

# Care Quality Commission

## Inspection Evidence Table

### Westwood Clinic (1-537739816)

Inspection date: 13 December 2018

Date of data download: 07 December 2018

## Overall rating: Inadequate

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

### Safe

### Rating: Inadequate

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

- The practice did not have an effective system in place to manage and monitor patients taking high-risk medicines.
- The practice did not have a fire risk assessment at the time of inspection.
- Recruitment checks were not always completed.
- The practice could not evidence all staff had received appropriate safety training. The practice provided a training matrix following the inspection which did not evidence staff had received all safety training relevant to their role.
- Equipment calibration was not always completed.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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.	Y
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).	Y <sup>1</sup>

Safeguarding	Y/N/Partial
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
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y <sup>2</sup>
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 <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – Practice staff told us they had received safeguarding training to a level appropriate to their role. However, the practice was unable to provide evidence they had oversight of staff training and did not provide evidence to us on the day of the inspection to show all staff had received safeguarding training. Following the inspection, the practice provided a training matrix to evidence all staff had received safeguarding training.</p> <p>2 – We found one clinical member of staff had commenced employment but a DBS check was not applied for by the practice for a further nine months. This DBS check had been received by the practice following the inspection.</p> <p>3 – The practice held regular meetings with other health care professionals such as health visitors. This meeting was attended by a non-clinical member of staff who had not received level 3 safeguarding training or any additional training or support. However, records were kept and we saw some evidence of the information from the meetings being disseminated to other practice staff. The practice advised us following the inspection the administrator would be attending level three safeguarding training in June 2019.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial <sup>1</sup>
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who required medical indemnity insurance had it in place.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found one clinical member of staff had commenced employment but a DBS check was not applied for by the practice for a further nine months. The practice had received the completed DBS check following the inspection.</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: July 2018	Y
There was a record of equipment calibration. Date of last calibration: August 2018	Y <sup>1</sup>
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks.	Y
There was a log of fire drills. Date of last drill:	N <sup>2</sup>
There was a record of fire alarm checks. Date of last check: July 2018	Y
There was a record of fire training for staff. Date of last training:	N <sup>3</sup>
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion:	N <sup>4</sup>
Actions from fire risk assessment were identified and completed.	N <sup>4</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – Whilst we saw evidence of equipment calibration having taken place in August 2018, we found two items of equipment which had not been calibrated, a pulse oximeter and weighing scales. The practice told us the equipment was occasionally used across in other locations, which meant the equipment was not on site the day of the calibration and was subsequently missed.</p> <p>2 – The practice could not provide evidence of fire drills taking place, although we were told by the provider and staff that fire drills did take place.</p> <p>3 – The practice was unable to provide evidence of fire safety training for all staff. Following the inspection, the practice sent us a copy of their training matrix which evidenced only one member of staff had received fire safety training.</p> <p>4 – A fire risk assessment had not been completed. The practice advised us following the inspection a fire risk assessment had been booked for January 2019.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: See below	N <sup>1</sup>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: See below	N <sup>1</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – We asked to review a health and safety risk assessment but were not provided with one on the day of the inspection. Following the inspection, the practice conducted a health and safety risk assessment.</p> <p>On the day of the inspection we found loose wiring connected to a vaccine refrigerator which was a potential trip hazard and could lead to the refrigerator being accidentally unplugged. Following the inspection, the practice told us this had been resolved.</p> <p>In addition to this, on the day of the inspection we found both a cleaning cupboard and the staff entrance to reception unlocked. The cleaning cupboard contained hazardous substances which could be potentially harmful to patients and the reception door allowed access to confidential medical information. Following the inspection, the practice told us cleaning staff had been reminded to lock the cleaning cupboard door and the reception door had been locked.</p>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met; however, the practice could not evidence how audit and training requirements were met.**

	Y/N/Partial
An infection risk assessment and policy were in place.	Partial <sup>1</sup>
Staff had received effective training on infection prevention and control.	Partial <sup>2</sup>
Date of last infection prevention and control audit: April 2018	
The practice had acted on any issues identified in infection prevention and control audits.	N <sup>1</sup>
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice had started to complete an infection control risk assessment in April 2018. However, we found this had not been completed in full and where actions were required, there was no information to advise the progress of any actions or who was responsible for them. There was no oversight from the practice management team in relation to the assessment and they did not have an understanding around what actions were required. The practice completed an infection control audit following the inspection.</p> <p>2 – Staff we spoke with advised us they had completed infection control training. However, the practice was unable to provide evidence of this training. Following the inspection, the practice provided a training matrix which evidenced a number of staff had not received infection control training since 2016.</p>	

