

Care Quality Commission

Inspection Evidence Table

Merton Surgery (1-553754596)

Inspection date: 13 December 2018

Date of data download: 17 December 2018

Overall rating: Inadequate

At the last inspection in December 2017 we rated the practice as requires improvement for providing well-led services because:

- The practice needed to continue to review and improve their governance and practice management arrangements currently in place.
- The practice needed to review and reconcile the list held of children on the child protection register with external agencies to ensure they are current.
- Include significant events, safeguarding and complaints as standing agenda items for discussion at practice meetings. Ensure significant events are documented and investigated at the earliest opportunity.

At this inspection, we found numerous areas where patients were put at risk. For example, we found evidence of poor leadership a lack of good governance, inadequate systems and processes that had potential to adversely affect patients. Examples included, safeguarding, recruitment, infection prevention and control. health and safety, staff training, appraisals, medicines management, poor consultation documentation, paper prescription serial number monitoring and medical indemnity oversight. We found that any governance arrangements in place were not proactively monitored or reviewed and some processes such as medicines management and actions on patient safety alerts did not reflect best practice. There was also a lack of risk assessment for emergency medicines not held at the practice and the practice is now rated inadequate overall.

Safe

Rating: Inadequate

The practice was rated as inadequate for providing safe services because:

- We found specific instances where care and treatment had not been provided in accordance with best practice guidelines. We identified numerous areas where patients were being put at risk.
- The management of safety systems was not evident particularly in relation to safeguarding, infection control, employment checks and health and safety risk assessments.
- The management of patient medicine reviews was not always effective or evidenced within the patient records sampled. Risks associated with blank prescription form management had not been considered in respect of home visits and serial number logs.
- A risk assessment had not been carried out in respect of emergency medicines not held at the practice.
- Gaps were found in the system in place for the analysis and response to Medicines and Healthcare Products Regulatory Agency (MHRA) alerts.
- The systems, processes and practice that help to keep patients safe and safeguarded from abuse were insufficient. The system in place at the practice had not always ensured that all children who did not attend their appointment following referral to secondary care were appropriately monitored and followed up. There was no vulnerable adults list or register for the practice to refer to. The safeguarding policies did not outline who to go to for further guidance nor reflect updated categories or definitions of the types of abuse for example, modern slavery.
- Staff recruitment checks did not meet legal requirements. There was no formal system in place to monitor that professional registrations or medical indemnity were in date.
- Assessment of staff immunity against health care acquired infections was not present for all members of staff. Risk assessments to demonstrate how patients and staff would be protected had not been completed.
- The practice had completed an Infection Prevention and Control audit the action plan had yet to be developed. There were no completed cleaning schedules other than that of floor cleaning. Areas within the practice were cluttered and unkempt.
- The impact of General Data Protection Regulations (GDPR) had not been considered.

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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Policies were in place covering adult and child safeguarding.	Partial
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	N
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial
There was active and appropriate engagement in local safeguarding processes.	N
Systems were in place to identify vulnerable patients on record.	N
There was a risk register of specific patients.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	N
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Safeguarding systems, processes and practices had been developed, implemented and communicated to staff. However, during the inspection on 27 November 2018 these did not reflect current best practice updates. The practice safeguarding children policy had been reviewed in August 2017, August 2018 and the next review set as August 2019. The adult safeguarding policy was last reviewed in December 2017 and set for a review in December 2018. These policies did not reflect current updates such as Modern Slavery and Female Genital Mutilation (FGM).</p> <p>On 13 December 2018 the practice had sought advice from the Supporting Change Team and guidance had been put in place for staff on Female Genital Mutilation and Modern Slavery. The practice policy had yet to be updated with these changes. Staff had not been in receipt of up to date safeguard training to reflect these changes. There was no policy update in place in respect of patient use of on-line services. One staff member had to use either hard copy policies available in the practice manager room or the reception area as these were not available on the electronic system in the room they used</p> <p>The practice nurse training record showed the completion of safeguarding children training in her previous employment on 14 February 2018. Although the certificate did not demonstrate the level achieved we were informed that it was a training event specific for practice nurses. The nurse had completed vulnerable adults safeguard training in February 2018 in her previous employment. The practice safeguarding lead GP had completed their overdue safeguarding children level three in November 2018. The regular locum GP had completed safeguarding children level three in November 2015. This was overdue. Staff training records required better governance and oversight. There was no</p>	

Safeguarding	Y/N/Partial
staff training record or matrix to assure the practice that all staff had completed training relevant to their role to the level required. Clinical staff held and managed their own training records.	
We found there was a lack of active and appropriate engagement in local safeguarding processes. Health Visitors were invited to practice meetings, but we saw no evidence of reconciliation of the practice safeguard register.	
There was a lack of a systematic review in place to identify vulnerable patients. For example, in one patient record we found that there was a lack of recorded or documented follow up following an admission to A&E of a patient with potential new safeguarding concerns.	
We saw some evidence of electronic pop up alerts for children in need, on child protection registers and there was a child safeguarding register at the practice. The safeguarding Lead GP informed us that the list was system generated but it had not been recently reviewed. We sampled 11 patient records, and several did not have alerts highlighting that they had safeguarding concerns, some had not been seen for years by the practice and others had attended A&E in the last year with concerning issues which had not been followed up by the practice. There was no evidence seen of electronic pop up alerts for vulnerable adult patients and there was no vulnerable adults or adult safeguarding register. On 13 December 2018 this remained unchanged. We reviewed letters received into the practice and identified two patients that required safeguard electronic coding and follow up GP contact that had been set aside for general scanning with priority clinical review.	
There were discussions between the practice and health visitors. There was no clear evidence or clear documentation in place for the practice to refer to. We found letters and some patient records randomly selected that showed little or no follow up contact had been completed by the practice when alerted to potential safeguarding concerns.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Staff who required medical indemnity insurance had it in place.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>On the 27 November 2018 one clinical staff member did not have a DBS completed for this employment. The practice held a copy of the DBS from their former employer which was dated 2013. On 13 December 2018 we found that a DBS had been submitted in respect of this staff member.</p> <p>The DBS records were not readily available within staff records including for staff who provided a</p>	

chaperone service.

