

# Care Quality Commission

## Inspection Evidence Table

### Braithwell Road Surgery (1-3910418013)

**Inspection date: 17 December 2018**

**Date of data download: 10 December 2018**

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

At the last inspection in April 2108 we rated the practice as requires improvement overall and for providing safe, effective and well led services because:

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- There was limited evidence of clinical audit of the quality of care and outcomes for patients.
- There was no evidence the practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).
- There was a lack of understanding about the practice areas of responsibility in relation to fire safety.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person maintained securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular:

- There was no clear audit trail of use of blank prescriptions and blank prescriptions were not always stored securely.
- Staff vaccination records were not accessible.

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- There was a lack of records to evidence staff had received up-to-date safeguarding training appropriate to their role.
- There was a lack of records to evidence staff had received training in health and safety matters.
- Not all staff had received an appraisal and there was a lack of clinical input for practice nurse appraisals.
- Performance of employed clinical staff was not monitored, for example, through audit of their consultations, prescribing and referral decisions.

At this inspection, we found that the provider had not satisfactorily addressed all these areas and the practice remains rated as requiring improvement overall.

## Safe

## Rating: Requires Improvement

We rated the practice as **requires improvement** for providing safe services because:

- The practice did not have clear systems and processes to keep patients safe.
- The practice did not have appropriate systems in place for the safe management of medicines requiring refrigeration.
- Recruitment procedures had not been followed in the recruitment of non-clinical staff.

### Safety systems and processes

**The practice had systems, practices and processes to keep people safe and safeguarded from abuse but these had not all been maintained.**

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.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	N (1)
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 (2)
There was active and appropriate engagement in local safeguarding processes.	Y
Systems were in place to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y (3)
Disclosure and Barring Service (DBS) checks were undertaken where required.	N (4)
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: (1) The safeguarding policy and procedure required updating with the new practice managers details. (2) At the last inspection we found there was a lack of records to evidence staff had received up-to-date safeguarding training appropriate to their role. At this inspection we found there was no evidence the lead GP had undertaken safeguarding training at the appropriate level since 2016 and there was no evidence on file the salaried GP had undertaken training. There was evidence other staff had attended a clinical commissioning group (CCG) event in September 2018. Access to an eLearning package had also been provided recently. (3) The child at risk register was not being actively used. The practice manager told us they would check this and monitor it in future. Safeguarding flags were used on patients' records to alert staff to any	

