence:

(1) There were 89 patients recorded as having rheumatoid arthritis. On 24 October 2018 a GP recorded in the clinical records that they had completed 17 reviews of patients with rheumatoid arthritis. Review of these records indicated that these patients had not been seen but had been coded as having been reviewed. This indicated that the GP had recorded the reviews as having been done when they had not.

We looked at the records of patients shown as suffering depression. On 1 March 2018 it was recorded that one GP had completed the reviews of 99 patients between 1.38pm and 6.29pm. Review of these records showed that no contact had been made with the patient, but the review had been recorded as completed.

We looked at the records of three other patients which showed as reviews as having been completed. In the case of one patient, another patient was booked into the clinician's calendar at the time, and in the case of another patient it was recorded as having taken place on 4 March 2018, which was a Sunday. Another review was shown as 'an administration event' with no other details on the system. We could not therefore have any confidence that these reviews had taken place.

Patients living with dementia were recorded as having been reviewed and as having a care plan in place. No such care plans could be identified in the clinical system.

(2) There was a back-log of new patient notes awaiting summarisation. One member of staff was allocated ten hours a week to complete the task, although they told us it was less, as they were currently mentoring new reception staff. This member of staff was unable to tell us how many sets of notes were waiting to be summarised but told us there were possibly hundreds and some related to patients who had joined the practice from the former Pottergate Surgery some two years previously. A search of the clinical system showed there to be 685 sets of notes awaiting summarising out of a patient list of 12,930. We asked the member of staff responsible for summarising patient notes whether they had been trained on how to correctly summaries patient notes. They told us no. We asked if they were aware of any protocol in place to govern the

activity of summarising patient notes. They told us no, they were not aware of any protocol. We later ascertained that there was a policy to govern this activity but there was no process in place to ensure staff were made aware of it.

(3) We found that the franking machine for outgoing post had been without any credit from 14 to 21 May. The GP partners had been alerted to the fact but had failed to provide credit for the machine. By the time the machine was operational again there were 675 items of post waiting to be sent. Staff told us the mail contained referrals as well as patient recall and cancellation of appointments letters. Following our inspection, the provider provided us with receipts that related to 31 postage stamps having been purchased during the franking machine was inoperative. Review of the minutes of partners meetings showed that the cost of the franking machine had been raised in February 2019, which was costing approximately £300 per week and reference was made to the difficult financial position the practice was in.

**Appropriate and safe use of medicines**

## The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA) | 1.21 | 1.04 | 0.91 | Tending towards variation (negative) |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2018 to 31/12/2018) (NHSBSA) | 11.2% | 10.4% | 8.7% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA) | 6.98 | 5.95 | 5.60 | Variation (negative) |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA) | 2.98 | 2.47 | 2.13 | No statistical variation |
| Whilst the practice were aware of the above poor performance they had not taken measures to address this | | | | |

| Medicines management | Y/N/Partial |
|---|---|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | No (1) |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Yes |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | No (2) |
| 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. | No (3) |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | No (4) |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | No (5) |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Yes |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |
| Explanation of any answers and additional evidence:<br>(1) Staff administered certain medicines namely flu vaccinations without there always being the | |

| Medicines management | Y/N/Partial |
|---|---|
| appropriate patient specific direction in place. We saw evidence that showed that GP authorisation had been added to medical records after the medicines had been administered.<br>(2) We could not be assured that repeat prescriptions were issued after structured reviews of patients had been completed. This was because of discrepancies in the patient records, with reviews being recorded as completed when they were not.<br>(3) We looked at the records of some patients prescribed medicines in secondary care. We saw an example of a patient prescribed azathioprine in hospital, but the fact was not displayed in the patient record without searching for the hospital letter, meaning that it would not be evident to a clinician viewing the patient record.<br>(4) The process of monitoring patients in receipt of antimetabolites was not effective. There were 15 patients who were overdue monitoring. One patient had not had any monitoring since November 2017.<br>Patients prescribed ACE inhibitors were not always subject to regular monitoring. There were 21 patients who had no monitoring in the previous 24 months. One patient had not had any monitoring since September 2012.<br>(5) The practice had not addressed the negative variation in prescribing | |

