

Care Quality Commission

Inspection Evidence Table

Upton Road Surgery (1-1577808904)

Inspection date: 12 December 2018

Date of data download: 05 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 as we found there to be ineffective systems to monitor risks to patients or respond to risks identified. Medicines were not being safely managed and infection control was not being safely managed. Staff were not safely recruited and there were inadequate safeguarding processes in place.

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. | Partial |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Partial |
| 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 |
| 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. | N |

| Safeguarding | Y/N/Partial |
|---|-------------|
| Staff who acted as chaperones were trained for their role. | N |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Although there was a safeguarding lead in place at the practice, the office manager and staff we spoke with were not aware of who this was. This lead role was not clearly defined at the practice and staff were unclear about who they would approach with any safeguarding concerns.</p> <p>We found that staff had been acting as chaperones without the required training.</p> <p>Two staff members had not been subject to the required Disclosure and Barring Service (DBS) checks and one of these staff members had been acting as a chaperone without the checks and without any safeguarding training. This staff member had also been working in the substance misuse service, with vulnerable patients without a DBS check or any safeguarding training.</p> | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | N |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | Partial |
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | N |
| Staff who required medical indemnity insurance had it in place. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>There were no systems in place to ensure that staff had the required recruitment checks completed on them. We found staff who had not had the required references submitted for them, two staff members who had commenced work without the required Disclosure and Barring Service (DBS) checks and gaps in employment history.</p> <p>There was no system in place to ensure staff vaccination was maintained in line with current PHE guidance as there was no oversight of this at the practice. We asked to see the policy in place in relation to staff immunisations three times during our inspection. No policy was made available to us.</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: | Y 14/09/2018 |
| There was a record of equipment calibration. Date of last calibration: | Y 14/09/2018 |
| Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | N |
| There was a fire procedure in place. | Y |
| There was a record of fire extinguisher checks. Date of last check: | Y 01/2018 |
| There was a log of fire drills. Date of last drill: | Y 12/12/2018 |
| There was a record of fire alarm checks. Date of last check: | Y 29/08/2018 |
| There was a record of fire training for staff. Date of last training: | Partial |
| There were fire marshals in place. | Y |
| A fire risk assessment had been completed. Date of completion: | Y 05/07/2016 |
| <p>Explanation of any answers and additional evidence:</p> <p>Not all staff who worked within the premises had completed the fire safety training offered by the practice. The staff who had moved over from the substance misuse practice had not received updated training according to the staff records we looked at during our inspection.</p> <p>One staff member we spoke to had not received any training since commencing their employment at the practice in June 2018.</p> <p>A risk assessment was implemented for the storage of hazardous substances following our inspection and we saw evidence of this. However, this was not in place at the time of our inspection.</p> | |

| Health and safety | Y/N/Partial |
|---|--------------------|
| Premises/security risk assessment had been carried out. Date of last assessment: | N |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: | N |
| <p>Explanation of any answers and additional evidence:</p> <p>There was no adequate oversight in relation to the premises. We asked to see evidence of how this was</p> | |

risk assessed on an on-going basis and were told that no such risk assessments took place.

The premises for the 571 vulnerable patients recently taken on from a nearby substance misuse service, many of whom were homeless, were not being seen in premises which were safe and suitable. Staff we spoke with told us they did not feel safe and the required modifications to the premises had not been made to ensure the safety of staff and patients. Staff could not see patients in the waiting area from the reception desk and staff reported to us that they did not have a safe system to alert people if they needed to. The premises did not provide adequate safety measures for this type of service and posed a risk to staff and patients. Staff we spoke with told us about an incident which had taken place which had compromised the safety of a member of staff. Following our inspection a number of steps were taken to make the premises safer, however, these planned adjustments had not been progressed at the time of our inspection and this lack of action was impacting on staff and patients.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

