

# Care Quality Commission

## Inspection Evidence Table

### Cambridge Medical Group (1-549891557)

Inspection date: 10 December 2018

Date of data download: 7 December 2018

## Overall rating: Inadequate

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

## Safe

## Rating: Inadequate

We rated the practice as inadequate for providing safe services because:

- The practice did not have clear systems and processes to keep patients safe.
- The practice did not have robust systems in place for the recruitment of staff.
- The practice did not have a fire risk assessment on the premises.
- The practice had not carried out an infection prevention and control audit. There was no evidence to show that staff had received training in infection prevention and control.
- The practice could not demonstrate that all confidential information was stored securely.
- The practice could not always demonstrate that the learning from significant events had been shared with all staff.

### 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.	N

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
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.	Partial
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.	Y
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.	N
Explanation of any answers and additional evidence:	
The lead clinician named in the policy for safeguarding was not currently working at the practice.	
Staff interviewed were not aware of who the safeguarding lead was. The policy had not been reviewed or updated.	
There was no evidence to show that regular discussions between the practice and other health and social care professionals took place.	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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.	Y
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Whilst the registration of clinical staff was checked at the point of employment there was no evidence to show that this was regularly monitored.</li> <li>Some of the information required to be held to support the recruitment of staff was not available. For example, in two of the four recruitment files we looked at there was no evidence of satisfactory conduct in place for either the persons' previous employment nor to determine their</li> </ul>	

character.

- There was no application forms or curriculum vitae in the two out of the four recruitment files. This was not in line with the practice's own recruitment policy and procedures.

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: 07/01/2019	Y
There was a record of equipment calibration. Date of last calibration: 10/2017	Y
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check: 12/2018	Y
There was a log of fire drills. Date of last drill: There was no drill recorded.	N
There was a record of fire alarm checks. Date of last check: 28/11/2018	Y
There was a record of fire training for staff. Date of last training:	N
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion:	N
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:            We were informed that the fire risk assessment was carried out by an external company and was not held on the premises. The practice was unable to provide an up to date fire risk assessment, therefore we were unable to see if any actions had been identified.            The fire procedure stated that fire evacuation drills would be carried out from time to time however, there was no evidence to show that any drills had taken place.            It was noted that staff were not up to date with fire safety training            At the time of our inspection, equipment calibration was out of date. However, the practice had arranged for the calibration of equipment to take place on 07/01/2019. We have subsequently received evidence to show this has taken place.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	N

Date of last assessment:	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	N
Explanation of any answers and additional evidence: At that time of our inspection, there were no health and safety risk assessments available.	

## 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.	Y
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
Explanation of any answers and additional evidence: The Nurse Practitioner interviewed said she gave infection prevention and control training to other members of staff. However, there was no documentation to show this. Whilst the clinical rooms and the practice in general looked clean the cupboard used for cleaning implements and products was dirty. This included the buckets, sink and floor. An infection prevention and control audit had not been done. The nurses were given 10 minutes each morning for the cleaning of equipment such as ear syringes and spirometers, however there was no evidence to show this was happening. There was damage to the flooring in the treatment room where the minor operations took place, therefore the flooring could not be properly cleaned.	

## Risks to patients

### There were adequate 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
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.	Y
Explanation of any answers and additional evidence: The partners had appointed a locum GP to cover maternity leave.	

## 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.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
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: Confidential patient information was not stored securely. We were told by the practice manager that three patient consent forms had been found in a cupboard following the inspection on 10 December 2018.	

Whist there was a system for processing information relating to new patients including the summarising of new patient notes, we were told that this was not up to date due to staff sickness.

## Appropriate and safe use of medicines

### The practice had 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)	1.08	1.19	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)	12.7%	9.9%	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.	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 monitored the prescribing of controlled drugs. (For example, investigation of	Y

Medicines management	Y/N/Partial
unusual prescribing, quantities, dose, formulations and strength).	
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures in place for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
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.	N
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>There were gaps in the recording of vaccine refrigerator temperatures in the clinical rooms. For example, for the refrigerator in the treatment room there were three days in both October and November 2018 without temperature recordings. On some recording sheets there was no indication of the month the temperatures related to.</p> <p>The practice did not have all the emergency medication in line with best practice guidance. For example, Glyceryl Trinitrate (GTN) spray. In addition, there was no risk assessment in place to identify the medicines the practice chose not to stock.</p>	

<b>Medicines management</b>	<b>Y/N/Partial</b>

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

**The practice learned and made improvements when things went wrong.**

<b>Significant events</b>	<b>Y/N/Partial</b>
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months: 9	Y
Number of events that required action: 9	Y
Explanation of any answers and additional evidence: The learning and dissemination relating to significant events was not shared with all clinicians.	

