Care Quality Commission

Inspection Evidence Table

Prospect Surgery (1-549668039)

Inspection date: 9 July 2021

Date of data download: 28 June 2021

Overall rating: Inadequate

Serious concerns were identified during this inspection with regards to the safe care and treatment of patients and the monitoring, risk assessments, record keeping and governance arrangements supporting that. We were not assured that the service was safe. We inspected the key areas of safe, effective and well led at this inspections.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe Rating: Inadequate

We rated the practice as inadequate in the key question of safe at this inspection. We found that systems, practices and processes did not keep people safe and protected from abuse. This included:

- Patients prescribed high risk medicines were not being monitored in accordance with current guidelines.
- Patients were being co-prescribed medicines outside of manufacturers guidelines and there was no evidence that the risks associated with this prescribing had been considered and no rationale recorded in the patient's notes.
- Medication reviews were not always carried out, structured, included only limited narrative, and did not relate to individual medicines.
- Records of staff vaccinations/immunity were not held.
- There was a lead member of staff for safeguarding, but some staff did not know who it was.

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.	Partial

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	N
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	N

Explanation of any answers and additional evidence:

There was a lead member of staff for safeguarding but some staff did not know who it was.

Some staff were overdue safeguarding training updates. Eight administrative staff for safeguarding adults and seven administrative staff were overdue safeguarding children updates. One nurse did not have any safeguarding training documented on the staff training matrix.

The practice did not have multi-disciplinary team meetings to discuss safeguarding issues.

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

Explanation of any answers and additional evidence:

We asked for a record of staff vaccinations/immunity and were told there were no records held. There was no evidence that the practice were assessing the risk to staff and others in this regard or protecting workers and others from exposure to pathogens.

There was a file detailing the registration of clinical staff, which included all three GPs. All but one were up to date with registration checks and the practice were in the process of getting an update for the remaining GP. There was no evidence at the time of the visit of a process for checking the registration for nurses.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 24/7/2020	Y
There was a record of equipment calibration. Date of last calibration: 24/7/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: June 2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: The portable appliance testing certificate was not available during the inspection but was sent to CQC by the provider on 20 July 2021. The fire policy was agreed in June 2021. The fire policy did not stipulate timescales for carrying out fire drills (instead it stated 'from time to time'). No risks were identified from the fire risk assessment.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: not available	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 13/8/2020	Y
Explanation of any answers and additional evidence: The provider had not been able to access the premises/security risk assessment from NHS Property Services, but stated they would forward it to CQC as soon as they had it – at the time of writing this report we were yet to receive this.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: N/A	N
The practice had acted on any issues identified in infection prevention and control audits.	N
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

The provider was unable to provide any records to demonstrate they had carried out infection prevention and control audits.

There were no mechanisms in place to ensure that infection prevention and control (IPC) measures were adequately carried out. We were told that the clinician who had been allocated the role of infection control lead had not carried out any audits. No spot checks of the environment had been recorded. The practice were not assessing the risk in order to prevent, detect and control the spread of infection.

The practice's infection prevention and control (IPC) policy did not make any reference to COVID-19 even though it was updated in April 2021. (COVID-19 was confirmed as a pandemic by the World Health Organisation on 11 March 2020.)

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.	N
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
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.	N

Explanation of any answers and additional evidence:

Staff were expected to cover each other if they were off on sick leave or self isolating due to the pandemic. We were told that the practice had experienced lots of staff sickness during the pandemic but no action plan was in place to address this.

Receptionists who were answering the telephone to patients did so without any guidance on how to identify deteriorating or acutely unwell patients. Following the inspection the practice implemented a flowchart to guide staff.

The staff training matrix indicated that three clinical staff members had not had training or updates in sepsis/sepsis awareness. It was unclear whether they had been trained and it was not recorded or not trained at all as staff files were not examined for evidence at the inspection.

Information to deliver safe care and treatment

Staff did not always 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.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Explanation of any answers and additional evidence:

We found that medication reviews were not always structured, included only limited narrative and did not relate to individual medicines. This meant that clinicians accessing the patient's record following the medication review would be unable to establish what had been discussed and agreed, therefore potentially putting patients at risk.

We found evidence of two incidents where communication from the hospital requesting changes to patients' medication had been missed.