| | Y/N/Partial |
|--|-------------|
| An infection risk assessment and policy were in place. | N |
| Staff had received effective training on infection prevention and control. | N |
| Date of last infection prevention and control audit: | N |
| The practice had acted on any issues identified in infection prevention and control audits. | N |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>There was no infection control lead across the service and no systems to ensure that regular infection control audits were completed. We asked to see the last infection control audit during our inspection and no such audit was found.</p> <p>Not all staff had received infection control training as part of their induction and staff were unclear as to who to refer any infection control concerns to.</p> <p>We looked at the infection control records in the substance misuse service at the practice and found the records to be empty. We found staff to be unclear as to how they reported any infection control incidents. One incident involving a blood spillage had been recorded in February 2017, however, no follow action or lessons learnt were recorded.</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. | N |
| There was an effective induction system for temporary staff tailored to their role. | N |
| 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. | N |
| 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 |
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>Due to a lack of effective practice management being in place, there was no evidence of any planning in terms of the practice workforce and there was little in place in terms of an effective and tailored induction programme for staff. One member of staff we spoke with had not had any induction prior to starting their role and had no training completed at the time of our inspection. They had been working at the practice since June 2018.</p> <p>The practice used locum GPs and we were told that these checks were carried out by the office manager. We were not assured that these checks were completed as required during our inspection due to the office manager being unable to produce evidence of these. We were told by the lead GP that these checks were completed.</p> <p>Staff we spoke with knew the action they would take in the case of an acutely unwell patient. However, staff had not received any training in relation to Sepsis.</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 |

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) | 0.87 | 0.91 | 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) | 8.6% | 9.3% | 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. | N |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | 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 |
| 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. | Y |
| 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 |

| Medicines management | Y/N/Partial |
|---|-------------|
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>We looked at the safety of storing medicines within the substance misuse service which the provider had taken over from 1 October 2018. We found one of the fridges used for storing vaccinations and medicines had been recorded at 9.1 degrees, each time the temperature had been checked since 1 November 2018. The Protocol for Ordering, Storing and Handling Vaccines issued by Public Health England states that vaccines should be stored between two and eight degrees, with a mid-range temperature of five degrees being best practice. 9.1 degrees was not within a safe range for the medicines stored in the fridge. There were a number of vaccines being stored which had been administered to patients during this timeframe. There had been no action taken to ensure these vaccines were safely administered. Patients had been put at risk due to this. The cold chain was not being safely managed at the practice.</p> <p>Blank prescriptions were not being stored securely overnight with access to these prescriptions due to personnel access throughout the building during these times. We found blank prescriptions in the Doctors bag and found that prescription numbers were not logged and monitored to ensure they were managed safely.</p> <p>Emergency drugs and equipment were kept securely and were safe for use.</p> | |

Track record on safety and lessons learned and improvements made

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

| Significant events | Y/N/Partial |
|---|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | N |
| Staff knew how to identify and report concerns, safety incidents and near misses. | N |
| There was a system for recording and acting on significant events. | N |
| Staff understood how to raise concerns and report incidents both internally and externally. | N |
| There was evidence of learning and dissemination of information. | N |
| Number of events recorded in last 12 months: | 4 |
| Number of events that required action: | 0 |
| <p>Explanation of any answers and additional evidence:</p> <p>We found an inadequate system to be in place for recording and acting on incidents and significant events which took place at the practice. Staff we spoke with were not always clear on where these should be recorded and we were shown numerous places in which staff thought they were recorded. All of these were hand written records.</p> <p>We were shown an incident book in the substance misuse service which was empty and which had pages removed. Staff we spoke with could not locate any records of any incidents or significant events and thought that these may be kept on the computer. However, none of the staff working on the day of our inspection had any access to these records. It was not clear how incidents or significant events would be recorded at the time of our inspection, or where.</p> <p>There was no evidence that incidents of significant events were monitored to look for any trends or patterns. There was no evidence of any learning from these.</p> | |

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|---|-----------------------|
| Action not taken following a hospital letter sent to the practice. The letter had been scanned but no action taken as a result. | None recorded. |
| Aggression from a patient towards staff. | None recorded. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <p>When we asked the office manager who distributed the safety alerts into the practice, we were told that</p> | |

the office manager printed them off and left them out on a desk for GP's to read and sign. This system did not ensure that all safety alerts were seen and recorded. We raised this with the practice who immediately took steps to tighten the processes around how safety alerts were managed at the practice.