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

<b>Event</b>	<b>Specific action taken</b>
A two-week referral for a patient was not processed by the GP.	Partners agreed that going forward all tasks for two-week referrals would be sent whilst the patient was still with the GP.
Clinical- Backlog of patients' clinical correspondence assigned to locum GP that had not been actioned/ checked or coded.	All letters to be filed and cleared by responsible GP weekly and not assigned to locum GP's without prior agreement.

<b>Safety alerts</b>	<b>Y/N/Partial</b>
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: The safety alerts were recorded whether action was required or not. If action was required, this was assigned to an appropriate member of staff and it was recorded when this action was completed. The safety alerts were available in the practice.	



## Effective

## Rating: Requires Improvement

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

- There was limited monitoring of the outcomes of care and treatment.
- Some performance data was significantly below local and national averages.
- The practice could not demonstrate that sufficient staff training was taking place.

### 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.

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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.53	1.10	0.81	No statistical variation

The areas that led to the rating of requires improvement impacted all population groups and so we have rated all population groups as requires improvement.

### Older people

### Population group rating: Requires Improvement

#### 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.
- 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: Requires Improvement

#### 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.
- 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.

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/l or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	58.4%	77.2%	78.8%	Variation (negative)
Exception rate (number of exceptions).	13.5% (49)	16.3%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	69.0%	76.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.8% (32)	11.9%	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) <small>(QOF)</small>	64.4%	79.0%	80.1%	Variation (negative)
Exception rate (number of exceptions).	14.3% (52)	16.4%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the	55.7%	74.5%	76.0%	Significant Variation

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)				(negative)
Exception rate (number of exceptions).	6.1% (28)	12.9%	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)	75.0%	87.6%	89.7%	Variation (negative)
Exception rate (number of exceptions).	10.8% (18)	16.3%	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)	71.0%	82.1%	82.6%	Variation (negative)
Exception rate (number of exceptions).	3.1% (32)	4.8%	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)	86.4%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (4)	6.0%	6.7%	N/A

### Any additional evidence or comments

The partners were aware that the QoF figures were low. Their plan was to have a QoF lead, the advanced nurse practitioner and for her to draw up a strategy plan. Protected time was to be given, one half day a week to the nurse and an administration person to improve the figures.

### Families, children and young people

### Population group rating: Requires Improvement

### 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.

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) <small>(NHS England)</small>	83	84	98.8%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	69	71	97.2%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	70	71	98.6%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	70	71	98.6%	Met 95% WHO based target (significant variation positive)

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

### Population group rating: Requires Improvement

#### 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.

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)	74.1%	72.9%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	74.1%	70.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	58.2%	54.0%	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)	64.4%	62.5%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	52.6%	50.3%	51.9%	No statistical variation

## People whose circumstances make them vulnerable

### Population group rating: Requires Improvement

#### Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

### Population group rating: Requires Improvement

#### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for

physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

- There was 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)	89.2%	87.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	27.5% (14)	15.9%	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)	88.4%	90.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	15.7% (8)	11.8%	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)	68.3%	83.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (9)	8.7%	6.6%	N/A

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	464	536	537.5
Overall QOF exception reporting (all domains)	6.3%	7.2%	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	N

information about care and treatment to make improvements.	
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Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

Reviews were carried out; however, they were on an ad hoc basis. A review was carried out regarding two-week referrals over three months in 2018. The aims were to follow the National Institute for Health and Care Excellence (NICE) guidance on two-week referrals, to improve safety, make an early diagnosis and to review if patients referred were appropriate. All the referrals made were according to the NICE guidance, although slightly above the national average. The expected outcomes similar to the national average.

A review was carried out to evaluate the infection rates in their patients post minor surgery. This was carried out over three months in 2018. None of the patients, who had minor surgery had any complications. The actual infection rate post minor surgery was 0%.

#### Any additional evidence or comments

The practice sent information, following the inspection to show that some improvement had been made in their Quality and Outcomes Framework (QOF) figures.

