

Care Quality Commission

Inspection Evidence Table

Harraton Surgery (1-1737302413)

Inspection date: 14 and 18 April 2023

Date of data download: 30 March 2023

Overall rating: Inadequate

We carried out a focused inspection at Harraton Surgery on 28 July 2021 to check what progress the provider had made to improve in those areas we said they should from their previous inspection. The practice was rated as good overall and good for safe and effective services. The practice was rated as requires improvement for well-led services.

We carried out this inspection to check what improvements had been made in well-led services. We had also received some information of concern.

At this inspection we identified concerns with regard to the delivery of effective, caring and responsive services and we have rated these key questions as requires improvement. We rated the practice inadequate for providing safe and well-led services due to concerns. The overall rating is inadequate, and the practice will be placed into special measures.

Safe

Rating: Inadequate

We rated the service as inadequate for providing safe services.

- The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- The provider failed to assess the risk of the prevention, detection, and control of the spread of infections.
- We found that safety and operating procedures were not always sufficient or effective.
- We were concerned there were not enough staff to provide nursing appointments and to prevent staff from working excessive hours.
- The practice did not have systems in place for the appropriate and safe use of medicines.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	*Partial
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.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The designated safeguarding lead nurse for the local Integrated Care Board (ICB) carried out an audit of safeguarding at the practice in November 2022. There was an action plan in place for improvement. The provider was the safeguarding lead; their deputy was supposed to be the advanced nurse practitioner, however at the time of our inspection this post was vacant. The provider divided their time between this practice and their other practice and was therefore not always on site, meaning there was not always a safeguarding lead for staff to access in-person. *We did not see any evidence of minuted safeguarding meetings. *Some non-clinical staff did not have a DBS check. There was no documented clear rationale for the decision or risk assessment to support that this was safe or appropriate. 	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2023	Yes
There was a fire procedure. January 2023	Yes
Date of fire risk assessment: January 2023 Actions from fire risk assessment were identified and completed.	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: None	No
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The infection control lead at the practice was absent. We were told the deputy lead for this was the provider. Following the inspection, we were sent an infection control policy, a hand washing audit and a blank template for a nurse room cleaning schedule. We asked to be provided with the latest practice-initiated infection control audit, however this was not provided. The practice infection control policy included an example of a detailed infection control audit which the policy stated would be completed annually by the practice. The practice had been audited by the lead infection control nurse from the local NHS trust in December 2022. There was an action plan in place for improvement by February 2023. Some of these actions had not been met, for example, action to de-clutter and remove various items to suitable rooms within the surgery. We found tins of paint stacked in the staff toilet and boxes of various items stored in offices, on the floor, in corners, and both sites were not tidy. The practice had recently replaced their cleaning contractors on the advice of the trust infection control nurse. However, there were not any cleaning schedules in place or any way of checking how effective the cleaning of the practice was. At Harraton Surgery we found that sharps boxes were not signed, and a used, full sealed box was stored on the floor in a treatment room. When we pointed this out to the provider it was moved and put in an unlocked cupboard in the reception area. Staff told us there was no room to store clinical waste and it was collected from each treatment room every week. We found at both surgeries' issues presenting an infection control risk, as these areas could not be cleaned effectively or there was a lack of proper maintenance to the buildings which posed a risk for patients and staff. At Harraton Surgery we saw in the patient toilet that the toilet seat was stained. There was no paint on the wall and holes where a repair had not taken place. There were black damp marks on the wall at floor level. The paint on the door frame into the reception area and on the handrail on the stairs to the upstairs offices was flaking off, exposing bare wood underneath. At Springwell House in the patient toilet the toilet brush container was made of metal and had corroded. The sealant around the bottom of the toilet was black with what appeared to be mould. Some of the encasement of the water pipes next to the toilet had disintegrated and was black 	

with what appeared to be mould. The radiator in the toilet was rusty on the top at patient level. In the nurse's treatment room there were marks on the walls underneath the paper towel dispenser.