Safeguarding	Y/N/Partial
possible concerns.	
<p>(4) The practice policy and procedure relating to DBS checks had not been followed in respect of two non-clinical staff employed since the last inspection. For example, one DBS was received a month after employment commenced and in another case a previous employers DBS had been obtained, dated 12 months prior to employment by the practice, and the practice had not sent for an up to date DBS since employment. Risk assessments had not been completed in respect of starting the employment of these staff prior to all checks being completed.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N (1)
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial (2)
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial (3)
Staff who required medical indemnity insurance had it in place.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(1) The practice policy and procedure for recruitment had not been followed in respect of obtaining references and DBS checks prior to employment for two administration staff employed since the last inspection and a health assessment had not been completed. Risk assessments had not been completed in respect of starting employment of these staff prior to all checks completed.</p> <p>(2) At the last inspection we found staff vaccination records were not accessible. At this inspection we found staff vaccination information was available for nurses and the health care assistant but was not available for GPs or other staff in line with the Department of Health Immunisation against infectious disease guidance (the Green Book).</p> <p>(3) Registration of clinical staff had been checked prior to employment but the new practice manager was not aware of any systems to regularly check these to ensure they were up to date. They were checked on the day of the inspection and registrations were up to date. The provider told us they would put systems in place to check registration status in future.</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: 8 November 2018	Y
There was a record of equipment calibration. Date of last calibration: 8 November 2018	Y
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	NA
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check:	N (1)
There was a log of fire drills. Date of last drill:	N (1)
There was a record of fire alarm checks. Date of last check:	N (1)
There was a record of fire training for staff. Date of last training: 2016	N (2)
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion: February 2017	Y
Actions from fire risk assessment were identified and completed.	NA as there were no required actions identified
<p>Explanation of any answers and additional evidence:</p> <p>(1) At the last inspection there was a lack of understanding about the practice areas of responsibility in relation to fire safety. At this inspection we were told the tasks relating to maintenance of the fire systems were undertaken by an external company arranged by the landlord. The practice manager told us the fire alarm was checked weekly and fire drills were arranged annually by this company. The landlord also completed a fire risk assessment but the practice had not reviewed this to identify and manage their responsibilities as a tenant of the building.</p> <p>(2) There was no evidence of any fire training undertaken by staff since 2016 although information provided by the practice indicated this should be completed annually as part of their mandatory training. The practice manager told us staff had recently been provided with access to eLearning for all health and safety training needs and the target date for completion was the end of March 2019. The practice manager told us a full evacuation of the practice had been undertaken as part of a building evacuation fire drill in November 2018. We did not see records to evidence this.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	N/could not be found (1)
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 2016	Y (1)
<p>Explanation of any answers and additional evidence:</p> <p>(1) We have seen risk assessment documents on previous inspections but on the day of the inspection staff struggled to access these documents due to lack of knowledge of where these were kept in the electronic filing systems. They were not aware of which assessments had been completed or if the ones found were the most recent documents. They told us they would review this area however, they had not received training in health and safety risk assessment.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
An infection risk assessment and policy were in place.	Y
Staff had received effective training on infection prevention and control. (IPC)	Y (1)
Date of last infection prevention and control audit: Clinical waste audit September 2018. The last full IPC audit was completed in 2016. The audit showed that no shortfalls had been identified which required action.  The provider has provided a copy of an IPC audit completed after the inspection. This audit showed that no shortfalls had been identified which required action.	Partial
The practice had acted on any issues identified in infection prevention and control audits.	NA
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(1) The last IPC training had been completed in October 2017. The practice manager told us staff had recently been provided with access to eLearning for all mandatory training needs and the target date for completion was the end of March 2019.</p> <p>We found the practice to be clean and tidy throughout. Fabric privacy curtains were used in consultation rooms and these required changing/cleaning every six months. The practice was not aware of when these were last changed or who was responsible for this and it was not included in the audit.</p>	

## Risks to patients

There were some 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.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
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.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial (1)
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.	N (2)
<p>Explanation of any answers and additional evidence:</p> <p>(1) At our last inspection we recommended the provider should review and improve reception staff training for their role in the management of patients with severe infections such as sepsis. At this inspection we found staff were able to tell us about the actions they would take if they encountered an acutely unwell patient which included prioritising their request for an appointment and/or discussion with a clinician to ensure timely intervention. However, reception staff had not had any specific information about Sepsis and actions to be taken if this was suspected.</p> <p>(2) A new practice manager had been appointed in April 2018 but the provider had no formal process to monitor and assess their progress in the role and no oversight to ensure systems and processes were adequately maintained.</p>	

## Information to deliver safe care and treatment

Staff had 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.	Y
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.	Y
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.	Y

## 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)	1.21	1.06	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	6.4%	6.2%	8.7%	No statistical variation

Medicines management	Y/N/Partial
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Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial (5)
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y (1)
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.	Y
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.	Y
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.	Y (3)
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N (2)
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.	N (4)
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.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
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.	N (5)
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found there was no clear audit trail of use of blank prescriptions and blank prescriptions were not always stored securely and there was no evidence the practice monitored the prescribing of controlled drugs (for example, audits for unusual prescribing, quantities, dose, formulations and strength).</p>	



Medicines management	Y/N/Partial
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At this inspection we found there was an improved system for storing and monitoring the use of blank prescriptions. Although there was no monitoring of controlled drug prescribing by the provider a pharmacist provided by the CCG to the practice completed work in this area.