## Risks to patients

**There were gaps in systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	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.	Y
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 <sup>1</sup>
There were systems in place to enable the assessment of patients with presumed sepsis in	Y

line with National Institute for Health and Care Excellence (NICE) guidance.	
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – Whilst equipment was available to enable assessment of patients with presumed sepsis or other clinical emergency; we found a pulse oximeter which was overdue calibration and therefore could not be relied upon to provide an accurate reading.</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 <sup>1</sup>
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
Explanation of any answers and additional evidence: 1 – We found one clinical record which had an incorrect coding of a patient's diagnosis, the provider took action to amend this immediately.	

## 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)	1.18	1.01	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)	8.4%	12.2%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
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.	N <sup>1</sup>
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.	N <sup>2</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures in place for the safe ordering, receipt, storage, administration, balance	N/A



Medicines management	Y/N/Partial
checks and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols in place for verifying patient identity.	N/A
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found patients who were prescribed medicines on repeat prescriptions were not well managed and monitoring of some of these patients was overdue; however, the medicines continued to be prescribed.</p> <p>2 – We found patients who were prescribed high-risk medicines were not well managed; we saw examples of patients who did not have appropriate and timely monitoring in place prior to prescribing and there was no effective system in place to identify this risk. Some patients were monitored by a hospital consultant, but the practice had no system for reviewing this monitoring prior to prescribing. In addition to this, we found some patients who should have been monitored by the practice, but were not.</p> <p>Patients were at risk of harm as they were not appropriately monitored.</p> <p>During the inspection we requested information from the practice and were at times provided with incorrect information. For example, the practice was initially unable to provide us with an accurate number of patients taking certain high-risk medicines.</p>	

## 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 <sup>1</sup>
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 in last 12 months:	Nine
Number of events that required action:	Nine
Explanation of any answers and additional evidence: 1 – The practice had identified prior to the inspection that not all significant events were recorded as there was confusion around what a significant event was; however, the practice had taken action and implemented a new policy and guidance to staff which evidenced an improvement to the number of significant events reported.	

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

Event	Specific action taken
A test result was not reviewed in a timely manner.	The practice implemented a new policy for staff and guidance around how results should be handled.
The wrong dosage of medicine was issued to a patient.	The practice investigated the cause of this and found it was due to a change in dosage being agreed with the patient in a consultation but the system not being updated to reflect this change. Clinicians were reminded of their responsibilities to update records after consultations.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Patient safety alerts were received into the practice by the practice manager, the alerts were distributed amongst clinical staff and actions were taken where appropriate.	

## Effective

## Rating: Requires Improvement

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

- The practice's exception reporting rate for diabetes and mental health indicators was higher than the CCG and England averages.
- The number of patients attending for cervical screening was lower than both the CCG and England averages. The practice were aware but had no actions in place to address this.
- The number of patients attending for bowel cancer screening was lower than both the CCG and England averages. The practice were aware but had no actions in place to address this.
- We were unable to ascertain how the practice reviewed the competency of staff involved in advanced clinical practice and the practice did not provide us with evidence that any staff received appraisals.

### 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.	N <sup>1</sup>
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: 1 – We found patients were not always regularly reviewed and records were not always updated. For example, we found the practice did not regularly review all patients prescribed high risk medicines.	

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)	1.16	0.90	0.81	No statistical variation

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- All patients aged 75 and over were listed on a register in order for the practice to monitor them more efficiently and closely on an ongoing basis.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- All older patients had a named GP.
- Older patients whom were deemed high risk or were on end of life care were discussed during a monthly practice meeting.

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

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

- The practice's exception reporting rate for diabetes indicators was higher than the CCG and England averages.
- We were unable to ascertain how the practice reviewed the competency of staff involved in advanced clinical practice and the practice did not provide us with evidence that any staff received appraisals.