There was no evidence of recruitment records held on file at the practice for the Locum GP staff employed at the practice between 27 November 2018 and 13 December 2018.

On 27 November 2018 full staff immunity history was not recorded in the files reviewed or electronically. Clinical staff hepatitis B status was evidenced within the locum GP record reviewed. On 13 December 2018 we found that three staff records held evidence of staff immunity history.

There was no evidence of periodic professional registration checks completed within the staff records reviewed on either 27 November 2018 or 13 December 2018.

On 27 November 2018 there was no evidence available at the practice for staff medical indemnity other than for the practice nurse and a Locum GP. There was no indemnity cover seen for the healthcare assistant or the GP partners.

On 13 December 2018 the healthcare assistant had indemnity which started on 13 December 2018 and one of the GP partners indemnity records was now held at the practice and available for review.

There was no assurance from the locum agency of the locum staff recruitment records including their medical indemnity.

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:	Y 02/02/2018
There was a record of equipment calibration. Date of last calibration:	Y 05/01/2018
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check:	Y 02/07/2018
There was a log of fire drills. Date of last drill:	Y 23/11/2018
There was a record of fire alarm checks. Date of last check:	Y 23/08/2018
There was a record of fire training for staff. Date of last training:	Y

There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion:	Y 12/09/2018
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Additional observations:	
<ul style="list-style-type: none"> • Fire Certificate 02/07/2018 • Two nominated fire marshalls 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial 16/10/2018
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 16/10/2018
Explanation of any answers and additional evidence:	
<p>The practice Health and Safety Audit checklist records that there was an annual gas service undertaken and that this took place in August 2018. The gas certificate was not available on 27 November 2018 but was located by the 13 December 2018.</p> <p>The practice operated close circuit TV as an external security measure and this was serviced annually.</p> <p>We found that there was no evidence of a whole practice medical indemnity scheme.</p> <p>The health and safety audit completed in October 2018 noted immediate actions were required such ensuring all staff completed relevant health and safety training. We were advised by the practice manager that this was ongoing. There was no clear oversight on who had or had not completed this training. There was no evidence that the actions identified were in progress or had been completed.</p> <p>A legionella risk assessment had been completed on 23 September 2016. The practice manager demonstrated that they had spoken with the company who provided this service in May 2017. They were informed by the company that there was no need to have a further assessment.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
An infection risk assessment and policy were in place.	N

Staff had received effective training on infection prevention and control.	N
Date of last infection prevention and control audit:	22/11/2018
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice held a copy of the Infection Prevention and Control code of practice which they referred too. The healthcare assistant and practice manager took the lead in IPC. The practice nurse was to take up the role following training in January 2019. One of the GP consulting rooms was dirty, with visible dust and extremely cluttered, and this area was not addressed within the audit reviewed.</p> <p>There was no evidence of any recent hand wash training for staff or infection prevention and control training.</p> <p>The last audit had been completed in November 2018 by the healthcare assistant and the practice manager. There were several actions identified however an action plan had yet to be developed.</p> <p>Our observations of the practice environment on 27 November 2018 for example found:</p> <ul style="list-style-type: none"> • There was no cleaning schedule available or completed for each room. • The cleaning logs that had been completed were for the practice floor areas only. • One of the GP rooms was particularly cluttered and untidy, it housed several pairs of shoes and ornaments, and the sink and wash basin areas were cluttered and would be difficult to clean. There was no single piece of flat surface not covered in boxes, paper (including patient identifiable information), bottles, food, trays, books and ornaments. We saw evidence of several unsigned handwritten paper prescriptions which contained patient names and addresses but were left blank lying in a tray. • Several areas including the waiting room wall paint décor was dirty and the paintwork was dirty. • The toilet sink had grouting/sealant that required replacing, a toilet brush and hand towel rail was still in place. There was no foot operated bin or sanitary-ware bin in either the staff or patient toilets. • One of the bodily fluids spillage kits was out of date (2013) the other was undated. The practice had some pressure monitoring devices which contained mercury and there was no mercury spillage kit available as required. <p>Our observations on 13 December found:</p> <ul style="list-style-type: none"> • A cleaning schedule had been signed as completed for each room. We found one GP's room remained dusty with out of date blood bottles, intrauterine device equipment, needles and cleaning products including Hibitane and surgical spirit. Old used urine dip sample pots, used bits of bandage and expired Mefix tape were seen on the treatment surface. The desk area was tacky to touch and lean on. • Several areas including the waiting room wall décor remained dirty. • The toilet sink had grouting/sealant that required replacing. There was no sanitary-ware bin in either the staff or patient toilets. The patient toilet door had a notice reporting the door as faulty. The notice was undated and therefore it was unclear when this had been reported or what 	

action had been taken.

- The bodily fluid spillage kit had been replaced.
- The couch in the healthcare assistant room had two rips in the fabric which had the potential to be an area of infection risk.
- The cleaning equipment such as mop buckets and mops were not stored in accordance with best practice.

We observed one staff member holding a urine specimen sample to take this into the reception staff area. The sample had not been placed in the specimen basket held in reception and the staff member was not using gloves.

On 27 November 2018 we observed that the clinical waste storage area bin was lockable but not locked. At the time of the inspection the bin was empty. The practice manager ensured that this was locked following our observations. On 13 December 2018 we observed that the clinical waste storage area bin was lockable but again had not been locked.

There had been no assessment of risk regarding the requirement of a mercury spillage kit in the event that the mercury blood pressure device was damaged or broken.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	N
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
Panic alarms were fitted, and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Partial
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.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	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
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial
Explanation of any answers and additional evidence:	
We saw no evidence of an appropriate and effective induction system for temporary staff tailored to their	

role.

The sample of patient records we reviewed did not demonstrate that patients were always in receipt of comprehensive risk assessments, or that risk management plans were developed in line with national guidance. For example, on 27 November 2018 we found 12 patients who had been in receipt of a blood test to assist in the diagnosis of diabetes had not been appropriately followed up for further assessment and screening, lifestyle advice, education or assessment to optimise their health outcomes. On 13 December 2018 we found that only one of these patients had been contacted by the practice via phone for a follow up consultation.