- (1) There was a system in place to monitor patients prescribed high risk medicines and records were maintained. However, the up to date record was only available on the member of staff computer system who was responsible for this, the records available to other staff were eight months out of date.
- (2) The practice relied on the CCG pharmacists advice on their regular visits to the practice to monitor prescribing but had no ongoing reviews or actions of their own. The provider was unaware of their own prescribing numbers although data showed they were comparable with other practices.
- (3) The practice advised us they had had a vaccine fridge failure prior to our visit and had acted in respect of this and the vaccine fridge involved was no longer in use. We reviewed the fridge temperature monitoring records and found there were no temperature records for September 2018 for this fridge and the temperature recorded was outside the recommended range for storing vaccines on several occasions over a three-month period prior to the failure of the fridge. Action relating to these events had not been recorded and staff were not able to describe the action taken in respect of these incidents. Records relating to a second fridge were in place. We noted from the records that when staff, who usually took the temperatures, were not available the fridge temperature had not been recorded. For example, when the nurse or healthcare assistant was on leave the temperature of the fridge in their respective rooms had not been recorded. We reported our findings to the South Yorkshire and Bassetlaw Screening and Immunisation Team and asked the provider to also report these issues to them.

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

#### The practice 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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
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.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded since the last inspection	5
Number of events that required action:	5
Explanation of any answers and additional evidence: The practice had acted appropriately in respect of the individual incidents and a trend analysis was in	

place.

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

Event	Specific action taken
Patient over ordering of prescription for pain relief.	GP reviewed the patient and frequency of prescription.
Blood results identified as outside recommended range for patients prescribed blood thinning medicines.	Patients were contacted and reviewed and medicines adjusted as required.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: At the last inspection we recommended the practice review and improve management oversight of medical alerts. At this inspection we found no action had been taken in respect of this. We were told safety and medicine alerts were sent to clinicians by the practice manager for action but there was no system to monitor action taken.	

### Effective

### Rating: Requires improvement

We rated the practice and all population groups as **requires improvement** for providing effective services because:

- There was limited monitoring of the outcomes of care and treatment.
- The practice was unable to show that staff had the skills, knowledge and experience to carry out their roles.
- These areas affected all population groups so we rated all population groups as requires improvement.

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was 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.	Y

Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence:	

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)	0.96	0.83	0.81	No statistical variation

### Older people

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.</li> <li>Those identified received a full assessment of their physical, mental and social needs.</li> <li>Where needs are identified the practice liaised with, or referred onto, or request input from the appropriate services, such as referrals to the continence service, carers resilience services and social prescribing.</li> <li>Doctors and nurses who treated long term conditions visited housebound patients for reviews and urgent and continuing care.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks were offered to patients over 75 years of age.</li> </ul>

### People with long-term conditions

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> <li>Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.</li> <li>Staff who were responsible for reviews of patients with long-term conditions had received</li> </ul>

specific training.

- Adults with newly diagnosed cardio-vascular disease were offered appropriate medication.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

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)	72.4%	71.8%	78.8%	No statistical variation
Exception rate (number of exceptions).	6.7% (15)	7.3%	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)	70.8%	72.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.1% (16)	6.1%	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)	81.2%	79.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	8.0% (18)	10.4%	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)	74.0%	74.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (6)	3.6%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a	85.9%	85.7%	89.7%	No statistical variation

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)				
Exception rate (number of exceptions).	8.8% (13)	6.5%	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)	85.9%	83.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.5% (11)	2.3%	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)	82.7%	89.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	5.8%	6.7%	N/A

**Any additional evidence or comments**

**Families, children and young people**      **Population group rating: Requires improvement**

Findings
<ul style="list-style-type: none"> <li>• Childhood immunisation uptake rates were slightly below the World Health Organisation (WHO) targets in three of four areas. The practice nurse monitored the uptake of immunisations and followed up patients who did not attend.</li> <li>• The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.</li> <li>• The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care and would liaise with health visitors when necessary.</li> </ul>

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)	35	35	100.0%	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)	40	45	88.9%	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)	40	45	88.9%	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)	40	45	88.9%	Below 90% minimum (variation negative)

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

**Population group rating: Requires improvement**

Findings
<ul style="list-style-type: none"> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.</li> <li>Patients had access to appropriate health assessments and checks. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.</li> <li>Patients could book appointments and order repeat medication online without the need to attend the surgery.</li> </ul>

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)	77.2%	76.3%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) <b>(PHE)</b>	80.5%	75.2%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) <b>(PHE)</b>	56.3%	55.9%	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. <b>(PHE)</b>	71.4%	64.3%	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)	44.4%	46.0%	51.6%	No statistical variation

#### Any additional evidence or comments

The practice nurse had recently completed training to undertake samples for cervical screening which will enable the practice to offer more appointments for this service. Patients who did not attend for cervical screening were followed up.