### Findings

- 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.
- The practice had shared care agreements and consent procedures in place to enable the sharing of data and information with relevant organisations for co-ordination of care. Although the effectiveness of the shared care agreements was not always evidenced, as we found the practice had failed to maintain oversight of patients prescribed high risk medicines.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- In those patients with atrial fibrillation, the percentage of patients who are currently treated with anti-coagulation drug therapy was lower than both the CCG and England averages. The practice were aware but had no actions in place to attempt to address this.
- The practice had a higher exception reporting rate for diabetes indicators. The practice were aware of this and were completing recalls in line with national guidelines, however, the practice had no plans to try to reduce the number of exceptions made by actively following up patients who did not attend.

<b>Diabetes Indicators</b>	<b>Practice</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 IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.8%	80.4%	78.8%	Significant Variation (positive)
Exception rate (number of exceptions).	29.7% (97)	15.7%	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)	91.1%	74.5%	77.7%	Variation (positive)
Exception rate (number of exceptions).	24.5% (80)	11.9%	9.8%	N/A

	<b>Practice</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)	87.6%	79.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	33.6% (110)	15.5%	13.5%	N/A

<b>Other long-term conditions</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)	76.8%	76.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	7.2% (16)	7.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.9%	90.7%	89.7%	No statistical variation
Exception rate (number of exceptions).	12.4% (12)	13.6%	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)	85.2%	82.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.7% (32)	4.7%	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)	78.6%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.3% (1)	7.6%	6.7%	N/A

#### Any additional evidence or comments

## Families, children and young people Improvement

Population group rating: Requires

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

- We were unable to ascertain how the practice reviewed the competency of staff involved in advanced clinical practice and the practice did not provide us with evidence that any staff received appraisals.

#### Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets with a range of 91% to 92%.
- 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.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception. Contraceptive devices were fitted at the practice.
- A weekly midwife clinic was held at the practice.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib)(i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)	60	65	92.3%	Met 90% minimum (no variation)
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)	72	79	91.1%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	72	79	91.1%	Met 90% minimum (no variation)
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)	73	79	92.4%	Met 90% minimum (no variation)

#### Any additional evidence or comments

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

Population group rating: Requires

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

- The number of patients attending for cervical screening was lower than both the CCG and England averages. The practice were aware but had no actions in place to address this.
- The number of patients attending for bowel cancer screening was lower than both the CCG and England averages. The practice were aware but had no actions in place to address this.
- We were unable to ascertain how the practice reviewed the competency of staff involved in advanced clinical practice and the practice did not provide us with evidence that any staff received appraisals.



## Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The number of patients attending cervical screening was lower than both the CCG and England averages. The practice were aware but had no action plan in place to attempt to address this.
- The number of patients attending for bowel cancer screening was lower than both the CCG and England averages. The practice were aware but had no action plan in place to attempt to address this.

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)	64.0%	71.2%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (PHE)	68.5%	74.1%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)(PHE)	45.4%	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)	83.3%	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)	64.3%	59.7%	51.6%	No statistical variation

## Any additional evidence or comments

**People whose circumstances make them vulnerable**  
**Improvement**

**Population group rating: Requires**

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

- We were unable to ascertain how the practice reviewed the competency of staff involved in advanced clinical practice and the practice did not provide us with evidence that any staff received appraisals.

<b>Findings</b>
<ul style="list-style-type: none"><li>• End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.</li><li>• The practice held a register of patients living in vulnerable circumstances including those with a learning disability.</li><li>• The practice had shared care agreements and consent procedures in place to enable the sharing of data and information with relevant organisations for co-ordination of care.</li><li>• The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.</li><li>• The practice demonstrated that they had a system to identify and support people who misused substances.</li><li>• Nurses conducted home visits to patients who required blood tests and chronic disease reviews if the patients were unable to leave their home.</li></ul>

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

**Population group rating:**

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

- The practice's exception reporting rate for mental health indicators was higher than the CCG and England averages.
- We were unable to ascertain how the practice reviewed the competency of staff involved in advanced clinical practice and the practice did not provide us with evidence that any staff received appraisals.

**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 a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients attending A&E or who have had contact with out of hours services were followed up by the practice to see if any additional support was required.
- A local mental health team provided weekly specialist clinics at the practice.
- The practice had a significantly higher exception reporting rate for mental health indicators. The practice were aware of this and believed the higher exception rate was due to a lower prevalence of mental health conditions in the practice population, meaning that each exception reported will lead to a higher average.