The electronic system in place had an inbuilt panic alarm system. Staff advised that they also shouted out to each other in the event of an emergency. On 27 November 2018 we found there was no risk assessment in place of emergency medicines not held by the practice. On 13 December 2018 we found that staff were unaware of where the emergency medicines such as those needed in the event of a seizure and in the event of suspected meningitis were held. Medicines for suspected croup in a child, a severe allergic reaction or pain were not in place.

One GP we spoke with was not aware of the alternative medicine used in a suspected case of meningitis where the patient was allergic to penicillin, or that only one vial of the benzylpenicillin was available at the practice which would be insufficient to treat an adult patient.

Reception staff were able to describe the actions they would take if they encountered a deteriorating or acutely unwell patient. However, there was no documented guidance or training on identifying such patients provided to staff. Staff pointed out that they had information on sepsis leaflets posted in the staff area of reception and in the reception rooms that they could refer to but had not received any specific recognition training. Staff advised they would refer any concerns they had regarding patient ill health immediately to the GPs. Staff we spoke with advised they had learnt the actions to take via their experiences and when they completed basic life support training.

There was equipment available to enable assessment of patients with presumed sepsis or another clinical emergency. However, all staff were overdue their basic life support training which had been booked for January 2019.

There was no governance or system in place that could clearly demonstrate that when there were changes to services or staff the practice assessed and monitored the impact on safety other than ensuring staff covered each other for sickness, leave or absence.

Information to deliver safe care and treatment

Staff did not have all 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.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y

Referrals to specialist services were documented.	Y
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.	Partial
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 and additional evidence:</p> <p>Consultation notes in some of the individual care records we sampled, including clinical data, were not comprehensive or written and managed in line with current guidance and relevant legislation. For example, we found that some patient medicine reviews had been coded as complete but without a record of the advice given.</p> <p>There were systems in place to scan, electronically read code patients diagnosis and electronically receive patient test results. However, from the sample of patient records we reviewed these were not all managed appropriately. One staff member at the practice had been in receipt of GP workflow support and training. We found that the staff did not use the electronic task system. Instead scraps of paper were used to pass messages on to receptionists regarding patients or actions from test results. One staff member was on annual leave during the unannounced inspection on 13 December and some post was over five weeks old. We reviewed this post and found two items that needed to be reviewed by a GP which had been marked as routine.</p> <p>There was an undocumented approach to the management of test results. However, we found that where patients' blood results were within a diabetic rather than prediabetic range these had not been acted upon in a timely manner.</p> <p>In the sample of records reviewed we found instances where all the information needed for a patient's ongoing care was not shared appropriately in line with relevant protocols or not documented as this having taken place in respect of safeguarding A&E attendances. Another instance included a lack of an alert for a learning disability patient and we found no evidence of a written care plan for this patient.</p>	

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) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	1.54	1.02	0.94	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	5.9%	6.8%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	NA
There was a process in place 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.	Y
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).	N
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 in place for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
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 in place for verifying patient identity.	NA
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.	N
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems were in place 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had not ensured medicines were stored safely and securely with access restricted to authorised staff. One of the unlocked vaccine fridges was housed in an unlocked room on the patient reception corridor. Medicines were found in one of the GP consulting rooms which was unlocked on the treatment worksurface and under the sink area in a box. Medicines were found in the healthcare assistant room under the sink in an unlocked cupboard.</p> <p>Blank paper prescriptions were kept securely but their use was not monitored in line with national guidance. Electronic prescriptions were seen as accessible in the printer in an unlocked GP consulting room. Paper prescriptions taken on home visits were not appropriately monitored or kept securely. Staff completed the paper prescription adding the patient's name and address for the GP visiting, these were added to a printout of the patient's summary notes and placed in a visit book for the GPs to review. We were informed that if the GP did not use the unsigned paper prescription it would be destroyed. According to the staff we spoke with there were no paper prescription serial log maintained. During our observations we saw paper prescriptions in an unlocked GP consulting room.</p> <p>In some of the records randomly selected for review we found evidence that the practice did not operate an effective system to ensure that they had taken appropriate action on all GP practice related alerts issued by the Medicines and Healthcare Regulatory Agency about medicines.</p> <p>During the inspection on 13 December 2018 we found that a medicine was being prescribed for conditions for which it is not recommended or licensed. We found in an unlocked cupboard in one GP room 10 patient dispensed medicines of Sustanon and Nebido (medicines containing testosterone a male hormone). This had also been dispensed to five women without clear rationale documentation within the patient consultation records.</p> <p>We also found that medicine reviews with regular blood test monitoring had not always taken place within a best practice acceptable time frame.</p> <p>On 27 November 2018 we found medicine management reviews were not well documented within the consultation records we sampled. Consultation notes in some of the individual care records we sampled, including clinical data, were not comprehensive or written and managed in line with current guidance and relevant legislation. For example, we found that some patient medicine reviews had been coded as complete but without a record of the advice given.</p> <p>Higher levels of medicine prescribing such as hypnotics were seen. There was a process for the management of medicines including high risk medicines. However, patients on these medicines were not receiving monitoring according to recommended guidelines. For example:</p> <ul style="list-style-type: none"> • On 27 November 2018 we found that none of the six records reviewed for Azathioprine (a medicine used to suppress the immune system) had alerts to highlight the patient was taking a high-risk medicine but four had system alerts which highlighted that monitoring was overdue. 	

- None of records had an alert to highlight the patients were taking a medicine used for rheumatoid arthritis (leflunomide). One patient had an alert stating they were on methotrexate only, but they were taking both medicines. Electronic system alerts highlighted they were overdue for high risk blood monitoring.
- We identified over 40 patients out of 705 who had been prescribed medicines used to treat high blood pressure (ACE/ARB) in last 12 months and not had specific blood tests completed for over a year.
- We identified 17 patients out of 155 who had not had a particular blood test performed in the last 18 months but had a history of thyroid problems.

There was evidence that prescribing guidelines were not followed in some of the patient records sampled. We reviewed 10 patients and their consultations with one of the GPs. In the randomly selected consultations we found examples of poor consultation documentation, poor management plans, treatment that did not follow national guidance and prescriptions that were for incorrect dosages.

