

# Care Quality Commission

## Inspection Evidence Table

### Welland Medical Practice (1-542283575)

Inspection date: **29 November 2018**

Date of data download: 20 November 2018

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

## Safe

**Rating: Inadequate**

- We rated the practice as inadequate for providing safe services because the provider had not ensured care and treatment was provided in a safe way to patients.

### Safety systems and processes

**The practice did not have clear systems to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs).	Yes
There was active and appropriate engagement in local safeguarding processes.	Partial
Systems were in place to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required	No
Staff who acted as chaperones were trained for their role.	Yes
The provider had regular discussions with health visitors, school nurses, community midwives, social workers etc. to support and protect adults and children at risk of significant harm.	Partial

Explanation of any answers and additional evidence:

- On the day of the inspection the practice failed to show they had undertaken appropriate DBS checks or risk assessments for all clinical staff. There was no evidence that two members of the nursing staff had received an appropriate DBS check or had an appropriate risk assessment undertaken. Following the inspection, the practice submitted DBS certificates for the staff members that had been undertaken from other employers. The practice submitted evidence that they had applied for an up to date DBS for one member of staff.
- Meetings for safeguarding and with the health visitor and other Multidisciplinary Teams took place at another practice (the same provider) close to Welland Medical Practice, however, the GPs responsible for the patients at Welland Medical Practice did not regularly attend these meetings. Minutes were taken and cascaded to all the GPs, we noted that a non-clinical member of staff from Welland Medical Practice used to attend these meetings but they no longer work at the practice.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who required medical indemnity insurance had it in place.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to show clear evidence that they had recruited all staff safely. Not all staff had received DBS checks or had a risk assessment undertaken. We found inconsistency in recruitment files such as not all staff had received two references, or had received an appropriate, documented formal induction.</p>	
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: April 2018	Yes
There was a record of equipment calibration. Date of last calibration: 13 April 2018	Yes
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals.	Yes
Fire procedure in place.	Yes
There was a record of fire extinguisher checks. Date of last check: 27/11/2018	Yes

There was a log of fire drills. Date of last drill: 27/11/2018 and previous 21/6/2018	Yes
There was a record of fire alarm checks. Date of last check: 22/11/2018	Yes
There was a record of fire training for staff. Date of last training: online training undertaken by staff evidence seen that staff had completed	Yes
There were fire marshals in place.	Yes
A fire risk assessment had been completed. Date of completion: 27/11/1018 for both sites.	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	
<b>Health and safety</b> Premises/security risk assessment carried out. Date of last assessment: August 2018	Yes
Health and safety risk assessment and actions Date of last assessment: August 2018	Yes
Explanation of any answers and additional evidence: We saw evidence of risk assessments undertaken for example, loose covering on the stairs, this was repaired and safety tape used to highlight area.	

## Infection control

### The practice had systems and processes in place to manage infection control.

	Y/N/Partial
Infection risk assessment and policy in place	Yes
Staff had received effective training on infection control.	Yes
Date of last infection control audit: 20/12/2017	Yes
The provider had acted on any issues identified in infection control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The infection prevention and control policy covered issues including spillages, waste management, needle stick injuries, disposal and use of sharps and sample handling.</li> <li>The infection prevention and control audit had been completed and identified actions had been acted upon. For example, we found clinical rooms had been de-cluttered and pedal bins had been purchased.</li> </ul>	

## Risks to patients

The systems to assess, monitor and manage risks to patient safety needed to be improved.

Question	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	No
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinician review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
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.	Yes
When there were changes to services or staff the provider assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was experiencing recruitment issues and at the time of the inspection did not have any practice nurses employed. An advanced nurse practitioner and one healthcare assistant were employed. The practice managed this shortfall by offering patients appointments at another practice close by of which they are also the provider.</li> <li>There was no clear evidence that staff received an appropriate formal induction programme. There was no evidence to show that staff had been assessed as competent to undertake the role they had been employed to do.</li> </ul>	

## Information to deliver safe care and treatment

Staff generally had the information they needed to deliver safe care and treatment to patients.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the	Partial

summarising of new patient notes.	
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
There was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
The provider demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice did not have systems and processes in place to monitor the quality of medical summaries which were completed by trained non-clinical staff.</li> <li>• The practice had systems or processes in place to monitor delays in referrals. GPs sent electronic tasks to alert secretarial staff to an urgent referral, however these were not always received.</li> </ul>	