Effective

Rating: Requires Improvement

The practice was rated as requires improvement for providing effective services as we found that consent was not always being sought as required by law and that staff were not being adequately trained and supported in their roles.

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 |

| 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) | 0.80 | 0.65 | 0.81 | No statistical variation |

Older people

Population group rating: Inadequate

| Findings |
|---|
| <ul style="list-style-type: none"> The practice had failed to assess the clinical needs of elderly people who lived in a care home they had been aligned to. There had been no assessment of people's needs and patients were not being seen as required. One patients had waited for seven weeks to have a blood test. We found evidence that consultations had taken place over the phone and medicines prescribed without patients getting the care and treatment they required. 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. Clinical staff had appropriate knowledge of treating older people including their psychological, |

mental and communication needs.

- Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: **Good**

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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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 was lower than the CCG and England average. The practice needed to consider this.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- 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) <small>(QOF)</small> | 64.8% | 77.8% | 78.8% | Variation (negative) |
| Exception rate (number of exceptions). | 3.3% (19) | 15.4% | 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) <small>(QOF)</small> | 79.2% | 76.6% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 3.1% (18) | 11.1% | 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) | 76.5% | 79.6% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 4.7% (27) | 13.6% | 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) | 86.8% | 75.6% | 76.0% | Variation (positive) |
| Exception rate (number of exceptions). | 1.4% (5) | 5.9% | 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) | 95.4% | 89.9% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 3.6% (4) | 9.5% | 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) | 84.2% | 82.6% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 2.8% (23) | 3.7% | 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) | 85.7% | 91.1% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 4.5% (3) | 6.1% | 6.7% | N/A |

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- 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. IUD and coil fittings were carried out.

| 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) | 130 | 139 | 93.5% | 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) | 129 | 143 | 90.2% | Met 90% minimum (no variation) |
| 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) | 131 | 143 | 91.6% | 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) | 131 | 143 | 91.6% | Met 90% minimum (no variation) |

Working age people (including those recently retired and students)

Population group rating: **Good**

| Findings |
|--|
| <ul style="list-style-type: none"> 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. |

| 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, | 67.1% | 73.4% | 72.1% | No statistical variation |

| | | | | |
|---|-------|-------|-------|--------------------------|
| and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England) | | | | |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE) | 62.7% | 70.8% | 70.3% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE) | 37.7% | 54.9% | 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) | 80.0% | 77.1% | 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) | 33.3% | 49.9% | 51.6% | No statistical variation |

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

| Findings |
|---|
| <ul style="list-style-type: none"> The practice had recently taken over a substance misuse service, taking in approximately 600 patients with substance misuse needs, many of whom were homeless. The practice had failed to adequately plan care and treatment to safely meet these patients' needs. 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 homeless people, travellers and those with a learning disability. The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. |

People experiencing poor mental health (including people with dementia)

Population group rating: Good

| Findings |
|--|
| <ul style="list-style-type: none"> 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. |

| 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) | 96.6% | 90.6% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 2.2% (2) | 8.1% | 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) | 84.1% | 89.7% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.2% (2) | 7.0% | 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) | 97.8% | 85.0% | 83.0% | Variation (positive) |
| Exception rate (number of exceptions). | 4.2% (2) | 4.8% | 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) | 535.6 | - | 537.5 |
| Overall QOF exception reporting (all domains) | 4.0% | 5.2% | 5.8% |

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

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

No evidence seen during our inspection.

