

Care Quality Commission

Inspection Evidence Table

The Staunton Group Practice (1-573879781)

Inspection date: 2 October 2018

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

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
Policies were in place covering adult and child safeguarding.	N
Policies were updated and reviewed and accessible to all staff.	N
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	N
Information about patients at risk was shared with other agencies in a timely way.	N
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	N
Disclosure and Barring Service checks were undertaken where required	Y
Explanation of any 'No' answers: At our previous inspections in August and November 2017, we found the practice did not have effective systems and processes in place to safeguard patients from abuse. We found over 160 patients who had not been reviewed to reflect their current safeguarding status. Staff members were not able to demonstrate that appropriate safeguarding coding was used on patient records or whether pop up alerts would notify staff of any ongoing concerns. At our inspection in May 2018, we found the review was still not complete. We found the systems and processes used by the practice exposed patients to the risk of harm and would continue to do so until the practice had ensured all patients identified as being at risk were properly reviewed and coded so staff could see when safeguarding concerns existed. At our inspection on 2 October 2018, we were told the service's safeguarding processes had been reviewed. However, we found practice partners had limited involvement, with most of this work having been completed by the caretaker practice. New policies, guidance and templates to ensure correct codes were used in the future had been drawn up by the caretaking practice which the practice partners intended to adopt. However, when we asked practice partners to explain the new procedures they had limited knowledge of them, providing little assurance the changes made would be sustained or managed effectively. Practice partners said work on reviewing and improving adult safeguarding	

records was still ongoing. The adult safeguarding register was limited to patients on care plans. They told us the practice had plans, not yet implemented, to establish a register that included patients with learning disabilities, “Mental Health with history of self-harm”, homeless patients and sex workers. Until the process was put in place, we could not be assured all patients were receiving care and treatment appropriate to their needs.

Recruitment Systems	Y/N
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 and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y
Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test:	Y 2/3/2018
There was a record of equipment calibration Date of last calibration:	Y 3/2/2018
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	N
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	N
Fire marshals	N
Fire risk assessment Date of completion Actions were identified and completed.	Y 1/8/2018 Y
Health and safety	Y/N
Premises/security risk assessment? Date of last assessment:	N
Health and safety risk assessment and actions Date of last assessment:	N
Additional comments: At our inspection in May 2015, the acting practice manager told us they had not been given access to all	

the previous practice manager's files. These included safety records, such as risk assessments and inspection certificates. Accordingly, there was no assurance that risks to patients, staff and visitors were effectively reviewed, assessed and managed.

At our inspection on 2 October 2018, the new practice manager, appointed in July 2018, told us they too had not been given access to the safety records. Therefore, we could still not establish whether risk assessments relating to, for example, general health and safety, security, fire safety and the storage of hazardous materials had been carried out. We saw an invoice stating that medical equipment had been inspected and calibrated in August 2018, but there was no report or list of the equipment included in the inspection to provide evidence that all the equipment was safe to use.

Infection control	Y/N
Risk assessment and policy in place	N
Date of last infection control audit:	September 2018
The practice acted on any issues identified	N
Detail: outstanding issue, relating to boiler replacement and refurbishing the disabled persons' toilet, on hold pending funding being identified.	
The arrangements for managing waste and clinical specimens kept people safe?	Y
Explanation of any answers:	
The practice manager was unable to access safety records and risk assessments and policies, including any relating to infection prevention and control.	

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	N
Comprehensive risk assessments were carried out for patients.	N
Risk management plans were developed in line with national guidance.	N
Staff knew how to respond to emergency situations.	Y
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.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
Explanation of any answers:	

The practice could not provide evidence of effective risk management.

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	N
Referral letters contained specific information to allow appropriate and timely referrals.	N
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N
<p>Explanation of any answers:</p> <p>Staff did not have the information they needed to deliver safe care and treatment to patients. At our inspection in May 2018, we found for 615 patients who had transferred from other GP services since 2016, whose medical records had not been merged with those set up by practice. Accordingly, the records used by practice staff when providing care and treatment were incomplete, putting the patients at risk of harm.</p> <p>At our inspection on 2 October 2018, practice partners told us administrative staff had been trained appropriately to process transferred records and most of the 615 patients' notes had been consolidated to make up full records and medical histories. However, five patients' records remained to be consolidated and no written protocol had been drawn up to ensure the issue was not repeated in future.</p>	

Appropriate and safe use of medicines

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) (01/07/2017 to 30/06/2018) (NHS Business Service Authority - NHSBSA)	0.60	0.63	0.95	Variation (positive)
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). (01/07/2017 to 30/06/2018) (NHSBSA)	7.5%	10.2%	8.7%	Comparable with other practices