## Appropriate and safe use of medicines

The practice had some systems for appropriate and safe handling of medicines, however these needed to be reviewed and improved.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHS Business Service Authority - NHSBSA)	1.26	1.02	0.95	Comparable with other practices
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA)	9.4%	12.4%	8.7%	Comparable with other practices

Medicines management	Y/N/Partial
The provider had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	No

Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. We reviewed two high risk medicines and found all patients had been monitored appropriately.	Yes
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Yes
Patients were appropriately informed when unlicensed or off-label medicines were prescribed.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	No
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	No
There was medical oxygen on site.	Yes
The practice had a defibrillator.	Yes
Both were checked regularly and this was recorded.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes
Patients' health was monitored in relation to the use of medicines and followed up on appropriately.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice Healthcare Assistant administered B12 and seasonal influenza injections, however the practice had failed to ensure that a Patient Specific Direction was signed prior to the immunisation being given. This is a national requirement. The staff member had not received appropriate training to undertake this delegated work.</li> <li>• The practice had not undertaken any regular monitoring of the prescribing of controlled drugs but told us they discussed this in the clinical meetings.</li> <li>• The practice did not have evidence that they had risk assessed the medicines that would be required in the event of a medical emergency. For example, the practice did not have a GTN spray for patients who maybe suffering chest pain, a medicine Naloxone for the management of opioid overdose nor a medicine midazolam for the use in epileptic seizures. There was no list</li> </ul>	

available for stock checking of emergency medicines to ensure they were available and in date. All medicines we checked were within their expiry date.

### Track record on safety and lessons learned and improvements made

The practice track record on safety issues needed to be improved. The practice did not evidence that they learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months.	15
Number of events that required action	15
<p>Explanation of any answers and additional evidence:</p> <p>Staff were aware of how to raise events, the practice recorded them and the management team discussed them. However, they did not always carry out the actions agreed; for example, following two significant events where patient's medicines were not stopped at the appropriate time, the practice action was to review all patients on this medicine. This had not been undertaken. There was little evidence that learning was shared and monitored.</p>	

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

Event	Specific action taken
Out of date vaccines found in fridge.	Vaccines were disposed of immediately. The staff member responsible for monitoring the medicines had left the practice. All medicines we checked during our inspection were within their expiry date.
Medicine not stopped at appropriate time.	Discussed with patient, pharmacist and GP. Medicines were stopped and the GPs were reminded to use end dates for medicines not intended for long term use.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understand how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We looked at three alerts, two had been actioned satisfactory, the patient taking a medicine relating to a high-risk medicine and risk in pregnancy had been reviewed, however plans for pregnancy prevention had not been recorded.</li> </ul>	



## Effective

## Rating: Inadequate

We rated the practice and the population groups of people with long term conditions, working age people (including those recently retired and students) and people whose circumstances make them vulnerable as inadequate for providing effective services and we rated the population groups for older people and families, children and young people as requires improvement for providing effective services because the practice did not ensure there were systems and processes in place to ensure there was effective staffing and monitoring of quality and performance needed to ensure patients received appropriate and timely follow up. These failings affect all patients in all population groups. We rated the population group of those experiencing poor mental health as good for providing effective services.

**Please note: QOF data relates to 2017/18 unless otherwise indicated**

### Effective needs assessment, care and treatment

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Yes
Explanation of any answers and additional evidence:	

### Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	1.83	0.91	0.83	Comparable with other practices

- Although the practice performance in relation to the prescribing of hypnotics was statistically comparable to the CCG and national averages we noted it was higher. The practice had not reviewed their prescribing to ensure they were prescribing effectively.

## Older people

Population group rating: Requires improvement

### Findings

- Not all care and treatment was delivered by staff with evidence of appropriate training and checks in place.
- The practice performance in relation to antibiotics and hypnotics was higher than the CCG and national averages, they practice had not undertaken any quality reviews such as clinical audit to ensure they were prescribing effectively.
- The practice had not regularly review their end of life register to ensure patients were on the register appropriately. We saw some patients had been on the end of life register for more than two years. The GPs in the practice did not regularly attend the multidisciplinary meetings to discuss their patients with other professionals such as the district nurses.
- The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being severely frail had a clinical review including a review of medication and a review of any falls.
- The practice followed up on older patients discharged from hospital. It ensured their care plans and prescriptions were updated to reflect any extra or changed needs. The practice referred to a local rapid response team to reduce the number of unplanned admissions.