- At Springwell House we found an odour in the rooms where the windows had not been replaced. In these rooms the inside of the window frames inside had what appeared to be damp mould growing on them and between the ceiling and the window there were water mark stains consistent with a water leak. The boards on the front of the reception counter were loose, dirty, and scuffed.
- We found at both surgeries that the premises were not safe for their intended use by patients. For example, at the entrance to Springwell House we found the path on the disabled entrance was overgrown with weeds and the paint on the handrail was flaking off. There were empty boxes piled at the front entrance to the practice and a broken pane of glass and a large pile of leaves.
- At the entrance to Harraton Surgery there were at least 14 bags of domestic rubbish on the ground in plastic bin liners. Both council rubbish bins, household and re-cycling there were full. We were told the re-cycling bins were not emptied as they had been filled incorrectly which was why there was bagged rubbish on the ground. We brought this to the attention of the provider who said nothing and offered no explanation. No one was taking responsibility for the removal of this waste.

Risks to patients

There were gaps in 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.	*Partial
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours	No
<p>Explanation of any answers and additional evidence:</p> <p>* We were concerned that there were not enough staff at the practice to provide adequate nursing appointments. At the time of our inspection there was one locum practice nurse working one and a half days per week. Staff told us that they could not offer enough nursing appointments. They were having to rely on extended access appointments for this, particularly for cervical screening.</p> <p>Feedback from staff we received included comments that they were tired and there was low morale, as staff were working extra due to there being staff shortages.</p>	

Information to deliver safe care and treatment

Staff sometimes 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. ¹	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and 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.	*Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	*Partial
Explanation of any answers and additional evidence: *Staff told us laboratory and pathology results were not actioned in a timely manner; however, we did not find any evidence of this at our inspection.	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	1.15	1.00	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	12.3%	7.4%	8.5%	Tending towards variation (negative)
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 (01/04/2022 to 30/09/2022) (NHSBSA)	5.07	4.82	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	206.0‰	244.4‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.83	0.45	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	5.7‰	6.6‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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).	Yes

Medicines management	Y/N/Partial
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 effective medicines reviews for patients on repeat medicines. ¹	*Partial
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.	Yes
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. ²	*Partial
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 and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Yes
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
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 UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We carried out remote searches of clinical records to check how the practice monitored patients' health in relation to the use of disease-modifying antirheumatic drugs (DMARDs) and medicines requiring monitoring. We found that some patients had received appropriate monitoring at the required intervals, however there were some examples where they had not.</p> <ul style="list-style-type: none"> • All patients prescribed DMARDs were followed up and monitored by secondary care. • *We reviewed patients who were prescribed medicine to treat high blood pressure. From 587 patients prescribed this medication we identified 56 patients, (10%), who the searches indicated may not been monitored in the last 18 months. We looked at 5 of these patients in detail and found all 5 patients were overdue monitoring, 2 had not received the required blood test and 2 had not been recalled for monitoring since 2017. • *Our searches identified 8 patients who had a potential missed diagnosis of diabetes. Three of 5 records reviewed in detail showed these patients had not been clinically coded as prediabetes, 1 patient had not been reviewed since 2021. Another patient had not been informed of this diagnosis. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> *We reviewed patients who has been prescribed a short-acting beta agonist (SABA) inhaler which help patients with asthma breathe. Patients suffering with asthma who are receiving regular inhaled short acting beta agonists should also receive an inhaled corticosteroid. Twelve patients had been prescribed 12 or more of these in the last 12 months, which contradicted the latest recognised guidance. We looked at 5 patients in detail. One patient was diabetic and not clinically coded as such, 2 patients were pre-diabetic and not coded, 3 patients had not received the appropriate follow up or informed of this diagnosis and had not been referred for appropriate screening and monitoring. The National Report into asthma deaths states that excessive use of SABA inhalers is linked to increased risk of death. *Staff told us that repeat prescriptions were not signed on time and patients complained that they did not receive their medication in a timely manner. We did not find any evidence of this during our inspection. From our clinical searches we found no significant issues with patient's medication reviews in the last 3 months. 	

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.	*Partial
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.	*Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	22
Number of events that required action:	Unknown
Explanation of any answers and additional evidence: We asked for a report of significant events for the last 12 months. We received a database print out following our inspection. It was difficult to tell how they had been dealt with and any learning taken from them. Staff said they did not receive learning from significant events, there were no staff meetings where these or learning from them was discussed.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	*Partial
Staff understood how to deal with alerts.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We were unclear how safety alerts were managed. Staff told us various pharmacists had access to safety alerts and managed them. We were told that the provider's other practice managed alerts for this practice. 	