#### 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.	Partial
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	N
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
For patients who accessed the practice's digital service there were clear and effective	Y



processes to make referrals to other services.	
Explanation of any answers and additional evidence:	
Reception and administration staff had annual appraisals. Clinicians had not had appraisals for more than a year and learning needs had not been assessed.	
There was little evidence to show that staff training was taking place apart from basic life support. We were told that the practice had recently changed providers for staff training and they were unable to access previous training.	

## 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)	N
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.	N
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	N
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	
Whilst there were minutes to show that palliative care meetings took place patients' care plans were not discussed at the meetings.	
There was no evidence to show that there was regular discussion between the practice and other health and social care professionals.	

## Helping patients to live healthier lives

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

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: Staff would signpost patients to the appropriate service.	

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)	92.3%	95.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (7)	0.7%	0.8%	N/A

### Consent to care and treatment

**The practice was not able to demonstrate that it always obtained consent to care and treatment.**

	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.	Y
The practice monitored the process for seeking consent appropriately.	N
Explanation of any answers and additional evidence: Seven sets of patient records were looked at regarding consent. In three of the records there was no information regarding consent. Following the inspection, the office manager sent the three missing consent forms which had been found in a cupboard in a treatment room.	

## Caring

## Rating: Requires Improvement

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

- The national GP survey results showed that patients said that last time they had a general practice appointment the clinician was not good at listening to them.
- The healthcare professional was not very good at treating them with care and concern

## 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.	11
Number of CQC comments received which were positive about the service.	5
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	5

Source	Feedback
CQC comment cards.	<p>Patients commented that the staff were always friendly and welcoming, and they went out of their way to be helpful.</p> <p>Patients said that the nurses and doctors were always caring, and they felt listened to.</p> <p>The negative comments were about access to the practice and the telephone system.</p>

## 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
6959	262	101	38.5%	1.45%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	65.5%	88.0%	89.0%	Significant Variation (negative)
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)	70.0%	87.4%	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)	89.8%	94.6%	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)	57.2%	83.5%	83.8%	Variation (negative)
Question				Y/N
The practice carries out its own patient survey/patient feedback exercises.				N

Any additional evidence

### Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	One patient said that they thought the practice was improving.

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## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	79.0%	92.2%	93.5%	Variation (negative)

### Any additional evidence or comments

The partners informed us that each patient has a named GP which going forward will provide more continuity in their care.

	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: Staff had access to a telephone interpreting service. Large font information could be provided if required.	

Carers	Narrative
Percentage and number of carers identified.	1.8% which equates to 126 patients
How the practice supported carers.	Seasonal influenza vaccines were offered, and carers were signposted to organisations that would be helpful.
How the practice supported recently bereaved patients.	A telephone call was made to the bereaved person.

## 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	Y

during examinations, investigations and treatments.	
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: Inadequate

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

- The national GP patient survey results showed that patients were not always able to access care and treatment in a timely way.
- The practice could not show that learning from complaints was shared with all staff.

### 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 8pm
Tuesday	8am to 6pm
Wednesday	8am to 6pm
Thursday	8am to 6pm
Friday	8am to 6pm

Appointments available:	
Monday	Drs appts 8.10am to 4.10pm each day. Nurse appts 7.30am to 5.30pm each day
Tuesday	Drs appts 8.10am to 4.10pm each day. Nurse appts 7.30am to 5.30pm each day
Wednesday	Drs appts 8.10am to 4.10pm each day. Nurse appts 7.30am to 5.30pm each day
Thursday	Drs appts 8.10am to 4.10pm each day. Nurse appts 7.30am to 5.30pm each day
Friday	Drs appts 8.10am to 4.10pm each day. Nurse appts 7.30am to 5.30pm each day

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6959	262	101	38.5%	1.45%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	92.4%	93.9%	94.8%	No statistical variation

### Any additional evidence or comments

The areas that led to the rating of inadequate impacted all population groups and so we have rated all population groups as inadequate

### Older people

Population group rating: Inadequate

#### Findings

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

### People with long-term conditions

Population group rating: Inadequate

## Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised 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: Inadequate

## Findings

Nurse appointments were available until 5.30pm Monday to Friday for school age children so that they did not need to miss school.

- 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: Inadequate

## Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on a Monday, which helped those that were unable to attend during normal working hours.
- 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

## Population



## group rating: Inadequate

### 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. A longer appointment was given so that the patient could have all their needs met at one time.