## People with long-term conditions

Population group rating: Inadequate

### Findings

- Some patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. The practice did not have any employed practice nurses who were trained in the management of long term conditions. A diabetes technician commissioned by the CCG attended the practice to undertake physical checks with the patients. Medicines were reviewed by the GPs.
- The practice booked appointments at the nearby GP extended hours hub where patients could be seen for routine problems and follow ups.
- The practice's performance on quality indicators for long term conditions was mixed when compared with local and national averages. Although statistically comparable, we noted their performance and exception coding was mixed. The practice shared with us their unverified quality and outcome framework data for this current year 2018/2019 which showed the practice current total achievement was 49%. For the diabetes indicator the practice performance was showing 40% overall. The practice had until March 2019 to increase their performance and they told us that despite the nursing team shortage, they were confident they would achieve a high score but they did not have a formal action plan in place.

### Diabetes Indicators

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64	80.2%	80.4%	78.8%	Comparable with other practices

mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	18.7% (56)	15.7%	13.2%	
<b>Indicator</b>	<b>Practice performance</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	68.1%	74.5%	77.7%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	14.0% (42)	11.9%	9.8%	

<b>Indicator</b>	<b>Practice performance</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	74.8%	79.3%	80.1%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	11.0% (33)	15.5%	13.5%	

<b>Other long term conditions</b>				
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	75.3%	76.1%	76.0%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	3.6% (11)	7.9%	7.7%	
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>

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)	90.5%	90.7%	89.7%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	4.5% (3)	13.6%	11.5%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.8%	82.2%	82.6%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	5.1% (20)	4.7%	4.2%	
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	100.0%	90.8%	90.0%	Variation (positive)
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	5.6% (1)	7.6%	6.7%	

**Any additional evidence or comments**

**Families, children and young people improvement**

**Population group rating: requires**

**Findings**

- The practice GPs did not regularly attend the safeguarding meetings that were held at a nearby practice (under the same provider). The community health visitor attended these meetings, we

noted that a non-clinical member of staff from Welland Medical Practice used to attend these meetings but this member of staff no longer works at the practice. The GPs received minutes that had been taken from the meetings.

- Childhood immunisation uptake rates were above the target percentage of 90%. The practice contacted any patient who was not part of the immunisation scheme to find out why and provide education if required. On the day of the inspection, the practice did not have employed practice nurses, patient attended a nearby practice (under the same provider) to be given their immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Regular monthly meetings with the health visitor and school to discuss concerns were held at a nearby practice. However, the GPs did not regularly attend these meetings but felt they kept up to date via the minutes that were recorded and shared with them.

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)	64	66	97.0%	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)	79	83	95.2%	Met 95% WHO based target (significant variation positive)
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)	79	83	95.2%	Met 95% WHO based target (significant variation positive)
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)	79	83	95.2%	Met 95% WHO based target (significant variation positive)

#### Any additional evidence or comments

The practice proactively followed up children who had not attended their immunisation clinics.

#### Working age people (including those recently retired and students)

Population group rating: inadequate

## Findings

- The practice's uptake for cervical screening was 75%, which was below the 80% coverage target for the national screening programme and in line with the local and national averages.
- The practice's uptake for breast and bowel cancer screening was below the local and national average. The practice did not have systems and processes in place to encourage patients to attend their screening appointments.
- Due to the shortage of trained staff, the practice had offered limited access to appropriate health assessments and checks including NHS checks for patients aged 40-74. For example, the practice had only undertaken 11 NHS health checks.

## Cancer Indicators

Indicator	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	74.5%	71.2%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	61.3%	74.1%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	38.1%	56.9%	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)	85.7%	63.2%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	81.8%	59.7%	51.6%	Comparable with other practices

## Any additional evidence or comments

### People whose circumstances make them vulnerable

Population group rating: inadequate

## Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice liaised with the local palliative care team to discuss patients at the end of life. We found the practice had not regularly reviewed their register as we found some patients had been on the register for two or more years.
- The practice held a register of patients living in vulnerable circumstances including those with a

learning disability, however, the practice had not undertaken any reviews for patients who were carers or for patients with learning disabilities.