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.86	0.89	0.70	No statistical variation
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). (01/04/2020 to 31/03/2021) (NHSBSA)	11.4%	10.0%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	5.70	5.54	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	284.5‰	241.8‰	126.9‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.81	0.62	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	8.2‰	6.3‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
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.	Partial
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:
We found that the system in place for warfarin prescribing could be improved . The provider told us that they operated a yellow card system for warfarin prescribing, whereby the practice advised the patient which dose of warfarin to take based upon the blood test result. However, we found that warfarin was batch prescribed (repeat prescriptions, prescribed in advance) which meant that there were gaps in the process which could expose patients to potential harm.

We reviewed the remote searches of clinical records and found examples of patients prescribed high risk medicines such as azathioprine and methotrexate who were not being monitored in accordance with current guidelines. No regular searches were carried out to identify any overdue monitoring.

The latest publicly available prescribing data showed the practice were high prescribers of Pregabalin or Gabapentin per 1,000 patients compared to other GP practices in England. These medicines are normally used to treat epilepsy and anxiety and can also be prescribed to treat nerve pain.

Medicines management	Y/N/Partial

Track record on safety and lessons learned and improvements made

The practice did not have an effective 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.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	N
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.	N
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	6
Number of events that required action:	6
Explanation of any answers and additional evidence: Staff we spoke to at the practice were not clear on how to report a significant event and when asked were unable to locate a significant event policy. We saw evidence of a form for them to use but outcomes and learning from events were not discussed with all staff. We saw evidence that two significant events had been recorded following the identification of incidents during inspection activity.	

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

Event	Specific action taken
Wrong immunisation given to a child	Practice changed policy to state only one child at a time allowed to attend for immunisation to mitigate risk of error.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence: We found that patients prescribed some specific medicines were being placed at risk of harm. We saw limited evidence of signed pregnancy prevention plans for patients who were prescribed teratogenic drugs (for example, sodium valproate). If a clinical records search had been done when the MHRA alert linked to this area was published, existing patients on sodium valproate would have been identified and had a pregnancy prevention plan put in place and this would have ensured that patients were aware of the risks. We saw two examples where hospital letters requesting amendments to medication had been filed away by practice staff prior to being actioned by a GP. Only one of these was identified by the practice and one on the inspection.	

Effective Rating: Inadequate

- We rated the practice as inadequate in the key question of effective at this inspection. This was because patients needs were not assessed, they were not monitored appropriately and data for screening was lower than national targets with no plans in place to improve this. We were not assured that the practice were providing effective care to patients. Many of the issues we have identified leading to a lack of effective care apply to all population groups therefore all population groups are rated as inadequate.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was 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.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N

Explanation of any answers and additional evidence:

There was no regular system in place for staff to keep up to date with evidence based practice such as the discussion of NICE guidance.

There was a risk of patients presenting with urgent symptoms being missed as there was no guidance for non-clinical front line staff to identify such patients. Because of this and the potential for non identification of urgent cases, patients were at risk of not being informed when they needed to seek further help.

There were gaps in the systems and processes to monitor patients. We saw that patients were batch prescribed (repeat prescriptions, prescribed in advance) some medicines, such as asthma inhalers and warfarin. This meant that there was a lack of oversight of the use of these medicines. We found that the prescribing of asthma inhaler relievers had little control or oversight and did not support safe and effective asthma care. We saw evidence of one patient who had been prescribed 32 inhalers over 12 months. We found limited evidence of documented asthma reviews. We examined records of five

patients who were prescribed high numbers of salbutamol inhalers and of these, only one had had an asthma review within the last 15 months.

We found that the practice did not always provide care and treatment in a safe way. We reviewed the remote searches of clinical records and found examples of patients prescribed high risk medicines who were not being monitored in accordance with current guidelines. We also found that some patients who were prescribed angiotensin converting enzyme inhibitors, angiotensin-2 receptor blockers and spironolactone were also not being monitored in accordance with current guidelines. We were informed that no regular searches were carried out to identify any overdue monitoring and that the process of monitoring had been difficult due to staff shortages.

We looked at a random sample of the monitoring of five patients with chronic kidney disease. We found potential risk for three of them as the practice had not acted on the blood test results correctly. We were informed that the practice were not aware that the clinical system did not automatically assess and interpret the blood test results and had not been doing this manually.