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)	94.4%	91.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	33.3% (9)	13.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	89.7%	90.0%	Variation (positive)
Exception rate (number of exceptions).	18.5% (5)	11.7%	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)	73.3%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	31.8% (7)	6.6%	6.6%	N/A

#### Any additional evidence or comments

#### Monitoring care and treatment

The practice had a programme of quality improvement activity.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	556.19	-	537.5
Overall QOF exception reporting (all domains)	12.7%	6.6%	5.8%

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

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

- Following a patient safety alert, the practice completed an audit on identifying women of child bearing age who were taking sodium valproate. The practice identified patients and recalled them for a review. The practice repeated this audit six monthly to re-identify any new patients.
- The practice completed a two-cycle audit on patients who had been referred to secondary care under the two-week wait referral system for identifying potential cancerous conditions. The practice identified a number of learning outcomes such as the clinicians with higher referral rate and potential further learning form staff. The second cycle of the audit evidenced an improvement in the way referrals were processed.

**Any additional evidence or comments**

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial <sup>1</sup>
The learning and development needs of staff were assessed.	Partial <sup>2</sup>
The practice had a programme of learning and development.	Partial <sup>1</sup>
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.	N <sup>2</sup>
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N <sup>2</sup>
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.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>1 – Practice staff told us they had received training appropriate to their role. However, the practice was unable to provide evidence of staff training. Following the inspection, a training matrix was provided although this did not evidence specific training for nurses on immunisation and on sample taking for the cervical screening programme.</p> <p>2 – The practice informed us that clinical staff received regular appraisals. However, when we requested to review appraisals we were not provided with any examples. We were unable to ascertain how the practice reviewed the competency of staff. Clinical staff told us they were able to contact the partners by telephone if they required support, but did not receive regular appraisals. The practice informed us non-clinical staff had opted out of having an appraisal through the choice of individual 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 treatment.	Y
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
Explanation of any answers and additional evidence:	

## 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
Explanation of any answers and additional evidence:	

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)	97.5%	95.2%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.3% (13)	0.9%	0.8%	N/A

Any additional evidence or comments



## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

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

## Caring

## Rating: Requires Improvement

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

- The practice were aware of lower than average GP Patient Survey data however the practice had no actions taking place or being planned for the future in order to address this.

### 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
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	45
Number of CQC comments received which were positive about the service.	43
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Comment cards received from patients were positive about the way staff treated people. Comment cards contained a number of specific examples or named a number of staff who they felt were particularly caring.
Patient consultations	Patients we spoke with on the day of the inspection were positive about the way staff treated people.

## 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
5268	385	123	31.90%	2.33%

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)	77.4%	90.5%	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)	71.4%	89.1%	87.4%	Variation (negative)
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)	91.8%	96.3%	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)	76.1%	85.5%	83.8%	No statistical variation

### Any additional evidence or comments

The practice were aware of GP Patient Survey data which was lower than both the CCG and England averages; however, the practice could not provide any evidence of actions taking place or being planned for the future.

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

### Any additional evidence

The practice had an independent patient survey completed in September 2018. The survey results were in line with the GP National Patient Survey and indicated several areas where the practice required to improve. However, no actions were taken following the survey to improve patient experiences.

### 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
Explanation of any answers and additional evidence:	

Source	Feedback
Comment cards	Comment cards received from patients were positive about the way the practice staff involved them in decisions about care and treatment.
Patient consultations	Patients we spoke with on the day of the inspection were positive about the way the practice staff involved them in decisions about care and treatment. Patients told us they felt the practice was a community asset and staff treated patients well and took on board their comments and concerns.

### 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)	83.7%	94.5%	93.5%	No statistical variation

### Any additional evidence or comments

The practice were aware of GP Patient Survey data which was lower than both the CCG and England averages. We practice were aware of this data but when we asked the practice if they had taken any action to try to improve or address this, we were not provided with any evidence of actions taking place or being planned for the future.

	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
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 89 carers and supported them, which was approximately 1.69% of the practice population.
How the practice supported carers.	The practice provided carers with a pack of information in relation to local support services or groups. Carers were also offered routine health checks and flu vaccinations.
How the practice supported recently bereaved patients.	The practice told us they would send a bereavement card and additional support will be offered 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.	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
Explanation of any answers and additional evidence:	

# 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:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5268	385	123	31.90%	2.33%

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)	86.6%	95.5%	94.8%	No statistical variation

### Any additional evidence or comments

The practice were aware of GP Patient Survey data which was lower than both the CCG and England averages. The practice were aware of this data but when we asked the practice if they had taken any action to try to improve or address this, we were not provided with any evidence of actions taking place or being planned for the future.