**Population groups - People experiencing poor mental health (including people with dementia)**  
**Population group rating: good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The practices performance on quality indicators for mental health was statistically comparable but we noted higher than the CCG and national averages.

**Mental Health Indicators**

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QoF)	96.3%	91.1%	89.5%	Comparable with other practices
<b>QoF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.6% (1)	13.1%	12.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QoF)	92.6%	89.7%	90.0%	Comparable with other practices
<b>QoF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.6% (1)	11.7%	10.5%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	94.7%	85.0%	83.0%	Comparable with other practices

(01/04/2017 to 31/03/2018) (QOF)				
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0 (0)	6.6%	6.6%	

<b>Any additional evidence or comments</b>

### Monitoring care and treatment

The practice did not have a programme of quality improvement activity and did not review the effectiveness and appropriateness of the care provided.

Question	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice did not have a comprehensive programme of quality improvement activity and were only able to share single cycle audits; for example, an audit was carried out in July 2018 for patients taking a medicine Pioglitazone (a medicine used in the management of patients with diabetes) and the risk of bladder cancer. The practice planned to repeat the audit in July 2019.</li> </ul>	

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	97%	97%	96%
Overall QOF exception reporting (all domains)	10%	11%	10%

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

Improvement activity
<ul style="list-style-type: none"> <li>The practice was unable to demonstrate that improvements had been made as a result of audit or other improvement activity.</li> </ul>

### Effective staffing

The practice had not ensured that all 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	Partial



treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	
The learning and development needs of staff were assessed	No
The provider had a programme of learning and development.	No
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	No
Staff had access to appraisals, one to one, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	No
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Non- clinical staff we spoke with told us they had an annual appraisal but there was no evidence that clinical staff had regular reviews or clinical supervision from the GPs. The practice was supporting the advance nurse practitioner to be trained to take cervical screening samples. On the day of the inspection the practice did not have any employed practice nurses, patients were booked appointments at a nearby practice (under the same provider) or at the local GP hub.</li> <li>• The practice had not assessed the training or competency of all nursing team staff to ensure they were competent to carry out the tasks delegated to them. We found a healthcare assistant undertaking immunisations and vaccinations without evidence of appropriate training.</li> </ul>	

### Coordinating care and treatment

Indicator	Y/N
<p>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).</p> <ul style="list-style-type: none"> <li>• The GPs from the practice did not regularly attend these meetings which were held at a nearby practice. Meetings were attended by community nurses and GPs who looked after patients at a different practice. An administrator from the Welland practice had attended some meetings but at the time of the inspection this staff member had left and was no longer working at the practice. Minutes from the meetings were cascaded to the GPs for information.</li> </ul>	No

**Staff worked together and with other health and social care professionals to deliver effective care and treatment but this needed to be improved.**

	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams	Yes

and organisations, were involved in assessing, planning and delivering care and treatment.	
Care was delivered and reviewed in a co-ordinated way when different teams, services or organisations were involved.	Yes
The practice had regular (at least 3 monthly) multidisciplinary (MDT) case review meetings where all patients on the palliative care register were discussed.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>MDT meetings were held with a local practice, the GPs from Welland practice did not regularly attend these meetings, minutes of the meetings were cascaded to them. An administrator from the Welland practice had attended some meetings but at the time of the inspection this staff member had left and was no longer working at the practice. Minutes from the meetings were cascaded to the GPs for information.</li> </ul>	

## Helping patients to live healthier lives

**Staff were consistent and proactive in helping patients to live healthier lives.**

	Y/N/Partial
The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Wellness clinics and lifestyle coaches were available in the practice to support national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.</li> </ul>	

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)	95.9%	95.2%	95.1%	Comparable with other practices

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.2% (9)	0.9%	0.8%	

### Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance. However, there was no monitoring of this process.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Explanation of any answers and additional evidence:	

## Caring Rating: **Requires improvement**

**We rated the practice as requires improvement for providing caring services because:** Generally, feedback from patients showed that staff did not always treat patients with kindness, respect and compassion.