Older people — Population group rating: Inadequate

Findings

- The practice followed up on older patients discharged from hospital but did not always ensure that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice did not carry out structured annual medicines reviews for older patients.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

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

Findings

- Patients with long-term conditions were not offered a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. New staff were undergoing training and not yet able to perform the reviews.
- Patients with suspected hypertension were not offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were not always offered an asthma management plan.

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. (01/04/2019 to 31/03/2020) (QOF)	86.7%	78.3%	76.6%	Tending towards variation (positive)

PCA* rate (number of PCAs).	22.9% (67)	14.9%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	92.4%	91.8%	89.4%	No statistical variation
PCA rate (number of PCAs).	29.3% (60)	15.6%	12.7%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	69.2%	85.1%	82.0%	Variation (negative)
PCA* rate (number of PCAs).	9.9% (16)	5.5%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	62.7%	69.2%	66.9%	No statistical variation
PCA rate (number of PCAs).	16.7% (50)	16.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	62.9%	76.7%	72.4%	No statistical variation
PCA rate (number of PCAs).	12.9% (87)	7.9%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	92.5%	93.0%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	4.2%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	66.9%	78.1%	75.9%	No statistical variation
PCA rate (number of PCAs).	17.1% (51)	10.2%	10.4%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments
The practice were an outlier for a number of personalised care adjustments. Management stated that they had oversight of this but did not provide a rationale for the adjustments.

Families, children and young people Population group rating: Inadequate

Findings

- The practice had not met the minimum 90% immunisation targets for four of five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five childhood immunisation uptake indicators. We were not told of a plan in place to improve the uptake of childhood immunisations.
- The care and treatment provided for patients requiring cervical screening was lower than the national targets of 80% uptake in eligible women.
- Currently cervical screening figures were at 50% of eligible patients with a target of 80%. Childhood immunisations were currently all below 90% apart from the primary course which was 93%. The practice 2016 figures showed 60% of eligible patients were cervically screened therefore the current figure of 50% showed a further decline in trying to achieve national targets. We did not see evidence of any action plan in place to mitigate the decline in patients receiving this care and treatment, meaning that a significant number of women were at increased risk of undetected cervical cancer and children were at an increased risk of contracting a preventable disease.
- The practice did not always have arrangements to identify and review the treatment of newly pregnant women on long-term medicines. We found that patients prescribed some specific medicines were being placed at risk of harm. Some patients who were prescribed teratogenic drugs (sodium valproate) did not have a signed pregnancy prevention plan.
- Young people could access services for sexual health and contraception.
- Practice nursing staff did not have the appropriate skills and training to carry out reviews for this population group but were undertaking training.

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, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	70	75	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	56	64	87.5%	Below 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) (01/04/2019 to 31/03/2020) (NHS England)	55	64	85.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	56	64	87.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	69	81	85.2%	Below 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

Any additional evidence or comments
We asked for, and were not provided with any plans in place to address the low uptake of child immunisations.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings
• Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery. • We found that the prescribing of asthma inhaler relievers had little control or oversight and did not support safe and effective asthma care. The practice were not ensuring that British Thoracic Society Guidelines were being followed. We found limited evidence of documented asthma reviews. We examined records of five patients who were prescribed high numbers of salbutamol inhalers and of these, only one had had an asthma review within the last 15 months.

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). (Snapshot date: 31/12/2020) (Public Health England)	49.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	59.3%	70.0%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	54.0%	61.5%	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	95.5%	94.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	60.6%	57.1%	54.2%	No statistical variation

Any additional evidence or comments
We asked for, and were not provided with any plans in place to address the low uptake of cervical cancer screening.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- Same day appointments and longer appointments were offered when required.
- We were told that there was a problem with the coding on the clinical system to record whether patients with a learning disability had had an annual health check.
- End of life care was not always delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- We saw evidence that only three staff had received dementia training in the last 12 months.
- Many of the issues we have identified leading to a lack of effective care apply to all population groups, including people experiencing poor mental health.