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

## The practice did not have a system to learn and make improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|---|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 34 |
| Number of events that required action: | 26 |
| Explanation of any answers and additional evidence:<br>Four of the recorded events had positive outcomes and had been communicated to staff.<br>Four if the events related to errors by external organisations. | |

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

| Event | Specific action taken |
|---|---|
| A 14 week old baby was brought for an eight week check and was issued Dalevit 6 ml (Instead of 0.6 ml, as noted (given in hospital discharge letter). The error was | More training was provided for the staff concerned. Ensure clinicians look at the hospital letters during consultation, when new medicines were started by a specialist. |

| | |
|---|---|
| spotted and the medication was not started/given. | |
| Incorrect patient sent a letter of congratulations regarding birth of their child. | Staff members reminded not to assume anything but to ensure that the facts are correct before acting. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | No |
| Staff understood how to deal with alerts. | No |
| Explanation of any answers and additional evidence:<br>The system for dealing with MHRA alerts was not effective. Alerts were issued by MHRA in February 2019 in respect of carbimazole. The alert had not been identified and subsequently not actioned. Staff informed us that this was because the member of staff who normally deals with them was on holiday and there was no process in place to provide cover. | |

# Effective Rating: Inadequate

**Effective needs assessment, care and treatment**

## Patients' needs were not assessed, and care and treatment were not 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. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | No (1) |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | No (2) |
| There were appropriate referral pathways were in place to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| Explanation of any answers and additional evidence:<br>(1) There were 79 patients with learning difficulties recorded on the clinical system. Only one patient had received a health review in the year ending 31 March 2019.<br>(2) There was clear evidence that the patient's clinical records were not always accurate records as they stated patients had been seen face to face when there was no evidence that they had been seen or spoken to at all. | |

| 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) (01/01/2018 to 31/12/2018) (NHSBSA) | 2.22 | 1.18 | 0.79 | Variation (negative) |

**The areas we found inadequate affected all population groups, so we rated all population groups as inadequate.**

## Older people

**Population group rating: Inadequate**

**Findings**

- The practice did not use a clinical tool to identify older patients who were living with moderate or severe frailty. The electronic frailty index had been used to identify potential frailty in patients, but the practice has not completed any frailty assessments because of the electronic frailty index (EFI) or any other frailty indicators. Six patients had been recorded as having had a frailty assessment, but each of these had been coded by an administrator upon receipt of a letter from other another source. There was no evidence in the patient records that any clinical review had been carried out or any patient contact by a clinician.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

## People with long-term conditions

**Population group rating: Inadequate**

**Findings**

- Patients with long-term conditions did not always have a structured annual review to check their health and medicines needs were being met. We found that some patient records showed that reviews had taken place when they had not.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- QOF indicators for long term conditions showed the practice to be lower achieving than both national and CCG averages in a number of clinical indicators.

| 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) | 60.8% | 78.3% | 78.8% | Variation (negative) |
| Exception rate (number of exceptions). | 2.9% (25) | 11.4% | 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) | 76.2% | 78.3% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 1.9% (16) | 8.0% | 9.8% | N/A |

| | Practice | 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 (01/04/2017 to 31/03/2018) (QOF) | 65.0% | 79.4% | 80.1% | Variation (negative) |
| Exception rate (number of exceptions). | 5.8% (50) | 14.7% | 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) | 65.8% | 76.5% | 76.0% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 1.7% (16) | 8.8% | 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) | 53.6% | 86.1% | 89.7% | Significant Variation (negative) |
| Exception rate (number of exceptions). | 4.0% (14) | 12.2% | 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) | 80.7% | 84.2% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 3.1% (59) | 3.4% | 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) | 82.6% | 92.4% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 0.9% (2) | 4.6% | 6.7% | N/A |