### Kindness, respect and compassion

**Feedback from patients showed that staff did not always treat patients with kindness, respect and compassion.**

CQC comments cards	
Total comments cards received	23
Number of CQC comments received which were positive about the service	11
Number of comments cards received which were mixed about the service	Six
Number of CQC comments received which were negative about the service	Six

### Examples of feedback received

Source	Feedback
NHS Choices	There had been four reviews posted on NHS choices giving the practice an overall rating of two stars. One comment was wholly positive about the care they had been given but three comments were mixed about the kindness and helpfulness of staff.
Comment cards	Most of the comment cards had positive comments about their experience and six had negative comments about staff.
Patients we spoke with	Patients we spoke with were positive about the care they had received from staff.

### 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 has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3963	414	97	23.40%	2.45%

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)	87.0%	90.5%	89.0%	Comparable with other practices
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)	87.5%	89.1%	87.4%	Comparable with other practices
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)	97.0%	96.3%	95.6%	Comparable with other practices
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)	72.2%	85.5%	83.8%	Comparable with other practices

**Any additional evidence or comments**

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

Date of exercise	Summary of results
October 2018	Family and Friends test, 11 responses had been received and of these 10 were likely or extremely likely to recommend the practice.

### Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients.	The patients spoken to commented positively about their experience of care and treatment provided by the practice.
NHS Choices	There had been four reviews posted on NHS choices giving the practice an overall rating of two stars. One comment was wholly positive about the care they had been

Comment cards we received	<p>given but three comments were mixed about the kindness and helpfulness of staff.</p> <p>17 of the comment cards had positive comments about the care received and kindness of staff, six had negative comments about staff.</p>
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## 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)	92.9%	94.5%	93.5%	Comparable with other practices

Question	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language. Some staff spoke other languages including Gujarati, Hindi, Punjabi and Urdu.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	No
Information about support groups was available on the practice website.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they would access leaflets and information in other languages if the patient requested.</p>	

Carers	Narrative
Carers on the register	The practice had identified 34 patients as carers, less than 1% of the practice population. The practice told us they asked patients at registration if they were a carer and opportunistically during consultations.
Bereavement support in place	The practice offered support to bereaved patients and arrange consultations and home visits as appropriate at times convenient to the patient.

## 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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
Explanation of any answers and additional evidence:	

## Responsive

**Rating: Inadequate**

**We rated the practice as inadequate for providing responsive services because:**

Data from the 2018 GP patient Survey showed that patients satisfaction with access to the practice was statistically comparable but most indicators were below the CCG and national averages. Comments on NHS choices and on the comment cards we received reported negative experiences. The practice complaints procedures needed to be improved. These findings effect all patients in all the population groups.

### Responding to and meeting people's needs

**The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.**

	Y/N/Partial
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
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.	Partial
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice recognised the challenges to fully meet the needs of the patients as the premises they operated from lacked space and extending the building was not possible. The practice was working closely with the CCG to complete a new purpose-built practice, they told us they hoped to move into the premises in April 2019.</li> <li>Although staff who worked within the practice were able to provide effective care for those who were more vulnerable, the practice did not have any employed practice nurses. The patients who required treatment were booked appointments with a nearby practice (under the same provider) or at the local GP hub extended hours service and the practice did not always have clear oversight of their care co-ordination.</li> </ul>	

Practice Opening Times	
Day	Time
Eye Road Surgery	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 7.30pm
Wednesday	8.30am to 6.30pm



Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm
Church Walk Surgery	
Monday	8am to 2pm
Tuesday	8am to 2pm
Wednesday	8am to 2pm
Thursday	8am to 2pm
Friday	8am to 2pm

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3963	414	97	23.40%	2.45%

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)	97.1%	95.5%	94.8%	Comparable with other practices

Any additional evidence or comments

### Older people

Population group rating: inadequate

Findings
<ul style="list-style-type: none"> <li>The patients who required access to practice nurse services were offered appointments at a nearby practice (managed by the same provider) and at the local GP extended hours hub.</li> <li>All patients had a named GP who supported them in whatever setting they lived, the practice did not have care homes where they provided GP services.</li> <li>The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.</li> </ul>

### Population groups - People with long-term conditions inadequate

Population group rating:

Findings
<ul style="list-style-type: none"> <li>Some patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.</li> <li>Patients were offered appointments at a nearby practice (under the same provider) or at the local GP extended hours hub.</li> </ul>

- The practice held regular meetings at a nearby practice with the local district nursing team and community matrons to manage the needs of patients with complex medical issues. The GPs from Welland Medical Practice did not regularly attend these meetings but information was cascaded through minutes that were taken. GPs responsible for patients at the other practice attended. An administrator who was no longer employed at the practice had attended meetings previously.