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 (01/04/2019 to 31/03/2020) (QOF)	78.6%	88.2%	85.4%	No statistical variation
PCA* rate (number of PCAs).	28.8% (17)	25.1%	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	80.6%	82.9%	81.4%	No statistical variation
PCA rate (number of PCAs).	16.3% (7)	8.2%	8.0%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments
The practice provided no rationale for the high PCA rates.

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	503.3	533.9
Overall QOF score (as a percentage of maximum)	90%	95.5%
Overall QOF PCA reporting (all domains)	12%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N

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

An audit by the medicines optimisation support technician at Tees Valley Clinical Commissioning Group highlighted in the 6 months from March 2020, antibiotic prescribing in Prospect Surgery increased by 8% compared to the same 6 months the previous year, accounting for 100 additional prescription items in

total. The average increase in antibiotic prescribing in the CCG area was 10.2%. Prescribing of the '3C' broad spectrum antibiotics (co-amoxiclav, cephalosporins and quinolones) increased by 25%. We were not shown any evidence of an action plan or improvement on these figures.

Any additional evidence or comments
Most of the quality improvement activity at the practice had been undertaken by the CCG staff. However, we were shown a joint injection audit undertaken by the practice staff but it was a list of patients who had been administered a joint injection with no quality improvement noted or any narrative to indicate what the list actually meant.

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

Explanation of any answers and additional evidence:

The practice manager confirmed appraisals were overdue. They had last taken place in February 2020. We saw examples of two appraisals undertaken in Feb 2020. The practice told us that they had the practice nurses booked in for appraisals and planned to do appraisals for administrative staff w/c 26 July over a fortnight.

Staff told us that they should have protected learning time, but due to the pressures of work this quite often did not happen.

Induction for new employees starting work was observed in staff files, but this covered the practicalities of starting work (e.g. smart card, contracts) rather than induction to a specific job role.

The approach to supporting and managing staff was not clear, staff had mixed views, with some citing a lack of support from leaders.

Coordinating care and treatment

Staff did not work 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.	N
Patients received consistent, coordinated, person-centred care when they moved between services.	N
Explanation of any answers and additional evidence: The practice were not engaging effectively with other organisations to deliver effective care and treatment. For example, no meetings had been held with Health Visitors to discuss children who were at risk. We were shown examples of information sharing via tasks on the computer system.	

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.	N
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N
Patients had access to appropriate health assessments and checks.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: The practice were not consistent in their approach to monitoring patients. We found examples of patients who had not been monitored in line with the latest guidance, yet still had access to their medicines. The practice were below national targets set for the uptake of cervical screening, bowel cancer screening, breast cancer screening and four of the five targets for childhood immunisations.	

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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial

Explanation of any answers and additional evidence:

We found that only two GPs had undertaken training in the mental capacity act, only four members of staff altogether had undertaken the training.

We looked at patient records who had a Do Not Attempt Cardio Pulmonary Resuscitation decision and found that some were overdue a review date. We were told there was no process in place to routinely check this.

Well-led Rating: Inadequate

We rated the practice as inadequate for the key question of well led for this inspection. We found that leaders at the practice could not demonstrate that the governance, risk management, performance, and overall strategy ensured high quality and sustainable care. The overall governance systems were ineffective.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: We saw numerous examples where leaders had not responded to challenges to quality and sustainability, including failures to have oversight on patient monitoring, safety alerts and staff training. Staff views were mixed regarding visibility of leaders.	

Vision and strategy

The practice did not have 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.	N
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: Staff we spoke with wanted to improve the service to patients, but lacked direction and leadership from the partners and management. Staff were unaware of the vision and values of the practice and regular staff meetings were not held. There were no systems in place to ensure GPs responded to changes in National Institute for Health and Care Excellence (NICE) guidance. We saw that there were no documented checks in place to ensure that clinicians who were employed by the service had read this guidance	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Partial

Explanation of any answers and additional evidence:

Some staff told us that they had felt able to and reported concerns to leaders but they had not always been acted upon.

We saw some examples of emphasis on the safety and wellbeing of staff, such as risk assessments for covid-19, however staff reported feeling stressed and the practice had suffered from staff shortages due to sickness. New members of staff were not supported in new roles, for example the practice nurses were not engaging in meetings with other practice nurses in the area. This was implemented following the inspection.

The provider's whistleblowing policy made no reference to a Freedom to Speak Up Guardian.