## Families, children and young people  Population group rating: Inadequate

**Findings**

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.
- The practice did not have in place the necessary arrangements to identify and review the treatment of newly pregnant women on long-term medicines as they had not taken any action on the MHRA alert concerning carbimazole.
- The practice did not have effective arrangements for following up failed attendance of children's appointments following an appointment in secondary care.
- Young people could access services for sexual health and contraception.
- The practice provided breast feeding advice for new mums from the healthcare assistant who offered breastfeeding peer support.
- The practice had responded to calls for a female GP and now had a salaried female GP in post.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target |
|---|---|---|---|---|
| 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) | 161 | 179 | 89.9% | Below 90% minimum (variation negative) |
| 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) | 163 | 191 | 85.3% | 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) (01/04/2017 to 31/03/2018) (NHS England) | 169 | 191 | 88.5% | Below 90% minimum (variation negative) |
| 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) | 170 | 191 | 89.0% | Below 90% minimum (variation negative) |

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

**Population group rating: Inadequate**

| Findings |
|---|
| • Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.<br>• Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.<br>• Screening for cervical cancer was lower than the 80% standard and below the CCG average. |

| 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) | 71.9% | 75.5% | 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) | 72.8% | 74.5% | 70.0% | 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) | 52.4% | 60.2% | 54.5% | 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) | 56.8% | 60.2% | 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) | 52.9% | 55.4% | 51.9% | No statistical variation |

## People whose circumstances make them vulnerable

## Population group rating: Inadequate

**Findings**

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice demonstrated that they had a system to identify people who misused substances.
- On the day of inspection there were 79 patients who were recorded as having a learning disability.
- One health check for a patient with a learning disability was completed by the practice in the year 2018/19.
- Records showed that six health checks had been completed since 1 April 2019. The initial assessment of five was completed by a health care assistant and the records show evidence of weight, BMI, blood pressure, healthy eating advice etc. However, one completed in its entirety by a nurse did not contain the same level of information. The five reviews initially started by the HCA were completed by GPs. There was no evidence of any physical examination. Health care plans were recorded as having been completed but they were not visible on the clinical system.

**This population group was rated requires inadequate because of practice wide issues which affected all population groups.**

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

**Population group rating: Inadequate**

| Findings |
|---|
| • Quality outcomes frameworks performance was significantly below both national and CCG averages.<br>• Although patient records indicated that patients with dementia had been reviewed in a face to face consultation further examination of some of these records showed that not to be the case. |

| 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) | 43.0% | 85.4% | 89.5% | Significant Variation (negative) |
| Exception rate (number of exceptions). | 5.3% (6) | 18.3% | 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) | 53.6% | 86.2% | 90.0% | Significant Variation (negative) |
| Exception rate (number of exceptions). | 2.7% (3) | 16.1% | 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) | 76.1% | 82.7% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 6.3% (9) | 7.6% | 6.6% | N/A |

**Monitoring care and treatment**

## There was limited monitoring of the outcomes of care and treatment.

| Indicator | Practice | CCG average | England average |
|---|---|---|---|
| Overall QOF score (out of maximum 559) | 476.0 | 524.4 | 537.5 |
| Overall QOF exception reporting (all domains) | 4.3% | 5.6% | 5.8% |

| | Y/N/Partial |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | No |
| The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. | No |

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

We were provided with details of two audits that had been carried out. One was an audits of prescription stationary security. Another was a single cycle audit of patients receiving minor surgery. The audits did not provide sufficient clinical detail to demonstrate any improved outcomes for patients.

| Any additional evidence or comments |
|---|
| Given the discrepancies in patient records and their impact upon QOF achievement we could not be assured that the partners had effective clinical oversight or monitoring of outcomes for patients |