**Population groups – Families, children and young people**  
**inadequate**

**Population group rating:**

### Findings

- The practice offered appointments at a nearby practice (under the same provider) and at the local GP extended hours hub.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

**Population groups – Working age people (including those recently retired and students)**

**Population group rating:**

**Inadequate**

### Findings

- The needs of this population group had been identified and the practice had attempted to adjust the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice was able to book appointments for patients at the local GP extended hours hub.
- The practice had not been able to offer appointments for NHS health checks at the practice as there had been a shortage of staff to undertake this proactive healthcare.
- Online booking and prescription services were available for patients to use.

**People whose circumstances make them vulnerable**  
**Inadequate**

**Population group rating:**

### Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

## Population groups - People experiencing poor mental health (including people with dementia)

Population group rating:

### Inadequate

#### Findings

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held monthly multidisciplinary team meetings which were usually attended by a community mental health link worker at a nearby practice but the GPs did not regularly attend these meetings. Information was shared via the minutes of the meetings to the GPs.

### Timely access to the service

Data from the GP patient survey July 2018 showed low satisfaction from patients in relation to access care and treatment from the practice within an acceptable timescale for their needs.

#### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	42.3%	75.1%	70.3%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	44.0%	73.9%	68.6%	Comparable with other practices
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)	50.2%	69.2%	65.9%	Comparable with other practices
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)	56.8%	79.6%	74.4%	Comparable with other practices

#### Examples of feedback received from patients:

Source	Feedback
NHS Choices	There had been four reviews posted on NHS choices giving the practice an overall rating of two stars. One comment was wholly positive about the access they had

Comments cards	been given but three comments were negative about access.
Patients we spoke with	12 of the comments cards we received reported difficulties in access to appointments.  The patients we spoke with told us they experienced difficulties in accessing appointments in a timely manner.

### Listening and learning from concerns and complaints

The practice took complaints and concerns seriously however they did not always respond to them appropriately to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Six
Number of complaints we examined	Three
Number of complaints we examined that were satisfactorily handled in a timely way	Three*
Number of complaints referred to the Parliamentary and Health Service Ombudsman	None

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We found that only one letter had received a full written response that contained all the details necessary for the patient to be aware of who to contact if they were still not satisfied. The practice told us they dealt with complaints verbally whenever possible. We found little evidence that the practice reviewed these, always completed the actions identified or shared learning across the whole practice team.</li> </ul>	

## Well-led

**Rating: Inadequate**

- We rated the practice as inadequate for providing well led services because the provider had not ensured care and treatment was provided in a safe way to patients.
- People were not adequately protected from avoidable harm and abuse.
- There was insufficient assurance that people received effective care and treatment.
- The leadership, governance and culture of the practice did not assure the delivery of high quality care.
- Some legal requirements were not met.

### Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care however we found that the practice had failed to ensure the governance structure, systems and process provided safe and effective services.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme in place, including a succession plan.	No
<p>Explanation of any answers and additional evidence:</p> <p>The leaders were proactive in identifying issues relating to the premises from which they operated and were fully engaged in the building of new premises to meet the needs of their patients. However, they had failed to have clear oversight on the systems and processes currently in place to ensure safe and effective care for their patients.</p> <p>The practice did not show evidence to support action plans to encourage improvement or for succession planning of key members of staff.</p>	

### Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. However, this was not achieved as there was a lack of clinical oversight to monitor and address shortfalls in the care and provision of services offered.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes

There was a realistic strategy in place to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not evidence they had reviewed the shortfalls in the practice and did not show they had clear plans to ensure they improved.</p> <p>The practice leaders were focused on the building and development of the new premises which they told us would enable them to improve the services they offered to patients. The practice told us they believed the new premises would enable them to recruit and retain key members of staff, for example practice nurses.</p>	

## Culture

**The practice did not demonstrate a culture of high-quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was an emphasis on the safety and well-being of staff.	Yes
The practice's speaking up policies were in line with the NHSI National Raising Issues Policy.	Yes
<p>Explanation of any answers and additional evidence:</p>	

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

Source	Feedback
Staff	Staff we spoke with told us they strived to deliver high quality care but this was compromised because they worked from premises that they said were no longer fit for purpose. They told us they had easy access to the partners if they wanted to discuss any concerns.