Any additional evidence or comments

There was a lack of effective management oversight and we saw no evidence of effective clinical audits during our inspection, despite asking for these.

We found no evidence of improvement initiatives as a result of any quality improvement activity. The lack of effective practice management meant that there was little quality monitoring or audit activity at the practice.

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. | Y |
| The learning and development needs of staff were assessed. | N |
| The practice had a programme of learning and development. | N |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015. | N |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | N |
| 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. | N |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Although some staff had received an appraisal in the last 12 months, there was no on-going monitoring of staff performance and staff we spoke with told us that they did not attend regular one to one meetings with their line manager. Staff did say that management were approachable, however, when we asked to see an overview of staff training, this was not made available to us as no such overview existed.</p> <p>We found gaps in staff training and one staff member had not received any training since commencing their employment at the practice in June 2018.</p> <p>The records we looked at were chaotic and the office manager was unable to locate staff training files easily.</p> | |

Coordinating care and treatment

Staff worked 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 | Y |

| | |
|---|---|
| and organisations, were involved in assessing, planning and delivering care and 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) | 96.6% | 94.6% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.4% (6) | 0.7% | 0.8% | N/A |

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | N |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | N |
| The practice monitored the process for seeking consent appropriately. | N |
| Explanation of any answers and additional evidence: <p>The practice had registered 16 patients from St Anthony's Care Home in Watford, Hertfordshire. None of these patients had given consent to register with the practice and all the registration forms we looked at had not been signed to provide patient consent. We were told that this alignment of the care home to the practice was done as directed by the CCG. This did not remove the requirement for patient consent. Some of these patients may have lacked the mental capacity to agree to a change in their GP. This had not been considered by the practice.</p> <p>We found a lack of evidence in terms of how mental capacity was considered at the practice by clinicians and staff. There was a lack of understanding of this across the practice and improvement was needed in understanding and requiring the legal requirements in relation to consent and mental capacity.</p> | |

Caring

Rating: Requires Improvement

The practice was rated as requires improvement for providing caring services as patients had not always been treated appropriately and there was limited evidence of how the practice considered feedback from patients.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

| | Y/N/Partial |
|---|-------------|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Partial |
| Explanation of any answers and additional evidence: Patients who had been recently aligned to the practice who lived in a care setting had not received timely or appropriate care. Feedback regarding this patient group was negative about how patients at the home had been spoken to by the GPs. They had not had their concerns appropriately responded to and their consent had not been sought prior to them being aligned to the practice and therefore changing their GP. We saw limited feedback as part of this inspection due to the inspection taking place at short notice. | |

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 |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 8670 | 422 | 100 | 23.7% | 1.15% |

| 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) | 82.6% | 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) | 86.4% | 88.8% | 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) | 91.4% | 97.2% | 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) | 85.4% | 87.6% | 83.8% | No statistical variation |

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

Any additional evidence
 There was no patient feedback survey completed over the last 12 months. It was not clear how the practice assessed patient experience or how they took on feedback from patients to drive improvement.

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 |

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) | 80.0% | 94.2% | 93.5% | Variation (negative) |

Any additional evidence or comments
 As there was no service improvement plan, or any evidence of learning at the practice, it was not clear how the practice intended to improve in areas where patient experience was lower than national averages.

| | Y/N/Partial |
|---|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |
| Information leaflets were available in other languages and in easy read format. | N |
| Information about support groups was available on the practice website. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>There was a lack of information in easy read format and some of the information offered to patients in the waiting area was not in a format to ensure that all patients would have been able to access it. The practice needed to improve this.</p> | |

| Carers | Narrative |
|--|--|
| Percentage and number of carers identified. | 128 patients equating to >1% |
| How the practice supported carers. | The practice had a process in place for identifying carers and information was provided on a notice-board in the practice to signpost carers to organisations for help and support. There was a carers' register in place and two carers champions. Carers could be referred through to Carers in Herts Adult Care Services. |
| How the practice supported recently bereaved patients. | Patients would be signposted to organisations for support and counselling following a bereavement. This information was readily available to patients and would be made available by staff at the practice. |

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 |

Responsive

Rating: Requires Improvement

The practice was rated as requires improvement for providing responsive services as the practice had not always responded to patient needs.