Medicines Management	Y/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.	N
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
Up to date local prescribing guidelines were in use.	N
Clinical staff were able to access a local microbiologist for advice.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y
<p>Explanation of any answers:</p> <p>At our inspection in May 2018, we found the practice did not have reliable systems for appropriate and safe handling of medicines. Patients' health was not consistently monitored in relation to the use of high risk medicines or followed up appropriately. We reviewed a random sample of 20 patients' records and identified 11 examples of unsafe prescribing because of overdue medication reviews dating back to 2015. We also found multiple examples where records stated, "medication review", suggesting a review had been carried out, but no details, such as medicines involved or whether changes were made, were recorded.</p> <p>At our inspection on 2 October 2018, the practice partners told us prescribing protocols had been revised. However, we saw this had been done by the caretaker practice, which had also produced guidance notes to staff and an explanatory leaflet for patients. The caretaker practice's clinical pharmacist had carried out five prescribing audits relating to Amiodarone, Azathioprine (AZT), direct oral anti-coagulants (DOAC), Methotrexate and Warfarin. The audits related to practice clinicians, including partners, some of whom continued to work as locums during the suspension period. Although these showed some examples of good practice, they also highlighted various concerning issues, which needed to be addressed to ensure patient safety. Examples included: a lack of monitoring and wrong terminology being used for test results; not all test results being READ-coded; trends in patients' tests results not being considered, with clinicians only reviewing the latest results;</p>	

guidance from secondary care not being followed. By failing to appropriately monitor and manage patients prescribed high risk medicines, the practice had put patients at significant risk of harm or death.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to 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.	23?
Number of events that required action	Not able to establish

At our previous inspections in August and November 2107, we found the practice's processes for reporting, recording and investigating significant events was ineffective. Not all significant events were appropriately identified, recorded and analysed for learning. This exposed patients to the risk of harm. At our inspection in May 2018, the practice had not acted to introduce an effective system. We found evidence of three incidents, identifiable as significant events, which had neither been recorded nor investigated. One related to the practice failing to take appropriate action regarding a patient's health condition and there were two cases of coding errors relating to cervical smear test results, due to incorrect system programming. The process for handling significant events remained ineffective. Records were incomplete; the summary we were shown listed 23 significant events, but contained gaps, with seven missing ID numbers that staff were unable to explain. Minutes of staff meetings recorded three significant events being discussed, but there was no evidence the remainder had been reviewed. Not all staff were trained on the system and some remained unsure of the reporting process.

At our inspection on 2 October 2018, practice partners told us the significant events process had been reviewed. This had highlighted that previously staff had perceived there to be a "blame culture", making them unwilling to report incidents. The caretaker, with some input from practice partners, had developed guidance and a revised, simplified, reporting form to record new significant events and there had been some discussion at staff meetings regarding the new processes. However, staff could not access the records we had seen at our May inspection and we could not establish what action had been taken to investigate and review them since. Accordingly, we could still not be assured the practice had an effective system to review and learn from recent or historical significant events.

At our inspection in May 2018, staff had told us of two incidents where cervical screening test results for patients were incorrectly coded and patients needed to be recalled for repeat cervical screening tests. Initially, we were told these were due to laboratory errors. However, we were subsequently informed they were the result of staff setting up a default process which pre-coded test results as normal, even if the result had been abnormal. Patient cervical screening test results had been defaulted to normal prior to the actual results being received. As a result, patients whose results were in fact positive went without additional care and were put at risk of significant risk of harm. At our inspection on 2 October 2018 we found the caretaker practice had reviewed the coding errors relating to cervical smear tests as a significant event. The caretaker's review had identified the cause and it had been corrected. However, we found the practice partners had failed to take any action to address the issue.

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Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y
<p>At our inspection in May 2018, we found the practice had taken action to develop a system for the receipt and dissemination of safety alerts. However, we were not assured from our review of patient records, that doctors had read and implemented all relevant safety alerts, particularly in relation to medicines management. Our review of patient records found four out of five female patients of childbearing age prescribed Sodium Valproate (commonly used to treat Epilepsy) and not prescribed contraceptive medicine, had not been counselled by clinical staff of the risks of taking this medicine and pregnancies resulting in babies with congenital abnormalities.</p> <p>At our inspection on 2 October 2018, we found the caretaker practice had introduced an appropriate system for handling safety alerts, but with little input or understanding from the practice partners.</p>	

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	0.40	0.49	0.83	Comparable with other practices

People with long-term conditions

Diabetes Indicators				
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	62.6%	76.3%	78.8%	Variation (negative)

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	8.2% (77)	14.4%	13.2%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	62.7%	77.0%	77.7%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	6.1% (57)	11.5%	9.8%	

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	64.3%	75.8%	80.1%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	7.3% (68)	11.3%	13.5%	