## Governance arrangements

**The responsibilities, roles and systems of accountability to support good governance and management were inadequate.**

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The leaders failed to show they had clear oversight of governance in the practice. We were not assured that the leaders reviewed and monitored quality and safety to ensure patients and staff were kept safe from harm.</li> </ul>	

### Managing risks, issues and performance

**There were not 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.	No
There were processes in place to manage performance.	No
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had undertaken some audits there was no systematic programme of clinical and internal audit to review and monitor quality and performance to encourage improvement.</li> <li>The leaders failed to show they had clear oversight of managing risk in the practice. We were not assured that the leaders reviewed and monitored risks to ensure patients and staff were kept safe from harm. For example, we found that the practice had not reviewed the provision of emergency medicines and the management of Legionella needed improvement. Patients had been put at risk of harm as staff had not been fully trained to undertake the tasks that had been delegated to them.</li> <li>The leaders had put patients at risk of harm as they had not undertaken a clear risk assessment of the role of all clinical staff. They had implemented services without ensuring the staff member had evidence of appropriate training and skills and they had not formally assessed the competency of staff to perform these tasks.</li> </ul>	

### Appropriate and accurate information

**The practice did not clearly show they acted on appropriate and accurate information.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities include making statutory notifications understand what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had not reviewed patient's satisfaction data or put an action plan in place to address the findings. The practice believed that once they move into the new premises patient satisfaction would improve. The practice gave some access to patients at other sites for example at a nearby practice (under the same provider) or at the GP Hub extended hours service.</li> <li>• The practice had identified a shortfall in the provision of clinical staff to undertake areas such as reviews of patients with long term conditions. The practice did not have clear evidence of how they were mitigating the risks to ensure all patients would receive a review in a timely manner.</li> <li>• The practice told us they used information to hold staff and management to account however this was not always effective. For example, they did not have systems and processes in place to ensure the filing of patient's correspondence and summaries by non-clinical staff were accurate and well managed.</li> </ul>	

### Engagement with patients, the public, staff and external partners

**The practice did not fully involved patients, the public, staff and external partners to support high-quality sustainable services.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Partial
The provider worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice was unable to demonstrate they had reviewed or acted upon the views of patients or that they had a written plan of the improvements needed. They were working closely with the CCG to ensure the new premises would meet the needs and demands of the patients in the future. The practice told us they should be in the new premises from April 2019 and they were confident that they would address patient's poor satisfaction once they were in a building that was fit for purpose.</li> </ul> <p>The provider ran services from other sites and held quarterly meetings to discuss the planning and delivery of services from all sites. On the day of the inspection, practice did not have a</p>	



practice manager or practice nurses employed to represent the Welland Medical practice. Some staff we spoke with told us they were not involved in the planning and delivery of service.

### Feedback from Patient Participation Group

#### Feedback

- The practice told us they had tried to engage with patients and form a PPG, they told us they were address this shortfall once they were in their new premises.

### Continuous improvement and innovation

**There was a lack of systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement	Partial
Learning was shared effectively and used to make improvements.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had invested a significant amount of time and resource into the provision of new practice premises to improve the services they could offer to patients. However, we found a lack of evidence to show the practice had reviewed the areas which needed to be improved and had a clear action plan to ensure the improvements were made and monitored.</li> <li>• The practice told and develop the nursing team. Although they did not have any practice nurses in post at the time of the inspection, they had supported other staff in additional training such as deprivation of liability and mental capacity act training. An advance nurse practitioner had been supported to obtain their minor illness qualification and updates for providing women’s health.</li> </ul>	

#### Notes: CQC GP Insight

GP Insight assesses a practice’s data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice’s performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice’s data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice’s data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

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

The following language is used for showing variation:

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

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

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

#### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment. ( [See NHS Choices for more details](#)).