

Care Quality Commission

Inspection Evidence Table

Suttons Medical Group (1-544499363)

Inspection date: 17 July 2019

Date of data download: 16 July 2019

Overall rating: Good

Well-led

Rating: Good

Suttons Medical Group had been inspected previously on the following dates: -

25 and 26 July 2017 under the comprehensive inspection programme. The practice was rated as Requires Improvement overall with Requires Improvement for providing a safe and well-led service. A breach of legal requirements was found in relation to Safe care and treatment, Safeguarding service users from abuse and improper treatment and Good Governance. Requirement notices were issued which required them to submit an action plan on how they were going to meet these requirements.

12 July 2018 we carried out a comprehensive inspection and to follow up on breaches of regulations identified at our inspection in July 2017. At this inspection the practice was rated as Good overall with a Requires Improvement for providing a well-led service. The practice had made a number of improvements but further work was required to ensure that the systems and processes the provider had in place were established and operated effectively.

We carried out an announced focussed inspection at Suttons Medical Group on 17 July 2019 as part of our inspection programme. Following the Care Quality Commission's annual regulatory review, we inspected the domain area of well led along with information from our previous inspection.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

At the inspection in July 2018 the management staff told us they had oversight of both sites of the practice. However, we found that the management of the Sutton Bridge branch which was not consistent with that of Long Sutton.

- At this inspection we discussed the oversight further and we were assured that the management team visited the branch surgery at least twice a week and a GP provided clinical oversight on a daily basis

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: At this inspection the practice told us that from 1 July 2019 they were part of a Primary Care Network called South Lincolnshire Rural Primary Care Network. It consisted of 7 GP practices in South Lincolnshire with a patient population of approximately 54,000 patients.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
Explanation of any answers and additional evidence: At the inspection in July 2018 we found that the practice did not hold full team meetings which meant	

that we could not be assured that all staff were aware of significant events and complaints.

- At this inspection we found that the management team had reviewed the meeting structure and now had two full team meetings planned for 2019. We saw meeting minutes for the meeting held on 17 April 2019 and found significant events and complaints had been discussed with the staff along with learning and actions.
- We looked at a variety of other meeting minutes. For example, GP partner, Team Lead, Safeguarding, Anti-coagulation meetings and found they were well documented.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<p>At the inspection in July 2017 we found that Suttons Medical Group had governance arrangements in place to support the delivery of their strategy but some of the systems in place to monitor quality and make improvements were not effective.</p> <p>At the inspection in July 2018 we found there were clear responsibilities, roles and systems of accountability to support good governance and management. We found some systems and processes needed to be embedded more to ensure the wider team were included such as information recording and sharing.</p> <p>At this inspection we found:-</p> <ul style="list-style-type: none"> • We reviewed the system in place for the recording and investigating of significant events (SEA). We found that that practice manager kept a detailed spreadsheet of the SEAs for the practice along with learning and actions. Meeting minutes annotated the discussion, learning and actions that had taken place. However, when we looked at four individual SEA's we found that there was limited documentation. We looked at the SEA policy and found that it did not give sufficient guidance for staff to follow when recording and investigating the event. The management team told us they would review the policy and make the changes accordingly. • We looked at the process the practice had for acting on and learning from patient and medicine safety alerts. We saw the practice had a system in place for receiving of safety alerts and they were able to evidence that these had been disseminated to clinical staff. However, they did not complete a spreadsheet to ensure all the relevant alerts had been received and in meeting minutes we looked at we could not see any evidence that safety alerts had been discussed. We looked at one example, Carbimazole, in relation to patients who were of child bearing age and were not able to see if the practice had carried out any searches. We spoke with the 	

management team who told us that all alerts relevant to the practice were discussed via email but they acknowledged that this needed to be documented to provide an evidence trail. Since the inspection the practice had told us they had five patients on Carbimazole but were not at risk of pregnancy. Going forward the practice will review patient safety alerts at each monthly practice meeting and will record the discussion in meeting minutes along with any immediate actions taken.