- However, from our clinical searches we saw that the patient safety alerts we looked at were being actioned.

Effective

Rating: Requires Improvement

We rated the service as requires improvement for providing effective services.

- Care and treatment at the practice did not always reflect current evidence based guidance, best practice during assessment and when managing long term conditions.
- Few clinical audits were carried out and treatment was not always monitored regularly or robustly, including cervical screening. Results of monitoring were not always used effectively to improve quality.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always 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.	*Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	*Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	*Partial
There were appropriate referral pathways 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
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • *The provider told us the practice had protected learning time so that the staff could update their knowledge. Staff said that clinical updates were sometimes included in appraisals and sometimes there were meetings with the clinical staff from the provider's other practice. • We saw from the remote searches and review of clinical records we carried out that some patients did not always receive the appropriate monitoring at the required intervals, for example, asthma reviews and monitoring of angiotensin-converting enzyme (ACE) inhibitors. 	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- From the remote searches of clinical records, we carried out we saw that patients who received high-risk medication did not always receive appropriate monitoring at the required intervals.
- All patients with a learning disability were offered an annual health check.
- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- We carried out remote searches of clinical records to check how the practice managed patients' health who experienced long term conditions. We saw that these patients were not always reviewed to ensure their treatment was optimised in line with national guidance.
- We looked at patients who received thyroid replacement therapy. From 196 patients receiving this medication we found 9 patients who had not received thyroid function test monitoring in the last 18 months. Of the 5 records looked at in detail, 3 had been recalled and not responded. One patient had disseminated cancer and they had not been recalled.
- We looked at patients diagnosed with asthma. Out of 167 patients, 12 had received 2 or more courses of rescue steroids. Of 5 looked at in detail, 2 did not receive inhaled corticosteroids (ICS). One was reviewed in November 2022 there was no mention of these being discussed. One patient had not had an asthma annual review since November 2020. One completed a questionnaire in December 2022 and had not been invited to a clinician-led review. Not all patients were followed up following an exacerbation of asthma in accordance with the National Institute for Health Care Excellence (NICE) guidance.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus,	26	26	100.0%	Met 95% WHO based target

Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	27	29	93.1%	Met 90% minimum
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	27	29	93.1%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	27	29	93.1%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	46	51	90.2%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	68.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	61.7%	63.1%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	70.8%	68.7%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	48.3%	52.6%	54.9%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments
The practice were failing to meet the 80% UK Health and Security Agency target for cervical screening, currently at 68.8%. The provider told us this was because of coding issues; however, the staff we spoke with told us it was because there had not been enough nursing capacity at the practice and there was a reliance on extended access arrangements to provide cervical screening appointments. We asked if any audit had been carried out to establish how this uptake figure could be improved. We received a list of patients who had attended the practice for cervical screening between the dates 14 December 2022 and the 6 January 2023. This represented a data collection exercise rather than an audit and did not demonstrate evidence of improvement from one audit cycle to the next.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	*Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- We asked the practice to provide us with examples of clinical audits they had carried out. We received 1 2-cycle audit which looked at medication used to treat diabetes. We received 2 other audits; 1 we could not accept as it had patient identifiable information on it and the other was a data collection document. There was no scheduled programme of quality improvement activity.
- Due to the frequent change of staff and use of locum GPs the practice were unable to provide us with information of national and local improvement initiatives.

Effective staffing

The practice was able 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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	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 professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
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

Helping patients to live healthier lives

Staff were 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	*Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice were able to refer patients to a social prescribing team at the local alliance of GPs.• The team at the practice were small and the staff were able to keep in touch with, for example, elderly patients if they needed support.• *Not all patients were offered an appropriate health check.	

Consent to care and treatment

The practice 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes

Caring

Rating: Good

We rated the service as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff gave us an example where the practice had funded a taxi to collect a patient who needed to come to the practice to have their bloods taken.• Staff said they felt they were a small team who worked together to focused on giving good patient care.	