- On 13 December 2018 we found that 31 patients were on Spironolactone (a medicine that removes excess fluid from the body in congestive heart failure, cirrhosis of the liver, and kidney disease and is used in some patients for high blood pressure). Nine had not had a urea and electrolyte blood test completed for over six months, four of which had not had this completed in over a year. A diabetic patient had not had blood monitoring tests for diabetes since 2016. Their last blood pressure reading record was in May 2016. The practice had continued to issue medicines.
- We reviewed three medicine safety alerts and searched for patients on these medicines and checked records to establish and evidence actions taken. These included a medicine used in epilepsy (Valproate), a medicine used in focal seizures and for neuropathic pain (Gabapentin), and a medicine used to shrink an enlarged prostate (Finasteride). We found appropriate advice given to women of child bearing age regarding the medicine used in epilepsy. We reviewed a random sample of patients on a medicine used with others to prevent and control seizures/ chronic pain and saw no evidence that patients had been informed of the risk of respiratory depression or had had their medicine doses reviewed. There was no evidence that patients on a medicine used to shrink an enlarged prostate had been made aware of the risks and that their medication had been reviewed.
- On 13 December 2018 there were 22 patients prescribed both Clopidogrel and Omeprazole which can interact and should not be prescribed together. There was evidence of patients being recently prescribed this combination of medicines in November 2018, and of patients having a medicine review without interactions being recorded as discussed with the patient.
- On 13 December 2018 we found in the letters we reviewed that a patient prescribed medicines in secondary care had not had these added to their record.

We saw no evidence that the practice actively monitored the prescribing of controlled drugs.

On 27 November 2018 we found that not all emergency medicines were held by the practice and there was no risk assessment in place for medicines not held. Those not held included: rectal diazepam, dexamethasone, diclofenac, hydrocortisone, they had only one ampule of benzylpenicillin and no naloxone. We returned to the practice on 13 December 2018 and found the practice had two ampules of a medicine used in suspected meningitis which would be sufficient for an adult and older child and a medicine used to treat seizures both of which were absent on 27 November. However, the practice did not hold a medicine used for a severe allergic reaction, for suspected child croup or a patient in pain and there was still no risk assessment in place. There was a system in place to monitor stock levels and

Medicines management	Y/N/Partial
<p>expiry dates.</p> <p>On 27 November 2018 vaccines had been stored in unlocked vaccine fridges as the keys to these fridges could not be located. One of these fridges was located in an unlocked room on the patient reception corridor. On 13 December 2018 these fridges remained unchanged and no stock had been transferred to the fridge in the practice nurses' treatment room. Towards the end of the inspection a new set of fridge keys had been sought.</p>	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <p>There was a system in place however, there was evidence of underreporting and staff did not appear clear on what constituted an incident or significant event despite there being evidence from a discussion at a practice meeting.</p> <p>The practice had a significant event protocol in place with a proforma for completion. We were told about an example of a significant event which had not been formally recorded, although it had been discussed at a practice meeting. A healthcare professional reported concerns over the use of a hypnotic medicine prescribed for a vulnerable patient. The practice found over ordering of this medicine was taking place. The GP advised that over ordering of the medicine was stopped; this was discussed with the family and their rationale considered. We saw evidence of the practice meeting minutes where this had been discussed. As this was not documented as a significant event there was no documented root cause analysis or evidence of shared and embedded learning. The practice manager held paper records of events in a folder.</p> <p>One of the practice GPs was unsure of whom the practice lead accountable for serious incidents was or the number of incidents reported. It was clear that the staff were aware of their duty of candour by informing patient of the error and any potential risk of harm. All staff attended the practice meetings which included significant events as an agenda item.</p>	

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

Event	Specific action taken
A person walked into the practice to use the toilet. The patient had to be asked to leave due to security concerns.	<p>Staff were made aware by a patient that a person who was not a patient was able to walk in and use the facilities unchallenged.</p> <p>The GP informed the person they needed to leave, and they left.</p> <p>The incident was discussed and the GPs informed staff that it was in the best interests of all to lock the toilet door and to put a notice on for patients to ask at reception for key. Although this would be a bit of a nuisance for patients it was safer.</p> <p>The practice learning was that at busy times people can come into the building unnoticed by staff and for this to be discussed at the next meeting to consider other solutions.</p>
Damage to a car due to the poor maintenance of the practice carpark.	<p>The practice was contacted regarding damage to a car allegedly caused by a poorly managed surface on the practice carpark. The practice reviewed and investigated the incident. The learning was that they had ensured that they listened and investigated thoroughly before making any decision.</p>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The system in place was incomplete and there was no log or details of actions taken in response to the alerts and in those we reviewed we found that the system was ineffective. There was a named GP Lead responsible for Medicines and Healthcare products Regulatory Agency (MHRA) alerts. Alerts were forwarded to the named GP Lead by an administrator who performed electronic record searches and forwarded the results. These were held in a paper folder without a log of actions taken. We reviewed three medicine safety alerts and searched for patients on these medicines and checked records to establish and evidence actions taken. These included a medicine used in epilepsy (Valproate), a medicine used with others to prevent and control seizures and for chronic pain (Gabapentin), and a medicine used to shrink an enlarged prostate (Finasteride).</p> <ul style="list-style-type: none"> We found appropriate advice given to women of childbearing age regarding the medicine used in epilepsy. We reviewed a random sample of patients on a medicine used with others to prevent and control seizures/ chronic pain and saw no evidence that patients had been informed of the risk of respiratory depression or had had their medicine doses reviewed. There was no evidence that patients on a medicine used to shrink an enlarged prostate had been made aware of the risks and that their medicine had been reviewed. 	

Effective

Rating: Inadequate

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

The practice was rated as inadequate for providing effective services because:

- From the records reviewed we saw that clinicians had not always assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.
- The practice did not have oversight of up to date records of skills, qualifications and training for all staff.

These inadequate areas impacted all population groups and so we have rated all population groups 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: From the records reviewed we saw that clinicians had not always assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Updates to the National Institute for Health and Care Excellence (NICE) guidance were emailed to at least one of the GP partners, saved in a folder, summarised annually and circulated to staff. The practice systems to keep clinicians up to date with current evidence-based practice did not provide assurance, as from the records reviewed, we saw that clinicians had not always assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.	