#### People whose circumstances make them vulnerable

Population group rating: Requires improvement

#### 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 held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- There was a lead GP for patients with a learning disability and an active recall system for annual health checks.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Requires improvement**

**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.
- There was no formal system for following up patients who failed to attend for administration of long-term medication. The GP told us they knew their patients well and this would be identified.
- Patients at risk of dementia were offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

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)	91.3%	86.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.3%	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)	100.0%	85.9%	90.0%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	3.6%	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)	100.0%	82.2%	83.0%	Variation (positive)
Exception rate (number of exceptions).	5.0% (1)	7.0%	6.6%	N/A



## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	534.4	-	537.5
Overall QOF exception reporting (all domains)	3.5%	4.5%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N
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>At the last inspection we found there was limited evidence of clinical audit to enable the provider to monitor the quality of care and outcomes for patients. At this inspection we found there had been some activity to try to improve this area. We reviewed several documents provided as evidence of improvement work which included one external audit of treatment provided to patients at risk of osteoporosis and five searches relating to medicines. These documents showed the work undertaken was limited to searches of patient records with actions identified to improve care and treatment but there was no ongoing plan or changes made to improve in future and no plan for completing the audit cycle or for ongoing audit planning.</p> <p>For example, we saw audits of Calcium and Vitamin D3 Therapy completed by an external company in October 2016 and in June 2018. They had identified some areas for improvement relating to prescribing but we saw no action plan to support improvement.</p>
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## Effective staffing

The practice was not able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y

The practice had a programme of learning and development.	Partial
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.	Y
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
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>At the last inspection we found:</p> <ul style="list-style-type: none"> <li>• There was a lack of records to evidence staff had received up-to-date safeguarding training appropriate to their role.</li> <li>• There was a lack of records to evidence staff had received training in health and safety matters.</li> <li>• Not all staff had received an appraisal and there was a lack of clinical input for practice nurse appraisals.</li> <li>• Performance of employed clinical staff was not monitored, for example, through audit of their consultations, prescribing and referral decisions.</li> </ul> <p>At this inspection we found there was evidence nursing staff had undertaken training relevant to their role and the majority of staff had undertaken safeguarding and basic life support training. However, the central training log, to enable the provider to monitor completion of training had not been maintained in 2018, and staff had not completed training such as fire safety in 2018. The practice was in the process of enabling staff to access an eLearning package so training could be brought up to date by March 2019.</p> <p>All but one member of staff had received an annual appraisal in December 2018 and an individual training plan had been agreed but there was no written programme of training for the practice to show how this would be achieved. The lead GP had been involved in the appraisal and monitoring of the clinical staff.</p>	

## Coordinating care and treatment

### Staff worked 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	Y

treatment.	
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

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)	98.6%	95.9%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0.6% (6)	0.5%	0.8%	N/A

### Any additional evidence or comments

## Consent to care and treatment

### The practice 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.	Y
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## 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.	Y

### CQC comments cards

Total comments cards received.	41
Number of CQC comments received which were positive about the service.	41
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Patients were very positive about the service and care and treatment received. They said staff were caring and responsive to their needs and treated them with respect.

## 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
3331	328	123	37.5%	3.69%

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)	96.6%	89.8%	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)	94.2%	89.0%	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)	94.9%	95.0%	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)	93.5%	84.4%	83.8%	No statistical variation

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

Any additional evidence
The practice monitored the GP survey and friends and family test results. These surveys showed the practice scored highly in all areas for patient satisfaction. The friends and family test showed that, from 1206 responses in the last 12 months, 95% would recommend the practice to their family and friends.

### Involvement in decisions about care and treatment

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

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

Source	Feedback
Comment cards	Patients gave positive feedback about their involvement in care and treatment and said the staff listened to them.