## 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.
- The practice signposted patients to a medicines delivery service for housebound patients.
- The practice were trialling a regular clinic at a local care home to reduce the number of telephone calls received from staff.
- Older patients would be offered a priority or longer appointment where appropriate.

## 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.
- Nurses conducted home visits to patients who required blood tests and chronic disease reviews if the patients were unable to leave their home.

## Families, children and young people

Population group rating: Good

### Findings

- 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 were offered a same day appointment when necessary.

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

Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, online appointment booking and requests for repeat prescriptions.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.



**People whose circumstances make them vulnerable**  
**group rating: Good**

**Population**

**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.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability; for example, longer appointment booking.

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

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- 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:	

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)	72.3%	75.1%	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)	77.4%	73.9%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	72.2%	69.2%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	80.3%	79.6%	74.4%	No statistical variation

### Any additional evidence or comments

Source	Feedback
Comment cards	We received two comment cards which contained mainly positive comments but also a negative. The two negative comments both related to the patients' difficulties in accessing the practice by telephone and appointment.

## Listening and learning from concerns and complaints

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

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial <sup>1</sup>
Explanation of any answers and additional evidence: 1 - The practice's complaint log contained details of four complaints. However, practice staff told us that verbal complaints which could be dealt with immediately would not be formally recorded. This meant that the opportunity to analyse trends was and drive improvements was lost.	

Example(s) of learning from complaints:

Complaint	Specific action taken
A patient complained about the care received from a particular clinician.	The practice contacted the patient by telephone and followed this up with a letter to apologise for the patient's experiences. The practice identified additional learning needs for the clinician.
A patient was unhappy with the length of time taken for the practice to provide them with their test results.	The practice contacted the patient by telephone and followed this up with a letter to apologise for the patient's experiences and explained the process of test results.

## Well-led

## Rating: Inadequate

The practice was rated as inadequate for providing well-led services because:

- Practice staff reported leaders were not visible and approachable, this was evident on the day of our inspection.
- Some staff we spoke with told us they felt unsupported and under-valued by the practice partners.
- Comprehensive assurance systems were not in place, for example, not all building risk assessments were not completed and a lack of management for patients on high risk medicines.
- The practice could not evidence that risks, issues and performance were managed.
- The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care. For example, the practice did not act on negative patient survey data and there was no active patient participation group.
- We found the governance systems and the oversight of the management did not ensure that the practice had complete oversight of staff training and not all staff received annual appraisals.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial <sup>1</sup>
They had identified the actions necessary to address these challenges.	N <sup>2</sup>
Staff reported that leaders were visible and approachable.	N <sup>3</sup>
There was a leadership development programme in place, including a succession plan.	N <sup>4</sup>
Explanation of any answers and additional evidence:	
1 – The practice manager understood the challenges the practice faced, however, the partners did not have clear oversight or full understanding of the challenges faced by the practice.	
2 – The practice had not identified risk or challenges, as evident during our inspection visit where we found a lack of building risk assessments such as a fire risk assessment and lack of actions taken in response to risk identified such as the infection control audit.	
3 – Staff we spoke with told us they felt the practice manager was visible and approachable on a daily basis. However, staff also informed us the partners of the practice were not visible. This was evident on the day of our inspection when the partners were not available during the majority of the inspection process. The practice partnership team told us following the inspection they believe they are visible and approachable due to one partner attending the practice each Friday afternoon to support nursing staff and telephone support available for other staff where necessary. The GP partners told us following the inspection several meetings with staff regularly take place, however, no evidence was provided of these meetings and we were only provided evidence of one meeting from November 2018 with the two partners and the practice manager.	
4 – Staff informed us they were unaware of a leadership development programme or succession plan.	

## Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial <sup>1</sup>
There was a realistic strategy in place to achieve their priorities.	N <sup>1</sup>
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial <sup>1</sup>
Progress against delivery of the strategy was monitored.	N <sup>1</sup>
Explanation of any answers and additional evidence: 1 – The practice told us a partner who previously worked at the practice had a vision to be “a surgery for the community” and this is something the practice staff tried to maintain. The practice staff tried to maintain those values but there was a no vision or strategy provided by the new partnership team.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial <sup>1</sup>
Staff reported that they felt able to raise concerns without fear of retribution.	Partial <sup>2</sup>
There was a strong emphasis on the safety and well-being of staff.	N <sup>3</sup>
There were systems to ensure compliance with the requirements of the duty of candour.	Y
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>1 – Due to a lack of clear vision, values and support from the partnership team, responsibility for dealing with behaviour inconsistent with the previous vision and values was left to the practice manager.</p> <p>2 – Staff we spoke with advised they felt comfortable to raise concerns with the practice manager. However, not all staff we spoke with felt they could raise concerns with the partnership team.</p> <p>3 – On the day of the inspection some staff we spoke with told us they felt unsupported and under-valued by the practice partners and did not feel their own well-being was a priority.</p>	

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

Source	Feedback
Staff consultations	<p>On the day of the inspection some staff we spoke with told us they felt unsupported and under-valued by the practice partners.</p> <p>Staff told us the practice manager was accessible and available, however, the practice partners were only available for a short time each week.</p> <p>Some staff reported to us the working environment was not as positive as it had previously been.</p>

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	N <sup>1</sup>
Staff were clear about their roles and responsibilities.	Partial <sup>2</sup>
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found the practice did not have clear governance structures and systems in place; for example, staff did not always have lead roles and responsibilities which led to the delivery of care not always meeting the standards required. For example, there was no lead role in place to ensure patients on high-risk medicines were appropriately monitored.</p>	

## Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N <sup>1</sup>
There were processes in place to manage performance.	N <sup>2</sup>
There was a systematic programme of clinical and internal audit.	Y <sup>3</sup>
There were effective arrangements for identifying, managing and mitigating risks.	N <sup>4</sup>
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – Comprehensive assurance systems were not in place; for example, building risk assessments such as a fire risk assessment were not completed and a lack of management for patients on high risk medicines.</p> <p>2 – The practice informed us that clinical staff received regular appraisals, however, clinical staff told us they were able to contact the partners by telephone if they had any queries or concerns but they had no formal appraisals. When we asked to review appraisals we were not provided with any examples. The practice told us non-clinical staff did not want annual appraisals and therefore 'opted out' of having one.</p> <p>3 – Whilst we saw a program of clinical and internal audit, this did not ensure actions were taken to ensure improvements were made where needed.</p> <p>4 – We found the practice did not have effective arrangements for identifying, managing and mitigating risks. For example, the practice did not have all building risk assessments in place such as fire safety and a health and safety risk assessment was only provided two weeks following the inspection. Where the practice did have these in place, such as an infection control audit, this was not completed in full nor were actions taken to mitigate risks which were identified.</p>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial <sup>1</sup>
Performance information was used to hold staff and management to account.	N <sup>2</sup>
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial <sup>3</sup>
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We did not see sufficient evidence to show the practice used data to improve performance; for example, Quality Outcomes Framework exception reporting data was not reviewed by the practice to ensure it was always appropriate.</p> <p>2 – On the day of the inspection, performance information was not available.</p> <p>3 - During the inspection we requested information from the practice and were at times provided with incorrect information. For example, the practice was initially unable to provide us with an accurate number of patients taking certain high-risk medicines.</p>	

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

The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	N <sup>1</sup>
Staff views were reflected in the planning and delivery of services.	Y <sup>2</sup>
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – Despite being aware of negative feedback in the GP National Patient Survey, we were not provided with any evidence of actions taking place or being planned for the future to address or improve the patient experience. The practice did not have an active patient participation group at the time of the inspection and we found engagement with patients was minimal.</p> <p>2 – Staff we spoke with reported they felt their views would be taken on board by the practice manager, but they were unsure the partnership team would reflect their views in the planning and delivery of services.</p>	

Feedback from Patient Participation Group:

Feedback
The practice did not have an active patient participation group at the time of the inspection. The practice informed us they planned to review this following the inspection.

## Any additional evidence

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## Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a focus on continuous learning and improvement.	Partial <sup>1</sup>
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: 1 – Whilst the practice was able to evidence staff were given the opportunity to attend further training and development, the practice was unable to evidence effective systems for monitoring and improving the care provided. For example, the practice did not act on negative patient survey data.	

## Examples of continuous learning and improvement

The practice had recently employment two trainee nurses, in addition to supporting a nurse to train to become an Advanced Nurse Practitioner.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

### Glossary of terms used in the data.

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