**Effective staffing**

## The practice was unable 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 taking for the cervical screening programme. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | No (1) |
| There was an induction programme for new staff. | Yes |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of | No (2) |

| | |
|---|---|
| professional revalidation. | |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | No (4) |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | No (3) |
| Explanation of any answers and additional evidence:<br>(1) Staff that we spoke with told us that there was no protected learning time and they had to fit in their on-line training in-between patient appointments.<br>(2) There was limited evidence of regular supervision of staff through annual appraisal. Some members of staff that we spoke with told us they had had a conversation with a GP in October, at which the GP didn't make any notes and that they had been given their appraisal form on day the prior to our inspection. Another said us they had been told to write their own appraisal and get it signed by a GP. Another member of staff who had been at the practice several years had never had an appraisal.<br>Nurses told us there was no formal system of supervision although GPs were available for advice if required. The provider informed us that they had terminated the post of lead nurse as 'it had gone to their head'<br>(3) Staff throughout the practice and all levels told us that the management of the practice had broken down and that consequently they were unsure of the line of management. We were made aware by the provider that they had identified performance issues, but we were not assured that the issues were being correctly managed or that staff received any support.<br>(4) We could not be assured how the management assured themselves of the competence of staff employed | |

**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) | Yes |
| 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. | Yes |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Yes |

**Helping patients to live healthier lives**

## Staff were not 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. | No (1) |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | No (2) |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Partial. See (1) |
| Explanation of any answers and additional evidence:<br>(1) Patients at risk of developing diabetes, whose blood glucose levels were higher than normal, but not yet high enough to be classed as diabetic were not referred to the NHS diabetes prevention program.<br>(2) We looked at the records of some patients who had a diagnosis of dementia. The clinical records indicated that a review had been completed and care plan done. However, when we looked at the records there was no evidence of any care plan being in place and no evidence of any discussion with the patient and /or their carer. | |

| 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) | 93.2% | 94.5% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.8% (29) | 1.0% | 0.8% | N/A |

**Consent to care and treatment**

## The practice was unable to demonstrate that it 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. | Partial |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide. | No |
| The practice monitored the process for seeking consent appropriately. | No |
| Explanation of any answers and additional evidence:<br>We looked at the reviews of patients who had a diagnosis of dementia. The clinical records indicated that a review had been completed and care plan done. However, when we looked at the records there was no evidence of any care plan being in place and no evidence of any discussion with the patient and /or their carer. Since this was the case it followed that there was no process in place for monitoring that consent was appropriately obtained. | |

# Caring Rating: Requires Improvement

**Kindness, respect and compassion**

## Feedback from patients was mixed about the way staff treated people.

| | Y/N/Partial |
|---|---|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |

| CQC comments cards | |
|---|---|
| Total comments cards received. | 61 |
| Number of CQC comments received which were positive about the service. | 45 |
| Number of comments cards received which were mixed about the service. | 16 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|---|---|
| Comments cards | The 16 cards that had mixed comments all expressed negative views on the availability of appointments. All expressed positive views on the kindness, care and respect extended by staff. |

**National GP Survey results**

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 12946 | 253 | 92 | 36.4% | 0.71% |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018) | 81.2% | 88.5% | 89.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018) | 82.9% | 87.8% | 87.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018) | 89.8% | 96.8% | 95.6% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018) | 58.5% | 83.2% | 83.8% | Variation (negative) |

| Question | Y/N |
|---|---|
| The practice carries out its own patient survey/patient feedback exercises. | No |

**Involvement in decisions about care and treatment**

## Staff helped patients to be involved in decisions about care and treatment.

| | Y/N/Partial |
|---|---|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | No |
| Staff helped patients and their carers find further information and access community and advocacy services. | No |
| Explanation of any answers and additional evidence:<br>We were not assured that staff communicated sufficiently with patients regarding their care and treatment and that patients were advised about community and advocacy services. This was because care plans were not being produced for relevant patients which would have provided a key opportunity to communicate with patients and their carers. | |

**National GP Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018) | 96.5% | 94.2% | 93.5% | No statistical variation |

| | Y/N/Partial |
|---|---|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Upon request |
| Information about support groups was available on the practice website. | No |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 192 carers were recorded, which was 1.5% of the patient list. The practice had a goal of achieving 3% identification by November 2019. The practice provided us with information that stated that 2.7% of the practice list had been identified as carers, as did their action plan, but this was not supported by a search of the clinical system. |
| How the practice supported carers. | Signposting to the voluntary sector. There was an action plan for improving support for carers but many of the actions were outstanding |