Of the 15 staff employed, only 10 had completed equality and diversity training including one of the two GP partners.

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

Source	Feedback
Staff questionnaire	Some members of staff reported that communication was poor in the practice and said that concerns that they reported to management were not acted upon.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:
The systems in place to ensure that patients being prescribed high-risk medicines were always appropriately monitored was not effective. We found examples of patients being prescribed medicines including azathioprine and methotrexate who were not being monitored appropriately.

The system for managing alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) was not effective. This meant that patients were potentially placed at risk of harm. We found examples where MHRA alerts should have prompted the provider to take action to reduce the risk of harm to their patients, but this action had not been taken. For example, separate MHRA alerts linked to the prescribing of Citalopram, Amlodipine and Simvastatin, and Clopidogrel and Omeprazole had not been acted on for all patients deemed to be at risk

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.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N

Explanation of any answers and additional evidence:
There was no overview of clinical records. There had been no review of the records or performance of new staff, and that they had not had an interim appraisal.

The follow up system to improve quality outcomes for patients was ineffective. We found that Public Health England performance data was below the national average in several areas in relation to prescribing, childhood immunisations and cervical screening. Nationally reported data showed that achievement was below the national average and exception reporting was higher than local and national averages. We saw no evidence of actions taken to address these areas.

The quality improvement programme in place was in response to CCG guidance and performed by CCG pharmacy staff.

We found that the practice's approach to risk management overall was inconsistent and ineffective.

The practice had limited systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	N
The practice actively monitored the quality of access and made improvements in response to findings.	N
There were recovery plans in place to manage backlogs of activity and delays to treatment.	N
Changes had been made to infection control arrangements to protect staff and patients using the service.	N
Staff were supported to work remotely where applicable.	Y

Explanation of any answers and additional evidence:

There was not an effective system in place for the clinical triage of patients contacting the practice by telephone. We saw receptionists in the practice were being asked to answer telephone calls and triage patients. The reception staff had received no training in triage and did not have any flowcharts to guide them. Following the inspection the practice sent us a flowchart provided to guide staff.

The systems in place to support infection prevention and control within the practice were not effective. There had not been an infection prevention and control audit carried out.

The systems in place to support effective multi-disciplinary discussions in order to protect children or adults who were subject to safeguarding plans were not effective. There had been no discussions about children or adults who were subject to a safeguarding plan, despite the practice safeguarding policy stating that there should be regular meetings with members of the multi-disciplinary team. In addition, some staff were not clear who the practice safeguarding lead was.

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.	N
Performance information was used to hold staff and management to account.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	N

Explanation of any answers and additional evidence:
Public Health data had declined without any evidence of an action plan to address this.
No patient or staff questionnaires had been undertaken since 2018.

The registered manager had made no statutory notifications to the Care Quality Commission in respect of a notifiable safety incident in May 2021.

There was a lack of effective systems to ensure that the learning outcomes from significant events such as serious incidents and complaints were shared with staff. During the inspection, few staff were able to recall or describe an example of a significant event or describe the outcome. There was a lack of evidence that significant events were properly recorded, investigated, discussed or disseminated. There was no analysis of themes or trends which could have prevented incidents from recurring. Staff we spoke with were unclear how to report a significant event and there was no significant event policy available.

Engagement with patients, the public, staff and external partners

The practice 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.	N
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence: We found that systems to support communication were not effective. The practice had not had staff meetings or multi-disciplinary team meetings in the last year. We saw evidence they had started to have staff meetings in the week before the inspection and saw minutes relating to these.	

Feedback from Patient Participation Group.

Feedback
No feedback available

Any additional evidence
The practice had a virtual PPG but had not had any feedback from them.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: The system in place to monitor the completion of training by staff employed by the provider was not effective. We found that the staff training matrix had lots of gaps in the recording of staff training, including for sepsis, health and safety and the mental capacity act for one of the GP partners. Furthermore, there was a gap in the recording of mandatory training for basic life support for one of the GP partners. We were informed that the GP had done the training. The practice subsequently provided evidence of a certificate of basic life support training undertaken on 2 June 2021 that had not been recorded in the training matrix. Anaphylaxis training was also missing in the staff training record for the other GP partner.	

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. 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 CCG 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 CCG 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.
- **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.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.