Responding to and meeting people's needs

Services did not always 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. | N |
| The practice made reasonable adjustments when patients found it hard to access services. | N |
| The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice. | N |
| Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had recently taken over a substance misuse service. The premises for the 571 vulnerable patients whom the provider had recently taken on from a nearby substance misuse service, many of whom were homeless, were not being seen in premises which were safe and suitable.</p> <p>Staff we spoke with did not feel safe and the required modifications to the premises had not been made to ensure the safety of staff and patients. Staff could not see patients in the waiting area from the reception desk and staff reported to us that they did not have a safe system to alert people if they needed to. The premises did not provide adequate safety measures for this type of service and posed a risk to staff and patients.</p> <p>We saw feedback from patients of this part of the service who had raised that the premises were neither safe nor suitable for them. Although the practice management were aware of these issues, no progress had been made in making the premises safer and more suitable. Following our inspection, the practice took immediate steps to start working on making the premises suitable and safe for the patient group who used it.</p> | |

| Practice Opening Times | |
|------------------------|---------------|
| Day | Time |
| Opening times: | |
| Monday | 08:30 – 18:30 |
| Tuesday | 08:30 – 18:30 |
| Wednesday | 08:30 – 18:30 |
| Thursday | 08:30 – 18:30 |
| Friday | 08:30 – 18:30 |
| | |

| Appointments available: | | |
|-------------------------|---------------|---------------|
| Monday | 08:30 – 12:00 | 16:00 – 18:00 |
| Tuesday | 08:30 – 12:00 | 16:00 – 18:00 |
| Wednesday | 08:30 – 12:00 | 16:00 – 18:00 |
| Thursday | 08:30 – 12:00 | 16:00 – 18:00 |
| Friday | 08:30 – 12:00 | 16:00 – 18:00 |
| | | |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 8670 | 422 | 100 | 23.7% | 1.15% |

| 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) | 89.1% | 95.4% | 94.8% | No statistical variation |

Older people

Population group rating: Requires Improvement

| Findings |
|---|
| <ul style="list-style-type: none"> • The practice was not responsive to the needs of older patients who were living in residential care and we found evidence that people were not getting the care and treatment they needed. • The practice did offer urgent appointments for those with enhanced needs and complex medical issues. • Active screening was in place for Atrial Fibrillation in the over 75s. • Regular primary health care team meetings were held with the attached district nursing team. • Regular meetings took place with local palliative care team. |

People with long-term conditions

Population group rating: Good

| Findings |
|--|
| <ul style="list-style-type: none"> • 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

- 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.
- A weekly midwife run antenatal clinic was held.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- There was no extended hours offered at the practice. An out of hours service for when the practice is closed is provided by Herts Urgent Care.
- 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 offered flexible appointments to maintain continuity of care. Face to face consultations were available on the day as well as pre- bookable up to 14 days in advance.
- Telephone consultations with a GP and the nurse were available which supported patients who were unable to attend the practice during normal working hours.
- The practice offered temporary medical services to returning university students for example during university vacation periods.
- Through the Electronic Prescribing System (EPS) patients could order repeat medicines online and collect the medicines from a pharmacy near their workplace or any other convenient location.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The practice had failed to ensure that the substance misuse service it had taken over continued to be responsive to patients' needs. The premises were unsafe and unsuitable and patients and staff did not feel the service was meeting the needs of the patients.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. Patients had access to the wellbeing service hosted by the local mental health trust for care and support.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Patients newly diagnosed with depression were encouraged to contact the practice for a face to face or telephone consultation to assess their situation and care needs.
- Family members who cared for patients with dementia were offered health checks and support.