### 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)	93.0%	93.1%	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.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice manager told us information in different formats and languages would be available on request. The practice web site, which included some practice policies and procedures such as the complaints procedure, could be translated into different languages.</p>	

Carers	Narrative
Percentage and number of carers identified.	239 carers were identified on the carers register which was 7% of the patient population. The practice manager said they had been reviewing this number to ensure it accurately reflected the caring role.
How the practice supported carers.	Information about advice and support organisations was displayed for carers and flu clinics were offered.
How the practice supported recently bereaved patients.	The GP told us they contacted patients by telephone.

## Privacy and dignity

The practice respected / did not always respect 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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

Rating: Good

### Responding to and meeting people's needs

The practice organised and delivered services to meet patients' 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.	Y
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.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	
<p>The appointment system was flexible to meet people's needs. For example, telephone consultations were available for patients who could not access the service during opening hours and home visits were available for patients who could not attend the practice due to complex needs.</p> <p>The practice held monthly multidisciplinary meetings to assist with sharing information and coordination of care with other services for patients with complex needs.</p>	

## Practice Opening Times

Day	Time
Opening times:	
Monday	8.30am – 6.30pm

Tuesday	8.30am – 6.30pm
Wednesday	8.30am – 7.30pm
Thursday	8.30am – 6.30pm
Friday	8.30am – 6.30pm
Appointments available:	
Variable times during opening hours for both nurse and GPs.	
Patients also had access to appointments at local hub surgeries 6.30pm until 8.30pm Monday to Friday and Saturday and Sunday mornings. These appointments were booked via the practice.	

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3331	328	123	37.5%	3.69%

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)	96.7%	95.1%	94.8%	No statistical variation

### Older people

Population group rating: Good

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

### People with long-term conditions

Population group rating: Good

#### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.



## Families, children and young people

Population group rating: Good

### Findings

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

## Working age people (including those recently retired and students) group rating: Good

Population

### 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.
- The practice was open until 7.30pm every Wednesday. Pre-bookable appointments were also available to patients at additional locations within the area, these appointments were available until 8.30pm Monday to Friday and Saturday and Sunday morning.
- The practice offered online services including booking appointments and repeat prescription ordering and an electronic prescription service.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.

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

## Population group rating: Good

### Findings

- The practice identified and offered reviews to all patients attending accident and emergency with significant mental illness related problems.
- Annual health checks were offered for all patients on the severe mental illness and dementia registers.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

### 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
Explanation of any answers and additional evidence: GPs received the request for a home visit and they prioritised these according to need.	

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)	86.9%	70.9%	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)	85.9%	66.4%	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	70.8%	64.2%	65.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
31/03/2018)				
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)	80.2%	72.6%	74.4%	No statistical variation

Source	Feedback
Patient comment cards	Patients were satisfied with the appointment system and gave examples of how they had been offered an appointment in an emergency.

### Listening and learning from concerns and complaints

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

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

	Y/N/Partial
Information about how to complain was readily available.	Y (1)
There was evidence that complaints were used to drive continuous improvement.	N (2)
Explanation of any answers and additional evidence:	
(1) Information about how to escalate a complaint if a patient was not satisfied with the practice response was not included in the complaints procedures. The practice manager told us they would review and update this.	
(2) As there had been no complaints we could not assess if complaints would drive improvement.	

Well-led

Rating: Requires improvement

We rated the practice as **requires improvement** for providing well-led services because:

- While the practice had made some improvements since our inspection in April 2018, it had not appropriately addressed the Requirement Notice in relation to health and safety and staff training.

At this inspection we also identified additional concerns which may put patients at risk in relation to recruitment.

- While the practice had a clear vision and strategy there was a lack of monitoring to ensure objectives were achieved.
- The overall governance arrangements were not always effective.
- The practice did not have clear and effective processes for managing risks.
- The practice did not always act on appropriate and accurate information.
- We saw little evidence of systems and processes for learning, continuous improvement and innovation.