- On 27 November 2018 we sampled 11 patient records, several of which did not have alerts highlighting that they had safeguarding concerns. Some of these patients had not been seen for years by the practice and others had attended A&E in the last year with concerning issues which had not been followed up.
- We found 12 patients who had been in receipt of a blood test to assist in the diagnosis of diabetes had not been appropriately followed up for further assessment, screening or advice.
- One GP we spoke with was not aware of the alternative medicine used in a suspected case of meningitis where the patient was allergic to penicillin.
- We found that some patient medicine reviews had been coded as complete but without a record of the advice given.
- We found an instance where all the information needed for a patient's ongoing care was not shared appropriately in line with relevant protocols or not documented as this having taken place in respect of a safeguarding issue. Another instance included a lack of an alert for a learning disability patient and we found no evidence of a written care plan for this patient either.
- Data we were shown demonstrated there was an ongoing downward trend in the number of patients in receipt of antibacterial items and antibiotics and hypnotic medicines prescribed. Data showed that the practice still had significantly higher hypnotic medicine prescribing, over three times greater than the local CCG and England averages.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	3.60	0.92	0.81	Significant Variation (negative)

We spoke with the GPs in respect of their hypnotic medicine prescribing as this was significantly higher than that of the local CCG and England averages. The GPs had reviewed their hypnotic prescribing year on year. The findings were that between April 2016 to March 2017, 205 patients were prescribed hypnotic medicines, this had decreased to 188 patients between April 2017 and March 2018 and between April 2018 to November 2018, 156 patients. However, we saw evidence of patients prescribed hypnotic agents, often in combination with other medicines but without having had a regular medicine review.

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions

Population group rating: Inadequate

Findings

- Patients with long-term conditions in the records reviewed did not all have a structured annual review to check their health and medicines needs were being met
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions. However, the practice had not effectively managed patients' medicine reviews. We identified over 40 patients out of 705 who had been prescribed particular groups of medicines used to treat high blood pressure in last 12 months and not had specific blood tests completed for over a year.
- We identified 17 patients out of 155 who had not had a particular blood test monitoring performed in the last 18 months but had a history of thyroid problems. (The thyroid gland is a small butterfly-shaped gland in the neck that produces hormones that help regulate the body's metabolism).
- Patients taking high risk medicines did not always have alerts identifying they were taking these high risk medicines but did have system generated alerts identifying that monitoring was overdue. For example: None of the six records reviewed for a medicine used to suppress the immune system had alerts to highlight the patient was taking a high-risk medicine. Four had system alerts which highlighted that monitoring was overdue.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages with the exception of hypnotic medicine prescribing which was significantly higher.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.6%	74.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.8% (34)	9.6%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	81.6%	75.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.3% (21)	7.5%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	84.9%	80.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	12.2% (35)	11.8%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	77.1%	77.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.4% (4)	5.2%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	84.0%	88.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.7% (4)	9.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	87.1%	81.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.1% (9)	3.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	88.9%	91.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.0% (4)	5.1%	6.7%	N/A

Findings

- Childhood immunisation uptake rates were lower than the target percentage of 90% in children aged two. Immunisations had been managed by the GPs until the recent appointment of a practice nurse,
- The arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation was not always followed up in line with best practice.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	36	37	97.3%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	38	44	86.4%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	38	44	86.4%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	38	44	86.4%	Below 90% minimum (variation negative)

Any additional evidence or comments

- Immunisations in 2017/2018 had been managed by the GPS until the recent appointment of a practice nurse.
- We spoke with the practice nurse in respect of the practice not meeting the child immunisation targets in 2017/2018 where the practice had achieved 100% in immunisations for children aged two in 2016/2017. The number of non-attendances in children aged two amounted to six. Immunisations had been completed by the GPs in-between a practice nurse leaving and one starting their employment. They planned to improve the uptake. The practice nurse informed us there was a recall system in place for non-attendees and that this was documented in the patient records, should the patient not attend following invites on three occasions the health visitor would be alerted.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The practice's uptake for cervical screening was 75.4%, which was below the 80% coverage target for the national screening programme. In one of the records we reviewed we found a patient whose last cervical screening took place in 2005 with no evidence seen within the record reviewed that this had been followed up.
- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The outcome of health assessments and checks where abnormalities or risk factors were identified and reported to clinical staff however this was not always acted upon by clinical staff. For example, some patients that had been screened and found to have higher blood sugar levels but not had a clinical follow up.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	75.4%	70.7%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (PHE)	80.7%	72.0%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)(PHE)	56.7%	52.1%	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)	45.5%	70.7%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	65.0%	59.5%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The practice did not hold a vulnerable adult register but did maintain a register for patients with a learning disability. However, we found an example of where a patient with learning disabilities with a carer who when indicated following an event was not referred appropriately to address safeguarding issues.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- Data showed that the practice had significantly higher hypnotic medicine prescribing which was over three times greater than the local CCG and England averages.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.7%	85.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	2.4% (1)	9.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	97.6%	89.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.4% (1)	7.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.8%	79.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	8.8% (3)	7.0%	6.6%	N/A

Monitoring care and treatment

The practice had a limited programme of quality improvement activity and limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	553.73	-	537.5
Overall QOF exception reporting (all domains)	4.5%	5.6%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N