**Privacy and dignity**

## The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|---|---|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Yes |
| Consultation and treatment room doors were closed during consultations. | Yes |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Partial |
| Explanation of any answers and additional evidence:<br>The open plan nature of the reception area meant that maintaining patient confidentiality was difficult, although patients were encouraged to stay back from the desk whilst waiting to be dealt with. | |

# Responsive Rating: Inadequate

**Responding to and meeting people's needs**

## The practice organised and delivered services to meet patients' needs.

| | Y/N/Partial |
|---|---|
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice. | Yes |
| Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. | Yes |

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| Opening times: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| | |
| Pre-bookable extended hours appointments are available from Monday to Friday 6.30 to 8pm and on Saturday and Sunday mornings at the practice which acted as the GP extended hours hub | |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 12946 | 253 | 92 | 36.4% | 0.71% |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018) | 87.4% | 95.4% | 94.8% | Variation (negative) |

| Any additional evidence or comments |
|---|
| |

**The areas we found inadequate affected all population groups, so we rated all population groups as inadequate.**

## Older people — Population group rating: Inadequate

**Findings**

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Residential care homes and nursing homes were allocated a specific GP who conducted a 'ward round' visit to the home every three weeks as a matter of course.

## People with long-term conditions — Population group rating: Inadequate

**Findings**

- Patients with multiple conditions could make a double appointment and have their needs reviewed in one consultation.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- Anticipatory planning and prescribing for patients on the palliative care register.

## Families, children and young people — Population group rating: Inadequate

**Findings**

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice offers family appointments on request according to capacity.
- Reviews for children were planned for school holidays where that was appropriate.
- The practice had attempted a survey of parents and carers to understand what would improve the service we provide for young children and babies. Unfortunately, there were no responses, so the practice was looking at other ways to engage with parents.

.

## Working age people (including those recently retired and students) — Population group rating: Inadequate

**Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Appointments with a GP, a practice nurse and a healthcare assistant were offered early morning.
- The GP extended hours hub was hosted by the practice from 6.30 and 8pm each weekday evening and each morning on Saturday and Sunday. Appointments available, this included those with GP, nurses and healthcare assistants and included long-term condition reviews.
- An ultra sound service run by a third-party provider was available from the practice each Saturday from 9am to 1pm. Uptake has been positive, and discussions are ongoing about extending the service and potentially also providing physiotherapy.
- A Carers identification protocol had increased the identification of Carers to 2.7% of the patient list. The target was to identify 3% by 1 Nov 2019 and the practice aims to eventually achieve a recognition rate of 5%.

## People whose circumstances make them vulnerable

**Population group rating: Inadequate**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice liaised with community pharmacies for electronic prescribing and measured dosage packs for patients in the population group.
- Weekly medications and regular reviews by GP's of identified vulnerable substance misuse patients.
- Telephone contact made as a reminder of booked appointments for identified patients.

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

**Population group rating: Inadequate**

**Findings**

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Staff have received Dementia Friends training and Cleveland Surgery is a dementia friendly practice.
- The practice has undertaken the 15 Steps review of the building to ensure its suitability for people with dementia.
- The practice has an appointed a lead for dementia and have developed an action plan to improve services to people living with dementia over the next year. This includes regular visits to the practice from the Alzheimer's society.
- The surgery has patient alerts on the clinical system that can be set to ensure that staff are highlighted to any specific needs or reasonable adjustments required to support the patient prior to contact, i.e. patient hard of hearing.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

**Timely access to the service**

## People were not able to access care and treatment in a timely way.

National GP Survey results

| | Y/N/Partial |
|---|---|
| Patients with urgent needs had their care prioritised. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| Appointments, care and treatment were only cancelled or delayed when necessary. | Yes |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 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 (01/01/2018 to 31/03/2018) | 26.6% | N/A | 70.3% | Significant Variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018) | 38.3% | 68.2% | 68.6% | Variation (negative) |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018) | 39.1% | 65.0% | 65.9% | Variation (negative) |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018) | 52.7% | 75.5% | 74.4% | Variation (negative) |