Other long term conditions				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	72.8%	76.9%	76.0%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.0% (6)	5.0%	7.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of	84.3%	91.0%	89.7%	Comparable with other practices

breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	13.6% (19)	10.5%	11.5%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	74.0%	80.3%	82.6%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.2% (55)	6.5%	4.2%	
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	75.0%	85.2%	90.0%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	13.8% (16)	11.2%	6.7%	

Families, children and young people

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib) (i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	113	157	72.0%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	145	174	83.3%	Below 90% minimum (variation negative)

(01/04/2017 to 31/03/2018) (NHS England)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	127	174	73.0%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	129	174	74.1%	Below 80% (Significant variation negative)

Working age people (including those recently retired and students)

Cancer Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	63.2%	67.4%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (PHE)	62.2%	62.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (PHE)	45.1%	46.2%	54.6%	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. (PHE)	76.1%	76.9%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	29.6%	43.8%	51.6%	Comparable with other practices

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	84.4%	90.2%	89.5%	Comparable with other practices

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.2% (8)	6.9%	12.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.7%	90.1%	90.0%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.8% (7)	6.8%	10.5%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.6%	84.4%	83.0%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	8.5% (5)	6.3%	6.6%	

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	92.1%	95.3%	94%
Overall QOF exception reporting (all domains)	5.1%	5.6%	5.8%

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
At our comprehensive inspection in August 2017, we were told the system for monitoring of patients' two-week referrals in case of suspected cancer had lapsed due to staffing changes and training not being provided. In November 2017, at our follow up inspection, we saw that the monitoring system, using a spreadsheet log in the shared drive, had been reintroduced and were told it would be further refined. At our comprehensive inspection in May 2018, we reviewed the revised system and noted	

patients were being given the responsibility to organise their own hospital appointments rather than the practice or hospital doing so on their behalf. This meant there was a risk patient might not be accessing a timely appointment with secondary care and that the practice might not follow up to ensure the referral appointments had been made. A member of the practice staff had questioned the process with management 13 times over a 6-week period, but no remedial action had been taken.

At our inspection on 2 October 2018, practice partners told us the system for arranging two-week wait referrals had been revised, with the consulting GP now being responsible for setting up the referral and a named member of the administrative staff monitoring. The practice partners showed us a revised spreadsheet monitoring log, which they said had been developed by the practice's administrative staff, working with the caretaker. When we asked, the practice partners were not able to explain some aspects of the monitoring process or the spreadsheet log. We raised this with the caretaker's staff, who subsequently informed us that the practice partners had described a previous version of the new monitoring process and shown us an older form of the monitoring log. We could not be assured, therefore, that the practice could operate and maintain the process effectively to bring about and sustain improvement which put patients requiring these referrals at significant risk of harm.

Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.7%	94.8%	95.1%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.4% (10)	0.8%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately

No evidence of monitoring seen.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	23
Number of CQC comments received which were positive about the service	21
Number of comments cards received which were mixed about the service	2
Number of CQC comments received which were negative about the service	0

Patients' comments related to service provided by the caretaker practice in place since the suspension in May 2018.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14175	355	84	23.7%	0.59%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	63.4%	85.4%	89.0%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	68.6%	83.5%	87.4%	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	83.6%	93.7%	95.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	60.8%	80.4%	83.8%	Variation (negative)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y
No results since May 2018, when the registration was suspended.	Friends and Family Test

Involvement in decisions about care and treatment

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	76.6%	90.1%	93.5%	Significant Variation (negative)

Question	Y/N
Interpreter services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	N
Information leaflets were available in easy read format.	N
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers	143 – just under 1%

identified	
How the practice supports carers	The practice website had a page providing information to carers, which included contact details of support organisations.
How the practice supports recently bereaved patients	The practice website had a page providing information and guidance on bereavement.

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y

	Narrative
Arrangements to ensure confidentiality at the reception desk	We again noted that only two members of the reception team were on duty at the desk at any one time and we saw queues of patients waiting.

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	Time
Monday	08:00 - 18:30
Tuesday	08:00 - 18:30
Wednesday	08:00 - 18:30
Thursday	08:00 - 18:30
Friday	08:00 - 18:30

Appointments available	
	As above
Extended hours opening	
Weekdays	18:30 - 19:00

Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Y
If yes, describe how this was done	
The practice asked that request for home visits be made before 10.30 am. These were triaged by the duty GP.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14175	355	84	23.7%	0.59%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	80.0%	92.9%	94.8%	Significant Variation (negative)

Timely access to the service

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	35.1%	70.7%	70.3%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	33.5%	64.9%	68.6%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	43.9%	63.6%	65.9%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	41.6%	68.7%	74.4%	Significant Variation (negative)