Patient feedback	
Source	Feedback
NHS friends and family	The practice did not participate in NHS friends and family, this is a feedback tool for people who use NHS services to have the opportunity to provide feedback on their experience. After the inspection the practice told us they had signed up to start the surveys.
Complaints to CQC	The commission received 3 complaints from patients in the last 12 months. The themes in 2 of the complaints were the attitude of the GP and being unable to obtain an appointment or prescription.
NHS choices	There were no reviews of the practice on this website.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	87.6%	85.9%	84.7%	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 (01/01/2022 to 30/04/2022)	85.3%	85.2%	83.5%	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 (01/01/2022 to 30/04/2022)	93.3%	93.2%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	76.4%	75.5%	72.4%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> The practice had not sent out any surveys or sought the views of patients. The practice had received compliment cards from patients.

Involvement in decisions about care and treatment

Staff did not help 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice manager said that there was no carers champion in place and they were not actively doing anything to support carers.Following our inspection, the practice manager contacted us. They had made contact with a carer assessment worker who said they thought the practice were doing everything they could for carers. The carer assessment worker were going to help the practice to set up a carer's newsletter.	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	90.5%	89.9%	89.9%	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.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	There were 194 carers registered on the practice clinical system, which represented 5% of the practice population.
How the practice supported recently bereaved patients.	The practice had a bereavement pack which they sent out to bereaved relatives and they sent card to the family where appropriate.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
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.	Yes

Responsive

Rating: Requires Improvement

We rated the service as requires improvement for providing responsive services.

- Patients had not been formally consulted on their needs and what they thought of the service.
- The premises had not been maintained to an appropriate standard to meet patient's needs.

Responding to and meeting people's needs

Services did not always meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	No
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.	No
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Although the practice is small and staff told us knew the patients well, patients had not been formally consulted on their needs and what they thought of the service. • The premises had not been maintained to an appropriate standard to meet patient's needs, for example the disabled ramp at Springwell House had not been maintained. 	

Practice Opening Times		
Day	Time – Harraton Surgery	Time – Springwell House
Opening times:		
Monday	8am to 6pm	8.30am to 6 pm
Tuesday	8am to 6pm	8.30am to 6 pm
Wednesday	8am to 6pm	8.30am to 6 pm
Thursday	8am to 6pm	8.30am to 6 pm
Friday	8am to 6pm	8.30am to 6 pm
Appointments available:		
<ul style="list-style-type: none"> • We saw the clinical staff rota as an example with appointments for 1 month. There were appointments at Harraton Surgery every day with a GP, however a GP was not always available at Springwell House. • We were concerned that there were not enough nursing appointments available across both sites. 		

Further information about how the practice is responding to the needs of their population

- The provider was the patients named GP.
- 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.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice offered flexible appointments outside of school hours.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Appointments were also available to patients at additional locations within the area, due to local extended access arrangements.
- The practice held a register of patients living in vulnerable circumstances.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	No
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	*Partial
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: *We were concerned about the number of nurse appointments available at the practice due to nurse vacancies and absence.	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	70.9%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	70.6%	59.6%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	67.5%	57.8%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	79.0%	72.5%	71.9%	No statistical variation

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	3
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: Staff told us that the practice were good at dealing with verbal complaints and that they had received several of these when repeat prescriptions were not ready on time, however there was no log of verbal complaints, therefore no patterns or trends could be analysed from these.	

Well-led

Rating: Inadequate

The practice had been inspected under this provider 7 times since November 2015. The ratings have been as follows for well-led services.

November 2015 – Inadequate.

June 2016, March 2018, March 2019, October 2019 and August 2021 – Requires improvement.

In August 2021 we said

- The leadership, governance and culture did not always support the delivery of high-quality sustainable care.
- There was a culture of blaming others for incidents rather than looking objectively at what the practice could change to improve the care and support they offered to patients.
- Communication mechanisms within the practice were ineffective.
- The practice continued to struggle to build a sustainable and stable clinical team and there was low morale amongst staff.

At this inspection we rated the service as inadequate for providing well-led services.

- The provider could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- Communication mechanisms within the practice were still ineffective.
- The practice still continued to struggle to build a sustainable and stable clinical team and there was low morale amongst staff.
- Governance arrangements were ineffective.
- There were not clear and effective processes for managing risks, issues and performance.
- The practice did not actively seek the views of patients to sustain high quality and sustainable care.