Timely access to the service

People were not always 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. | Partial |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Partial |
| Appointments, care and treatment were only cancelled or delayed when necessary. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <p>We found instances of patients being treated without being seen by a GP when this would have been appropriate. One patient had waited for seven weeks for a blood test without any clear explanation from the practice as to why this had happened. The practice had failed to provide adequate care and treatment to this patient.</p> <p>We found that visits to a local care home had not always been made as planned. The practice had stated that this was due to staff shortages.</p> | |

| 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) | 82.0% | 73.0% | 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) | 80.4% | 72.4% | 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 31/03/2018) | 71.0% | 67.0% | 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) | 72.7% | 77.0% | 74.4% | No statistical variation |

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

| Complaints | |
|--|---|
| Number of complaints received in the last year. | 7 |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|--|-------------|
| Information about how to complain was readily available. | Y |
| There was evidence that complaints were used to drive continuous improvement. | N |
| <p>Explanation of any answers and additional evidence:</p> <p>There was no analysis or oversight of complaints at the practice. Although complaints were looked at and responded to, they were not collated to look for trends and patterns and no learning outcomes were identified as a result of complaints to drive continuous improvement. Systems were introduced to improve this following our inspection, however, these system were not in place at the time we inspected the practice.</p> | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|--|
| Patient moved house and was removed from the patient list. | Letter responded to explaining the practice's position in relation to this. No further action taken. |
| Lack of attendance at the care home for a patient who was unwell. | Patient referred to policy for care home patients. |
| Patient not advised of the outcome of a hospital visit. | Practice apologised. |

Well-led

Rating: Inadequate

The practice was rated as inadequate for providing well-led services as we found inadequate governance arrangements, a lack of management oversight and little evidence of how risk was being adequately managed. Staff were not clear on roles and responsibilities.

Leadership capacity and capability

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

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | N |
| They had identified the actions necessary to address these challenges. | N |
| Staff reported that leaders were visible and approachable. | N |
| There was a leadership development programme in place, including a succession plan. | N |
| Explanation of any answers and additional evidence: The practice had recently been through some changes and were in the process of making further changes. These changes had not been well managed and this had impacted on staff and patients at the practice. Risks and issues had not been identified, there were no structured processes in place to look at risks across the practice and there was a lack of effective management to safely and effectively implement the changes that needed to take place. There was no leadership development programme in place and indeed no clear management structure in place. There was no succession planning completed. | |

Vision and strategy

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

| | Y/N/Partial |
|--|-------------|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | N |
| There was a realistic strategy in place to achieve their priorities. | N |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | N |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | N |
| Progress against delivery of the strategy was monitored. | N |
| Explanation of any answers and additional evidence: Staff we spoke with were not clear on the vision and values of the practice. Staff told us that changes were not well communicated and that they were unclear on where the practice was going. Meeting minutes we looked at focussed on finances and we saw little evidence of how staff were made | |

aware of a strategy and vision.

The GP partners we spoke with told us that they felt under pressure due to the changes being implemented and that they did not have time to consolidate this work and plan effectively. We found this to be the case.

The provider had no overarching strategy in place and there was no clear leadership implementing the changes which were taking place.

Culture

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

| | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | N |
| Staff reported that they felt able to raise concerns without fear of retribution. | N |
| There was a strong emphasis on the safety and well-being of staff. | N |
| 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>As there was no clear vision and values in place at the practice, we found little in terms of how staff were expected to behave. However, we did find that staff were supportive of one another and that the focus was on providing good care for patients.</p> <p>There was little in place to ensure staff well-being due to the demands on the role of the office manager and the number of changes which had been implemented very quickly and with little support. Staff we spoke with in the substance misuse service were concerned about these changes and did not always feel supported.</p> | |