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

<p>The practice had a limited programme of quality improvement activity and from the records sampled had not been consistent in comprehensively reviewing the effectiveness and appropriateness of the care.</p> <ul style="list-style-type: none"> The practice had completed an audit to identify patients through review of those who may have Chronic Obstructive Pulmonary Disease (COPD) but had not yet been diagnosed or would benefit from being screened. <p>Patients were reviewed as part of the practice's Quality Improvement Framework (QIF) audit. The practice findings included the identification of seven new COPD patients. They had invited 15 patients to attend for spirometry. The practice reviewed the patients' history for symptoms of cough, shortness of breath, wheeze, chest tightness; and if smoking history, if pottery industry work or occupational dust exposure and if handled birds regularly in the past.</p> <p>The audit raised awareness to consider COPD in persistent chesty cough cases and requiring antibiotics, steroids and inhalers during the winter months. The practice had completed an audit as part of the practice's Quality Improvement Framework (QIF) audit and twenty hypertension (high blood pressure) patients were reviewed</p> <p>The practice found a number of reasons for patient non-compliance with their medicines</p> <ul style="list-style-type: none"> -Adherence -Education -Medicine intolerance <p>The findings were that the practice completed annual blood tests for patients with high blood pressure and offered six monthly blood pressure checks in patients for example with long term conditions, patients on contraceptive medicines and hormone replacement therapies. They found one patient was due for a review within the month and considered measures to encourage attendance such as opportunistically with their attendance for a flu vaccination.</p>
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Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Y
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	NA
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	NA
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a training policy to set out their staff training expectations. There was a lack of clarity on the learning needs of staff. Up to date records of skills, qualifications and training were not managed by the practice manager. Staff kept their own training records and so there was no oversight maintained of staff training. Staff we spoke with advised they were encouraged to develop their skills.</p> <ul style="list-style-type: none"> The practice nurse did not routinely complete long term condition reviews as this role had been undertaken by the GPs at the practice. Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. <p>There was no evidence of a job specific induction programme for new staff.</p> <p>Staff had not completed all mandatory training, for example in information governance. Arrangements for annual appraisals and career development were overdue and some staff could not recall their last appraisal date. Staff told us they would be supported to meet the requirements of professional revalidation where necessary. However, the practice had no governance or oversight on staff training or their training requirements in order that they could be assured that all staff were suitably skilled and qualified.</p> <p>There was no clear documented approach seen at the practice for supporting and managing staff when their performance was poor or variable.</p>	

Coordinating care and treatment

Staff did not work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice informed us that they completed regular multidisciplinary case review meetings. During the inspection we saw no evidence in relation to minutes of regular multidisciplinary case review meetings. Records we reviewed demonstrated that information was received into the practice from secondary care and this was scanned into patient's records. However, we found gaps in the coordinated approach to patients care and treatment for example where a patient had attended A&E with a safeguarding concern and we found no associated follow up within the patients' consultation record. 	

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
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice advised they were waiting to receive information and training on a local social prescribing scheme. The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity referrals. 	

Twelve patients who had a potential diagnosis of diabetes had not been informed of the diagnosis or received education, information or lifestyle advice to improve their health outcomes. Their notes had not been coded to identify they were diabetic.

We found evidence in the records reviewed that patients during their medicine review consultations had not all been in receipt of discussion around medicine interactions following patient safety alerts or for example had a review of their mood whilst on depression medicines.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	98.5%	95.9%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0.2% (2)	0.6%	0.8%	N/A

Consent to care and treatment

The practice always obtained / 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.	Y
The practice monitored the process for seeking consent appropriately.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found no evidence that the practice monitored that consent was sought appropriately. When patients required immunisations nursing staff completed the electronic template which noted patient consent and advice given. The practice nurse had been in receipt of Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) in February 2018. Clinicians understood the requirements of legislation and guidance when considering consent and decision making. The practice nurse demonstrated awareness of how to support patients to make decisions and had received appropriate Mental Capacity Act training. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial*
Explanation of any answers and additional evidence: On 13 December 2018 we found several patient consultation records not appropriately electronically coded which would enable staff to provide patients with appropriate and timely information. For example, a patient who was no longer pregnant was still coded in their patient electronic record as being pregnant. A patient under secondary care had no evidence within their record that medicines from secondary care were recorded. A patient with previous gestational diabetes was not appropriately electronically coded and was pregnant. That correspondence relating to a patient being reviewed by a consultant demonstrated safeguarding concerns, but the patient and child records had no evidence of alerts.	

CQC comments cards	
Total comments cards received.	22
Number of CQC comments received which were positive about the service.	20
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
NHS Choices	There were three reviews which gave the practice a five-star rating which were posted in spring 2017.
CQC Comment Cards	Patients reported positively on their experiences at the practice. They found staff friendly, caring, approachable and that they were not rushed.

National GP Survey results

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4079	253	98	38.7%	2.40%

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)	95.9%	88.3%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	92.7%	86.3%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	96.9%	94.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	90.8%	82.9%	83.8%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N

Involvement in decisions about care and treatment

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

	Y/N/Partial
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Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
Interviews with patients.	We spoke with three patients during the inspection they all reported high satisfaction with the care and treatment they received. They felt engaged with decisions about their 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)	94.5%	91.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation 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.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: Although there were no easy read documents in the waiting areas staff advised they could request these on a patient's behalf where required. The practice did not have a Patient Participation Group.	

Carers	Narrative
Percentage and number of carers identified.	The practice had a carer register which included 141 carers, (3%) of the practice registered population.
How the practice supported carers.	The practice signposted carers to various support groups and local carer coffee meetings.
How the practice supported	The practice maintained a register of deaths. Staff could refer to the register

recently bereaved patients.	to assist when speaking with bereaved patients and their families. There were leaflets available within the practice waiting on local bereavement support groups and services.
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Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
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.	Partial
There were arrangements to ensure confidentiality at the reception desk.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice had limited consulting room space, so this was subject to availability.</p> <p>The practice had limited space available within the practice to make reasonable adjustments. The practice reception had glass sliding windows which were opened when speaking to patients.</p> <ul style="list-style-type: none"> Patients reported practice staff as being caring, friendly, helpful and that they were not rushed during appointments within the CQC comment cards. We spoke with three patients who reported their privacy and dignity was maintained. 	

Responsive

Rating: Requires Improvement

The practice was rated as requires improvement for providing responsive services because:

- There was little information to review regarding learned lessons from individual concerns and complaints or analysis of trends to improve the quality of care.
- The complaint policy and procedures required amending as no evidence was seen of an acknowledgement of complaint letter or letter outlining the investigation and next steps the patient may choose to take.
- Records we looked at demonstrated gaps in the practice system to identify and enable effective care coordination for patients who were more vulnerable or who had complex needs. For example, children and young people who had a high number of accident and emergency (A&E) attendances.
- The facilities and premises were appropriate for the services delivered with some exceptions. For example, there was no lowered desk to enable ease of access for wheelchair users or automated doors to maintain patients' independence in accessing the premise

The overall rating for this practice was inadequate due to concerns in providing safe, effective and well-led services. These issues affected all the population groups.