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
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	*Partial
There was a leadership development programme, including a succession plan.	No

Explanation of any answers and additional evidence:

- The evidence we gathered during this inspection suggested the provider had not developed leadership capacity and capability within the service since our last inspection. They were not taking ownership to address the challenges and risks faced by the practice. Previously the practice were struggling to build a sustainable clinical team. Staff said morale was low and staff said they were working harder and not valued for this work. We found the same issues at this inspection. We first raised the staffing issue in our inspection report of May 2016.
- We were told that the integrated care board (ICB) had recently asked for a succession plan which had not been submitted by the provider.
- At our previous inspection in July 2021 staff reported there was a communication issue within the practice. Not all staff were invited to or found out what was discussed at team and clinical

meetings. At this inspection we found that there was no formal meeting structure for staff, resulting in staff still not receiving all the information they needed to do their job.

- As with our previous inspections, staff reported the practice management team was visible and approachable. However, they did not always report the same of the lead GP. Staff told us they were often late to respond or did not respond at all when they were contacted for information/actions.

Vision and strategy

The practice had a vision, but it was not yet supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	*Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	*Partial
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: The ICB had asked for a 5 year business plan which the provider had drafted, this was not yet agreed or in place.	

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	No
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.	No
The practice had access to a Freedom to Speak Up Guardian.	*Partial
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff said they felt morale was low and they were having to work harder due to low levels of staff. 	

- *The provider told us that there was a Freedom to Speak Up Guardian available at a different practice. However, from the staff questionnaires we received staff said they either did not know who the Freedom to Speak Up Guardian was or what one was.
- There were no formal meeting arrangements in place. The last staff meeting was held in May 2021.
- At our inspection in 2021 we found the significant events process was not effective at identifying and disseminating learning for the practice. Staff reported they did not get to hear about the outcomes of significant events generally, but also reported they did not get feedback when they raised significant events themselves. At this inspection we saw that this was still the same.
- This culture of poor communication mechanisms discouraged candour, openness and honesty.

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

Source	Feedback
Staff questionnaires	<p>We received 4 staff questionnaires.</p> <p>Staff said they felt that leaders at the practice were approachable, in particular the practice and office manager.</p> <p>They felt that they needed more staff and in particular nursing staff.</p> <p>Due to low staff numbers, they felt that they had a higher workload and did not feel adequately rewarded for the work they did. They said that morale was low, and staff were tired.</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	*Partial
Staff were clear about their roles and responsibilities.	*Partial
There were appropriate governance arrangements with third parties.	*Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • *Governance structures and systems were not regularly reviewed, for example, in respect of medicines management and infection control. • *The practice did not have a forward plan of clinical audits to improve patient care. • *There was no formal meeting structure to communicate information to staff. • *Staff reported that sometimes there were delays in actioning test results and repeat prescriptions. However, we did not see any evidence of this during our inspection. 	

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.	*Partial
There were processes to manage performance.	*Partial
There was a quality improvement programme in place.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
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.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The arrangements for identifying risks were not being followed, even though there were health and safety risk assessments in place at the practice. There were risks to patients, for example, the disabled access at Springwell Surgery was not maintained. Rubbish was left outside of both practices and not managed. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	*Partial
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was not a system in place to support clinical audit. Some staff reported they were not confident on safeguarding. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

Engagement with patients, the public, staff and external partners

The practice did not actively 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.	No
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	*Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice manager told us that they had struggled to bring together a group of patients to form a patient participation group. The practice did not actively seek patient views. *Staff did tell us that they did feel their views were taken into account when they gave feedback, for example changes had been made to the telephone system and times for patient contact. However, this was not supported by a formal meeting structure. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	*Partial
Learning was shared effectively and used to make improvements.	*Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• *We were concerned about the learning from significant events.• *The practice did not seek patient views and there was a lack of clinical audit to improve outcomes for patients.• The staff told us that they were a small, dedicated team committed to looking after patients and giving good care.• They said administrative tasks had been managed between the administration team well.• Staff said there were opportunities to progress at the practice.• One of the long term locum GPs hosted fourth year medical students.	

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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 SICBL average.
- 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). This indicator does not have a SICBL average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **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.
- **%** = per thousand.