| Any additional evidence or comments |
|---|
| The Patient Participation Group had carried out a survey of patient during October, November and December 2018. The results broadly re-enforced the findings form the national GP survey. We were provided with an action plan to demonstrate how the practice intended to address the issues and some of the actions were completed but there had been no measure as to whether the actions had been effective.<br><br>Although the practice was the hub for the GP extended hours access provision for the Gainsborough area and the service was staffed by Cleveland staff, the practice website made no reference to it at all, meaning that patients might not be aware of the existence of the service and the availability of these pre-bookable appointments. |

| Source | Feedback |
|---|---|
| NHS Choices | There were six comments recorded on NHS Choices from January 2019 to the date of our inspection. Five respondents gave the practice a rating of one star and one a rating of five stars. Comments included rude and inefficient receptionists, difficulty with the repeat prescription process, long waits for treatment, difficulty in getting an appointment and long waits for the telephone to be answered.<br>The positive comment concerned the female salaried GP. |

**Listening and learning from concerns and complaints**

## Complaints were not always listened and responded to or used to improve the quality of care.

| Complaints | |
|---|---|
| Number of complaints received in the last year. | 29 |
| Number of complaints we examined. | 5 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 4 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|---|---|
| Information about how to complain was readily available. | No |
| There was evidence that complaints were used to drive continuous improvement. | No |

Explanation of any answers and additional evidence:

There was no complaints information displayed in the patient waiting area. When we asked reception staff how they dealt with complaints we were told that they gave complainants a 'your opinion counts' form, told them to fill it in and then post it in the comments box.

The complaints policy was not available to view on the practice website.

We saw that those complaints that had been recorded were generally dealt with in a satisfactory manner, but we noted that one complaint dated 14 March 2019 regarding the behaviour of a GP partner had been referred to them for an explanation, but they had not responded.

Another complaint we looked at had been finalised but the letter to the complainant did not contain the required detail of how to contact the Ombudsman.

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| | Although we were provided with a trends analysis that identified some learning from complaints recorded for November and April 2019, there was no evidence that this learning had been implemented or cascaded to staff.<br>However, we did see that complaints and learning were regular agenda item at clinical meetings. |

# Well-led Rating: Inadequate

**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. | No (1) |
| They had identified the actions necessary to address these challenges. | No (2) |
| Staff reported that leaders were visible and approachable. | No (3) |
| There was a leadership development programme, including a succession plan. | No (4) |

Explanation of any answers and additional evidence:

(1) Three of the four GP partners were present at the inspection. They acknowledged that the governance of the practice had broken down and they told us there was a breakdown in communication at all levels within the practice. However, they also told us that in their view this was all the fault of non-clinical staff. Managerial staff were excluded from the pre-inspection presentation.

(2) The partners had appointed a manager consultant who worked with them for one afternoon a week to try and address the issues. They had developed a new management structure and hoped to be recruiting into the structure shortly. We did not have any confidence that one afternoon a week was enough time to make any significant impact on the underlying difficulties at the practice. Additionally, this consultant did not have experience in primary medical services.

(3) Except for one member of staff, all those we spoke with told us that GP partners, were not always approachable. One was described as intimidating, controlling and autocratic. Staff told us one GP had taken over control of most of the administration and non-clinical governance structures and had to approve everything personally, including any expenditure. This also included annual leave approval for non-clinicians. There was no evidence of any credible leadership or succession planning.

(4) There was no evidence of succession planning and leadership development

**Vision and strategy**

## The practice did not have 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. | No |
| There was a realistic strategy to achieve their priorities. | No |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | No |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | No |

| | |
|---|---|
| Progress against delivery of the strategy was monitored. | No |
| Explanation of any answers and additional evidence:<br>All staff we spoke with told us that providing a high class, safe service to patients was their priority. However, they also told us that as the communications within the practice had broken down, and with no clear lines of supervision or accountability it was increasingly difficult to become involved in improving the service.<br>The partners stressed that their strategy was to re-structure the governance of the practice to improve the service to patients, but we were not assured that the partners could achieve that aim without support.<br>The discrepancies in the QOF achievement figures meant that progress against the strategy could not be accurately measured and relied upon. | |