Responding to and meeting people's needs

The practice organised services to meet patients' needs but they did not meet their needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	N
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	N
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	N
Facilities and premises were appropriate for the services delivered with some exceptions. For example, there was no lowered desk to enable ease of access for wheelchair users or automated doors to maintain patients' independence in accessing the premise. Patients could access care and treatment in a timely way.	
Records we looked at demonstrated gaps in the practice system to identify and enable effective care coordination for patients who were more vulnerable or who had complex needs. For example, children	

and young people who had a high number of accident and emergency (A&E) attendances.

In the records sampled there was little documented evidence seen of a coordinated approach with other services.

Practice Opening Times		
Day		Time
Opening times:		
Monday		8am to 7pm
Tuesday		8am to 7pm
Wednesday		8am to 7pm
Thursday		8am to 1pm
Friday		8am to 7pm
Appointments available:		
Monday	09.20 am – 12.00pm	3.30pm – 7.00pm
Tuesday	09.20 am – 12.00pm	3.30pm – 7.00pm
Wednesday	09.20 am – 12.00pm	3.30pm – 7.00pm
Thursday	09.20 am – 12.00pm	Closed
Friday	09.20 am – 12.00pm	3.30pm – 7.00pm
North Staffordshire GP Federation Extended Hours Primary Care Services Programme:		Monday to Friday 4pm to 8pm & Saturday 9am to 4pm at five locations:
<ul style="list-style-type: none">• Hanley Primary Care Access Centre ST1 1LW• Haywood Hospital ST6 7AG• Bradwell Community Hospital ST5 7NU• Longton Cottage Hospital, ST3 4QX• Leek Moorlands Hospital ST13 5BQ		

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4079	253	98	38.7%	2.40%

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)	98.1%	93.9%	94.8%	No statistical variation

Any additional evidence or comments

Twenty-two patients completed CQC comment cards. Of the twenty, one reported negatively on obtaining a GP appointment, others reported positively on access.

Older people

Population group rating: Requires Improvement

Findings

- All patients had a named GP.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions Population group rating: Requires Improvement

Findings

- Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people Improvement

Population group rating: Requires

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example electronic alerts on some of the records we reviewed. However, records we looked at confirmed there were gaps in this process and the risks had not been mitigated by following up some patients who had attended A&E.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, practice extended opening hours until 7pm on weekdays with the exception of Thursday.

People whose circumstances make them vulnerable
rating: Requires Improvement

Population group

Findings

- The practice did not hold a vulnerable adults register. Patients living in vulnerable circumstances including homeless people were able to register at the practice. Patients with a learning disability were electronically coded to enable staff to ensure their needs could be met including quieter appointment times and longer appointments.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia)
Population group rating: Requires Improvement

Findings

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. Patients were requested to contact the surgery were able before 11am to request a home visit. Staff booked patients into the electronic home visit appointment system and information added to the home visit book. GPs visited patients at home at their request.</p> <ul style="list-style-type: none"> • On 13 December a patient was booked to see a GP at 8.30am and the GP did not arrive to consult until 9.20am. • A complaint had been received into the practice for a parent and child whose consultation had been delayed for over an hour. 	

Indicator	Practice	CCG average	England average	England comparison
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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)	76.4%	65.5%	70.3%	N/A
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)	75.8%	68.2%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	77.7%	68.4%	65.9%	No statistical variation
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)	82.6%	75.9%	74.4%	No statistical variation

Source	Feedback
CQC Comment Cards	Twenty-two patients completed CQC comment cards. One reported negatively on obtaining a GP appointment, others reported positively on access.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided complaints and comments literature for patients which were posted on the waiting room wall and on the practice website. However, patients would have to request a complaint leaflet from reception staff.</p> <p>The practice provided information on their local Healthwatch for its patients.</p> <p>We found that complaints had been dealt with by meetings with the practice team and resolved locally.</p> <p>There were no letters of acknowledgement or final letters following investigations with the steps patients could take following a complaint.</p>	

We found the complaint policy and procedures were in line with recognised guidance. There was however no evidence seen of an acknowledgement of complaint letter or following complaint investigations or meetings with the practice a final letter outlining the investigation and next steps they may choose to take.

- Complaints were discussed as a regular agenda item at practice meetings.
- There was little information to review regarding learned lessons from individual concerns and complaints or analysis of trends to improve the quality of care. There was basic documentary evidence on the learning that took place following complaints.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient had raised a complaint in respect of on-line medicine prescribing. The practice reviewed the complaint and were able to describe to the patient that controlled drugs could not be prescribed online. However, the practice GP had been contacted and a prescription was raised on the same day as the patient brought it to the practice's attention. In order that the patient received this medicine in a timely manner the GP signed the prescription on the same day. The patient was educated on the fact that controlled drugs could not be repeat ordered electronically.	

Well-led

Rating: Inadequate

The practice was rated as requires improvement for providing responsive services because:

- The practice had inadequate systems and processes that had potential to adversely affect patients. These included for example: safeguarding, recruitment, infection prevention and control, health and safety, staff training, appraisals, medicines management, poor consultation documentation, paper prescription serial number monitoring, a lack of following published best practice guidelines and medical indemnity oversight.
- We found that governance arrangements were not proactively monitored or reviewed and some processes, such as medicines management and actions on patient safety alerts, did not reflect best practice. The practice had not developed a strategy or succession plan.
- There was no embedded culture of shared learning, as evidenced with significant event reporting and complaints.

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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	N
Explanation of any answers and additional evidence: Between the two Care Quality Commission inspection visits on 27 November 2018 and 13 December 2018 the practice had failed to act to mitigate the immediate risks identified at the inspection on 27 November 2018. We found that the practice management lacked an understanding of issues, challenges and priorities in their service, and beyond. However, the practice had some plans in place and some ongoing improvement plans which included for example: <ul style="list-style-type: none">• A Quality Improvement Framework (QIF) action plan• The practice had recently implemented a text reminder service for appointments.• Participation in the extended hours which commenced in September 2018• Three percent of the registered patient population were known carers. Carers groups and signposting was available in the waiting room.	