Additional evidence
<p>At our previous inspections, dating back to 2015, it had been consistently evident that patients found contacting the practice by telephone and accessing appointments very difficult. We found this from direct feedback and from data such as the national GP Patient Survey and the Friends and Family Test. A telephone system, installed in 2015 did not operate effectively to meet patients' needs. We had been told over the course of four inspections that the practice was working with the phone system provider to upgrade and improve the system and therefore patient access. At our inspection in May 2018, the practice had told us a new system had been identified with a plan for its installation in September 2018. Feedback from patients remained very negative regarding accessing care. We concluded that until the practice improved patients' opportunity to make appointments when they needed them, patients were being exposed to the risk of harm.</p> <p>At our inspection on 2 October 2018, practice partners told us the system had not yet been installed, the process having been put on hold due to our inspection being announced, despite us receiving feedback from patients that telephone access remained very difficult. Because of the practice's failure to take appropriate action to address this sustained significant issue for patients, we were not assured the practice prioritized improvements to the service.</p>

Examples of feedback received from patients:

Source	Feedback
For example, NHS Choices	Recent reviews on NHS Choices relate to service provided by the caretaker practice, since the suspension in May 2018.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	41?
Number of complaints we examined	4

Number of complaints we examined that were satisfactorily handled in a timely way	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0

Additional comments:

In May 2018, we found the practice's complaints handling process did not adequately ensure patients' concerns were appropriately investigated, addressed and learned from. The records we saw were inadequately documented and did not provide evidence that the complaints were handled appropriately and learned from to improve services. We were shown log numbering 61 complaints having been received in the preceding 12 months. However, 20 serial numbers were missing, so only 41 complaints were summarised on the log. Staff could not explain the discrepancy.

On 2 October 2018, we were shown the same log, referring to 41 complaints with 20 serial numbers missing. Complaints received after the suspension were the responsibility of the caretaker and had been recorded separately. We were told the caretaker had carried out a review of the 41 complaints with the new practice manager. It had not been able to establish who within the practice was responsible for dealing with the complaint, once it had been logged and acknowledged. Some complaints had been found on the shared drive and it was unclear whether they were included in the main log. The review had not been able to establish whether the historical complaints had been addressed. In those cases, the patients involved had been sent letters offering further investigation if they felt their complaint had not been resolved. We reviewed the log with the practice manager and found it summarised two complaints, the records of which could not be located. Little had been done to improve the complaints handling process, which remained confused and ineffective.

Example of how quality has improved in response to complaints

No evidence seen.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice

The practice had failed to take effective action to address historical and ongoing concerns, such as the processes for managing significant events, handling complaints and telephone access.

The new practice manager had not been given access to all the previous manager's files and could not provide us with all the evidence we requested, such as health and safety risk assessments and staff training.

Vision and strategy

Practice Vision and values

The practice did not have a clear vision and credible strategy to deliver high quality, sustainable care.

Partners told us that two new prospective partners had been identified to provide additional management support and assist in bringing about improvement.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care

No evidence seen.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.

Changes made since our inspection in May 2018 had been implemented by the caretaker practice, with limited involvement of the Staunton partners. When we asked practice partners to explain the new procedures they had limited knowledge of them, providing little assurance the changes made would be sustained or managed effectively.

Some systems, such as those relating to adult safeguarding, remained to be fully reviewed and implemented.

	Y/N
Staff were able to describe the governance arrangements	N
Staff were clear on their roles and responsibilities	N

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	N
Staff trained in preparation for major incident Training records not available for inspection.	N

Examples of actions taken to address risks identified within the practice

The practice could not provide evidence of risk assessments being carried out.

Concerns we had identified previously had not been appropriately addressed by the practice.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	N
Any additional evidence	
Prior to our inspection in May 2018, we received applications in relation to changes to the provider's registration, with two partners leaving and another becoming the registered manager. However, no statutory notifications were submitted by the practice.	

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
<p>At our inspection in May 2018, we met with members of the patient participation group (PPG), who told us the practice had not engaged with the group over the improvements needed following our previous inspections. The PPG had previously been very positive regarding their collaboration with the practice.</p> <p>At our inspection in October 2018, we met with four members of the PPG. They said the caretaker practice had continued to have meetings with them, some of which were attended by the Staunton partners. However, the latter's involvement had been rather limited and unproductive. The PPG told us that telephone access to the service and the availability of appointments remained a concern for them.</p>

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years
<p>Limited use was made of clinical audits.</p> <p>There was no evidence that clinical audit was driving improvement. For example, a cytology audit carried out in August 2018 had identified the need for further staff training, but this was not programmed before February 2019.</p>

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 comparable, 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 comparable 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.

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:

<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ([See NHS Choices for more details](#)).