### Leadership capacity and capability

**There was compassionate and inclusive leadership at all levels but the leadership was not always effective.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	N
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:	
<p>Since our last inspection new staff had been recruited. Whilst the provider was supportive there had been a lack of oversight to ensure the systems and processes already in place were maintained. There was also a lack of training and mentoring to ensure the new staff could develop the skills and knowledge necessary for their role. A new manager had identified shortfalls in some areas such as staff training and supervision and had put systems in place to ensure these would be addressed.</p> <p>The provider had only partially responded to our findings at the last inspection and had not ensured systems had been put in place to address all the identified shortfalls.</p> <p>A salaried GP was employed to provide regular sessions each week to ensure continuity for patients.</p> <p>The practice had implemented the Rotherham care navigation system and staff had received training in this area to support and direct patients to the most appropriate care such as the pharmacy, mental health services or a physiotherapist.</p> <p>The practice held regular meetings and a full team meeting was held monthly. The practice also held monthly meetings with members of the multi-disciplinary team to discuss patient care plans.</p> <p>Staff reported that they felt well led and well supported.</p>	

### Vision and strategy

**The practice had a clear vision and a strategy to provide high quality sustainable care although**

there was a lack of monitoring to ensure this was achieved.

	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.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice focused on provision of patient centred care and data showed the practice achieved good outcomes for patients and high levels of patient satisfaction.</p> <p>There was a lack of monitoring in some areas related to health and safety and staff training and the provider had not monitored and assessed the progress towards resolving the shortfalls identified at the last inspection.</p>	

## Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
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.	N
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>At the last inspection we said the provider should review and improve systems to support duty of candour. At this inspection we found there was no written policy to support compliance with duty of candour and there was a lack of management understanding of the duty of candour.</p>	

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

Source	Feedback
Staff discussions	Staff told us they were well supported and they enjoyed working at the practice. New staff told us they had access to training relevant to their role and had been supported to complete this.

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## Governance arrangements

**There were systems to support good governance and management however, these had not always been maintained.**

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
The practice was in the process of reviewing the policies and procedures but some related to health and safety could not be located on the electronic systems and policies relating to recruitment and management of medicines requiring refrigeration had not been followed. There was a lack of oversight by the provider to ensure systems were maintained.	

## 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.	Y
There was a systematic programme of clinical and internal audit.	N
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.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
At the last inspection there was limited evidence of clinical audit of the quality of care and outcomes for patients. At this inspection we found there had been some recent audit activity in relation to medicines but this had not resulted in significant improvements or changes.	
Risk assessment activity was limited due to lack of oversight and provider awareness and the limited induction of a new manager in the risk assessment processes in place.	
Staff had received some training for emergencies such as basic life support and had received some fire safety instruction via the landlord through fire drills and in previous years training but the practice	

had not provided refresher training in 2018.

### 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.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
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>The practice used information and data to check progress against targets and information from national surveys to assess patient satisfaction. The practice data for these areas showed above average levels of achievement.</p> <p>Data for other areas such as staff training was not up to date to enable the provider to monitor these areas.</p> <p>The provider did not use prescribing information to monitor prescribing practice. However, the practice was supported by a CCG pharmacist who completed some of this work and some recent audits relating to medicines had been undertaken.</p> <p>The provider's oversight, and practice manager's knowledge of arrangements for the management of health and safety risks was limited and systems and processes had not always been kept up to date.</p>	

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

**The practice involved staff and external partners to sustain high quality and sustainable care. Whilst they did not actively involve patients they took account of public opinion.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the	Partial

needs of the population.	
Explanation of any answers and additional evidence:	
The practice monitored patient feedback and data showed high levels of patient satisfaction.	
Staff told us they were involved and meetings were held regularly where changes were discussed.	
At the last inspection we recommended the practice review and improve patient engagement as the provider did not have a patient participation group (PPG). At this inspection we found the practice still did not have a patient participation group. The provider told us there had been a lack of interest from patients to start a group. Information for patients was displayed in reception in relation to how to become involved in a PPG.	

### 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.	N
Explanation of any answers and additional evidence:	
A new eLearning package had been provided since the last inspection and clinical staff had been supported to access a wide range of training relevant to their role and to improve services available to patients. However, there was a lack of management monitoring to ensure training had been completed.	
We saw limited learning from recent audits and the last inspection.	