**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. | No (1) |
| Staff reported that they felt able to raise concerns without fear of retribution. | No (2) |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes (No (3) |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| Explanation of any answers and additional evidence:<br>(1) The culture of the practice did not nurture good behaviour and values. The manipulation of QOF performance data by GP partners demonstrated poor values at the top of the organisation.<br>(2) We spoke to five members of staff who told us that they did not have confidence in approaching any of the partners with their concerns. Some staff we spoke with told us of an autocratic and intimidating culture.<br>(3) We saw an example of a GP failing to respond to a complaint about their personal behaviour and another where a complainant had been responded to in writing by a person other than the complaints lead. The letter did not contain all the relevant and required information. | |

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

| Source | Feedback |
|---|---|
| Interviews with staff | Staff we talked with were generally negative about working in the practice in terms of the relationships between staff and the partners. However, one clinical member of staff said they received excellent support from one partner in particular. All the staff we spoke with said that in their view the care and treatment patients received was good and that was their priority. |

**Governance arrangements**

## The overall governance arrangements were ineffective.

| | Y/N/Partial |
|---|---|
| There were governance structures and systems which were regularly reviewed. | No (1) |
| Staff were clear about their roles and responsibilities. | No (2) |
| There were appropriate governance arrangements with third parties. | Yes |

Explanation of any answers and additional evidence:

(1) The governance both clinical and non-clinical was ineffective. There was no oversight of clinical performance and the appropriateness or otherwise of some entries into patient records undertaken by GP partners.
The governance structure had not identified the very high numbers of new patient notes waiting to be summarised or if it had no action had been taken to address the situation.

(2) Whilst clinical staff we spoke with were clear on their responsibilities, non-clinical staff told us that the management of the practice was chaotic. One clinical member of staff said there was a clear disconnect between the partner GPs and staff.

**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 which were regularly reviewed and improved. | No |
| There were processes to manage performance. | No |
| There was a systematic programme of clinical and internal audit. | No |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | No |

Explanation of any answers and additional evidence:

The systems in place to provide assurance for managing risks, issues and performance were ineffective. Poor and inaccurate clinical record keeping, and lack of clinical audit made it difficult to have an accurate oversight.

**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. | No (1) |
| Performance information was used to hold staff and management to account. | No (2) |

| | |
|---|---|
| Our inspection indicated that information was accurate, valid, reliable and timely. | No (3) |
| There were effective arrangements for identifying, managing and mitigating risks. | No (4) |
| Staff whose responsibilities included making statutory notifications understood what this entails. | No (5) |

Explanation of any answers and additional evidence:

(1) The unreliability of the data contained within patients records meant that they could not be relied upon.

(2) Performance information could not be relied upon as being accurate. For example, QOF performance data was shown to be inaccurate.

(3) As per (1) and (2)

(4) The system for identifying risk was ineffective. For example, there was no oversight of the build-up of un-summarised patient records and no oversight of the potential risk to patients by not sending mail for the period 14 to 22 May 2019.

(5) Two new GPs had joined the practice partnership in July 2016 and February 2018 respectively. The practice had not made the required changes to the CQC registration.

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

## The practice involved / did not involve 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. | Yes (1) |
| Staff views were reflected in the planning and delivery of services. | Yes (2) |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |

Explanation of any answers and additional evidence:

(1) Patients views were sought and acted upon. An example was the call for a female GP to augment the care and treatment provided by the four male partners. A female salaried GP had been appointed in response.

Feedback from Patient Participation Group.

| Feedback |
|---|
| We did not have any contact with the PPG. |

| Any additional evidence |
|---|
| We noted that the practice displayed a sign on the exterior of the building stating that it was a teaching practice. The practice was no longer a teaching practice. |

**Continuous improvement and innovation**

## There were systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|---|---|
| There was a strong focus on continuous learning and improvement. | No |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence:<br>There was an effective programme of meetings for staff across all groups. The meetings were well documented, with routine agenda items and any learning was communicated. However, there was no effective appraisal system in place. | |

**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.