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

| Source | Feedback |
|------------------|---|
| Staff interviews | Staff we spoke with felt that patients received good care and treatment at the practice and described working within supportive teams. However, some staff did not feel that changes to the practice had been communicated well and staff working in the substance misuse service expressed concern about the new premises and told us that they did not feel part of the practice. Staff in this part of the service did not feel supported and were not sure about the future of their roles. |

Governance arrangements

The overall governance arrangements were ineffective.

| | Y/N/Partial |
|--|-------------|
| There were governance structures and systems in place which were regularly reviewed. | N |
| Staff were clear about their roles and responsibilities. | N |
| There were appropriate governance arrangements with third parties. | N |
| <p>Explanation of any answers and additional evidence:</p> <p>There was no governance structure in place and when we asked to see any audits carried out we were</p> | |

told that there were none to see. The provider did not have systems and structures in place to ensure that the quality of care and treatment was being assessed on an on-going basis. Roles and responsibilities were not clearly defined which meant that information was recorded but that no analysis or learning happened as a result.

There was no evidence of the practice understanding their risks and no evidence of continuous improvement.

Managing risks, issues and performance

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

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems in place which were regularly reviewed and improved. | N |
| There were processes in place to manage performance. | N |
| There was a systematic programme of clinical and internal audit. | N |
| There were effective arrangements for identifying, managing and mitigating risks. | N |
| A major incident plan was in place. | N |
| Staff were trained in preparation for major incidents. | N |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | N |
| <p>Explanation of any answers and additional evidence:</p> <p>Due to ineffective management and governance at the practice there was no oversight of risk. No risk register was in place and there was no effective monitoring of staff performance on an on-going basis. The office manager and provider were not clear on staff training needs across the practice as a whole and staff had been transferred from another service without an audit of their performance, training and recruitment needs.</p> <p>Changes had been implemented at the practice without adequate planning and risk assessing by the provider and this had impacted on the quality of care and treatment across the practice as a whole.</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 |
| Performance information was used to hold staff and management to account. | N |
| Our inspection indicated that information was accurate, valid, reliable and timely. | N |
| There were effective arrangements for identifying, managing and mitigating risks. | N |
| Staff whose responsibilities included making statutory notifications understood what this entails. | N |
| <p>Explanation of any answers and additional evidence:</p> <p>There was an absence of clinical and quality monitoring data which meant that this could not be used to drive improvement and to act on information appropriately. Information we were shown during our inspection was difficult to locate and there was no oversight and effective management of information held at the practice. Risks were not being mitigated on an on-going basis due to a lack of oversight.</p> <p>The practice had not submitted any recent notifications to CQC despite these being required by law.</p> | |

Engagement with patients, the public, staff and external partners

The practice did not 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 |
| Staff views were reflected in the planning and delivery of services. | Partial |
| 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>The practice did work closely with the CCG in terms of planning how the practice would work in the future. However, there was little evidence of consultation with patients and we found no recent quality monitoring exercises.</p> <p>The practice had held a recent 'staff day' to update staff on changes which had taken place at the practice, however, many of the staff we spoke with during our inspection did not feel this change had been managed effectively and remained unclear about the future of their roles and the practice as a whole.</p> | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| <p>When we met with the PPG during our inspection, the people we spoke with were not sure when the last meeting had been and were unable to recall a recent meeting for the Upton Road Surgery. There was no structure to the group and we were unable to see any recent meetings minutes as no meetings had taken place.</p> <p>The patients we did speak with were positive about the Drs who worked at the surgery but felt that a lot of change had taken place at the practice which had not always been effectively communicated to patients. They told us that a lack of parking made getting into the practice difficult at time. However, they were complimentary about their own care and treatment and felt that the clinicians and staff at the practice treated them with respect.</p> |

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 |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice were not able to evidence any learning that had come out of significant events, incidents or complaints which had taken place at the practice. There was no oversight of these and therefore little work was done to</p> | |

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as 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.