- In the future social prescribing was planned with the practice having a link worker to help signpost patients to help with social isolation, carer support, housing and debt concerns.
 - A new practice Facebook account was planned
 - Attempts to engage with patients as they had no active patient participation group (PPG).
 - A local pharmacist attended the practice to discuss the pharmacy services they could provide to patients which included blood pressure checks, ear examinations and pharmaceutical products.
-
- The practice had not developed a strategy or succession plan. The practice manager advised there was no formalised succession plan in place and that the GPs would not engage in a conversation about succession planning.
 - One staff member at the practice had been in receipt of GP workflow support and training. We found that the staff did not use the electronic task system. Instead scraps of paper were used to pass messages on to receptionists regarding patients or actions from test results. During the inspection we evidenced numerous examples of these lying on desks around the practice and it was not clear if they had been actioned or not. This system did not provide an appropriate audit trail. The practice administrative staff said they did not use the electronic task system as the GPs did not know how to.
 - Not all staff had not been in receipt of Information Governance training. The practice manager informed us that the North Staffordshire GP Federation had appointed a person to assist practices with questions regarding GDPR. The practice therefore had not taken any action themselves.
 - Staff were seen leaving their personal ID smart cards in the electronic system whilst out of the room.
 - Inadequate systems and processes that had potential to adversely affect patients. These included for example: safeguarding, recruitment, infection prevention and control, health and safety, staff training, appraisals, medicines management, poor consultation documentation, paper prescription serial number monitoring, a lack of following published best practice guidelines and medical indemnity oversight.
 - We found that governance arrangements were not proactively monitored or reviewed and some processes, such as medicines management and actions on patient safety alerts, did not reflect best practice.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy in place 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	N

them.	
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice had some ongoing improvement plans but had not developed a strategy, succession or sustainability plan.</p> <p>The practice had developed a philosophy of care, in that patient welfare was the main objective for everything the practice did. Staff reported that they were aware the practice had a philosophy and that providing good care for patients was the practice focus.</p>	

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.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The leadership culture was deferential in that staff deferred to the senior partners view. We found there was no embedded culture of shared learning, as evidenced with significant event reporting and complaints. Other examples included, poor consultation documentation, not prescribing according to recommended guidelines both of which had not been subject to a healthy challenge.</p> <p>As evidenced in the records sampled and the systems reviewed there was a lack of dynamic leadership within the practice to drive forward improvements required to be assured of patient safety and safe care and treatment.</p>	

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

Source	Feedback
Staff	<p>One staff member described the practice leadership approach to change as only being able to take one a small step at a time.</p> <p>All staff we spoke with found the practice leadership approachable and supportive stating the whole team was like 'an extended family.'</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	N
<p>Explanation of any answers and additional evidence:</p> <p>There were clear undocumented roles and responsibilities within the team in relation to administrative processes, safeguarding, infection control, recall systems, performance data and clinical governance.</p> <p>The practice management did not demonstrate clear governance arrangements, for example in monitoring, receipt of patient safety alerts, safeguarding, staff training and development appraisals, recruitment, revalidation and staff medical indemnity.</p> <p>During the inspection we identified numerous areas where patients were put at risk.</p> <ul style="list-style-type: none">• We found evidence of poor leadership• A lack of governance• Inadequate systems and processes that had potential to adversely affect patients. These included for example: safeguarding, recruitment, infection prevention and control, health and safety, staff training, appraisals, medicines management, poor consultation documentation, paper prescription serial number monitoring and medical indemnity oversight. <p>We found that governance arrangements were not proactively monitored or reviewed and some processes such as medicines management and actions on patient safety alerts did not reflect best practice.</p> <p>The practice held meetings in which regular agenda items included, incidents and events, complaints and QOF/QIF data of which there were minutes available for staff to access. These included:</p> <ul style="list-style-type: none">• Practice meetings• Clinical meetings <p>The practice planned to participate in a research trial to determine whether an internet based self-management tool would be useful when compared with standard care provided by GPs.</p>	

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 in place which were regularly reviewed and improved.	N
There were processes in place to manage performance.	N
There was a systematic programme of clinical and internal audit.	Y

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.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
<p>The quality assurance systems in place were not proactively monitored or reviewed and some processes, such as medicines management and actions on patient safety alerts, did not reflect best practice.</p> <p>There was a lack of risk assessments, for example:</p> <ul style="list-style-type: none"> • A lack of risk assessment for emergency medicines not held at the practice. • A lack of risk assessment for staff without full vaccination histories or DBS checks. • Risks identified in Infection Prevention and Control yet to be acted upon. • System for patient safety alerts highlighted risks on 27 November 2018 yet to be fully actioned on 13 December 2018. <p>The systematic programme of clinical and internal audit was led by the practice Quality Improvement Framework (QIF) action plan with the CCG.</p> <p>Not all staff we spoke with were aware of the business continuity or major incident plan held by the practice manager.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	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:	
<p>Staff had not been subject to a regular annual appraisal and no evidence was seen of regular staff competency or performance reviews.</p> <p>The practice did not always have appropriate and accurate information.</p> <ul style="list-style-type: none"> • We saw gaps in the electronic coding within some patient records we reviewed. • Staff were seen leaving their personal ID smart cards in the electronic system whilst out of the room. • Staff had not actioned recent guidance for General Data Protection Regulations (GDPR). The 	

practice manager advised that support was available via a nominated staff member within the CCG.

There was not an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The practice did not have sufficient processes to manage current and future performance.

Engagement with patients, the public, staff and external partners

The practice did not involve the public or staff to sustain high quality and sustainable care, they did engage with external partners.

	Y/N/Partial
Patient views were acted on to improve services and culture.	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.	Y
Explanation of any answers and additional evidence:	
There was no Patient Participation Group to feedback on patient views or to engage with any planning strategies.	
There was no documented evidence seen that staff views were reflected in the planning and delivery of services.	
The service was transparent, collaborative and open with stakeholders about performance. There was little evidence seen of stakeholder involvement or engagement at the practice except for the Supporting Change Team inventions.	

Feedback from Patient Participation Group.

Feedback
There was no Patient Participation Group.

Continuous improvement and innovation

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.	Y
Explanation of any answers and additional evidence:	
There was little evidence of systems and processes to support learning, continuous improvement and innovation.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
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:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.