- The practice were able to evidence that translation services had been provided to five patients since the last inspection.

At the inspection in July 2018 we found that the practice had dispensary standard operating procedures in place but did not contain comprehensive information.

- At this inspection we found that all the standard operating procedures (SOPs) had been reviewed and contained the information required to ensure staff were able to carry out their role. These had also been reviewed by Controlled drugs accountable officers who had carried out a visit to the practice on 29/5/19. They found the SOPs to be comprehensive and contained all the relevant details required.

At the inspection in July 2018 we saw that exception rates in relation to the QOF were sometimes higher than local or national averages. However, the practice had a clear process for exception reporting where contact with patients was attempted and if there was no response after three attempts the patient was exception reported

- Prior to this inspection CQC received a report from NHS England called the QOF Post Payment verification report. The practice had been selected due to high achievement in achieving 100% QOF results. A visit was carried out on 9 April 2019. Within the report they identified that exception reporting for a number of long term conditions was higher than CCG and national average. The visit identified that exception reporting was an active process. The team demonstrated they had made every effort to contact patients and only exception reported if they did not attend the practice after three invitations. The decision to exception report was made by either a GP or a nurse. Since this visit the practice had an exception reporting policy in place to ensure the decisions to exempt did not affect patient care.
- At this inspection we also looked at the data for 2018/19 QOF. We saw that the practice had again achieved 100% but this data was unverified at the time of the inspection. Exception rates were not available but from a review of the disease registers we could see that the practice had high prevalence in a number of disease areas and how much hard work had been carried out by the teams to achieve 100%. We looked at the records of five patients on the register for lithium therapy. We found that four had care plans documented in their notes and one record needed to be reviewed by the clinical team. We looked at four patients on the dementia register and found three had evidence of care plan discussions and one patient record needed to be reviewed by the clinical team.

Since the last inspection the practice have put in place the Eclipse system to enhance the safety of patients registered at the practice. ECLIPSE stands for: Electronic Checking Leading to Improved Prescribing Safety & Efficiency. Although it is still in the initial phase it allows for true Risk Stratification, Safety Alerts, Centralised Project Management, Integrated Care and Automated Patient Care Plans. The lead GP demonstrated that when it is fully implemented it will support the work the

practice carries out on medication reviews and the prescribing of medications.

Managing risks, issues and performance

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

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice involved 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
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
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:	
<p>At this inspection we saw that the practice had recently carried out an inhouse patient survey. We saw a well-documented review of findings. Positive comments were received about the care and treatment received. For example, Excellent service, staff obliging, caring, friendly. GP and nurse always listen and the on-line facility is very good. Negative comments in relation to phone access, appointments and length of time to get a routine appointment.</p> <p>We looked at the 2019 GP patient survey figures which had been released on 12 July 2019. We found the practice had improved in 15 out of the 18 questions against the CCG and national average. Three questions were below CCG and national average and these were in reference to overall experience of the practice, understanding mental health needs and receptionists being helpful. The practice told us they would be reviewing the findings and these would be discussed at the next team meetings.</p> <p>We looked at the Family and Friends Testing (FFT) for 2018. The practice had 153 responses over 12 months. 86% of those who responded were extremely likely or likely to recommend the practice to a family member.</p> <p>From January to June 2019 the practice had received 78 FFT responses. 97% of those who responded were extremely likely or likely to recommend the practice to a family member.</p>	

Continuous improvement and innovation

There were / 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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<p>The practice had a programme of quality improvement and used information about care and treatment to make improvements.</p> <p>At the July 2018 inspection the practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.</p> <ul style="list-style-type: none"> At this inspection we looked at the quality improvement activity since the last inspection. We 	

found that a considerable amount of work had been undertaken in terms of the safety of prescribing medicines. We saw examples of five audits, one of which, dated back from 2017 and had five audit cycles. The audits were well written, detailed and evidence of the discussion that had taken 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 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 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.