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

### Population group rating: Inadequate

### 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 not 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 necessary.	Y
Explanation of any answers and additional evidence: Home visits were shared out between the clinicians.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it	30.5%	66.7%	70.3%	N/A

Indicator	Practice	CCG average	England average	England comparison
was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)				
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)	37.0%	67.3%	68.6%	Variation (negative)
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)	46.1%	64.9%	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)	46.9%	74.0%	74.4%	Variation (negative)

Any additional evidence or comments	
Source	Feedback
For example, NHS Choices	<p>Since June 2018 there had been 10 reviews on NHS choices. One was a good review. Three were complaints and they had been responded to by the partners. However, a further five reviews were complaints and the practice had not responded to those. The complaints were regarding appointments, repeat prescriptions, clinical results and the telephone system.</p> <p>The practice told us they had listened to patients' complaints and changed their appointment system. The appointments had changed to being staggered so they became available to pre-book in advance every day. The practice also kept a number of appointments back that could only be used on the same day, which enabled them to provide more urgent same day appointments. Each GP was also given information about patients who were unable to get an appointment. The GP would then give a patient an appointment or have a telephone consultation. The practice told us they offered a late-night clinic every Wednesday with GP and healthcare appointments available. However, despite these changes' patients continued to complain about access to the practice.</p> <p>Patients commented that most GP's at the practice were part time which made it difficult for continuity of care.</p> <p>A patient said that it was very difficult to get an appointment either on the phone or on line. Therefore, they went into the surgery when it opened at 8am, which was more successful.</p> <p>One patient felt that they were actively encouraged to find another GP surgery because of the poor service.</p>

### Listening and learning from concerns and complaints

**Complaints were listened and responded to but not always used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	8
Number of complaints we examined that were satisfactorily handled in a timely way.	8
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.	P
Explanation of any answers and additional evidence: Information regarding complaints and outcomes was not shared with all clinicians. There was some evidence that showed improvement had been made following the outcome of complaints. This was where an administration procedure required changing.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient felt rushed during consultation and that the GP did not listen to them.	After speaking with the patient, a letter was sent apologising and advising patients are asked to book a double appointment for more than one problem.
Patient complained as their medication had suddenly been halved on their prescription.	The GP concerned apologised for the error.

## Well-led

## Rating: Inadequate

We rated the practice as inadequate for providing well-led services because:

- Leaders were not always visible and approachable. They could not show that they had the capacity and skills to deliver high quality, sustainable care.
- The practice could not demonstrate that they had a clear written plan and vision for the future.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

- **We saw little evidence of systems and processes for learning, continuous improvement and innovation.**

### **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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme in place, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The partners had recently employed two pharmacists and a long-term locum GP. The existing Locum GP was to stay until spring 2019.</p> <p>One of the two main partners at the practice only worked one day a week and the other main partner did not have a patient list and didn't work clinically on a regular basis.</p> <p>This meant that the lead partners were not always visible in the practice</p>	

### **Vision and strategy**

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	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
<p>Explanation of any answers and additional evidence:</p> <p>The partners said they had thoughts and a vision for the future, however staff were not aware of the practice vision.</p> <p>There was no written strategy in place. Consequently, progress against a strategy could not be monitored.</p>	

## Culture

**The practice did not have a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	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>Staff interviewed said they were able to raise concerns. They were aware of the whistle blowing procedure.</p>	

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

Source	Feedback
Staff	Two members of staff said they enjoyed working at the practice and the office manager was there if they needed any help. Another member of staff felt unsupported in their role.

## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Systems in the practice were not regularly reviewed. There was no designated person who had overall oversight for governance arrangements at the practice.</p> <p>Significant events were not disseminated to all clinicians and there was no evidence of any shared learning throughout the practice</p> <p>There were no full staff team meetings held in the practice.</p>	

## Managing risks, issues and performance

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

## issues and performance.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N
There were processes in place to manage performance.	Y
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	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>There was not a programme of audits, they were carried out on an ad hoc basis. The practice could not demonstrate any shared learning for audits/reviews that had taken place.</p> <p>There were some risk assessments in place, however they were generic, and some were not appropriate for a GP practice. For example, there was a risk assessment for operating theatres.</p> <p>Staff were not trained for all major incidents. They were not up to date with fire safety training and had not participated in a fire evacuation drill.</p>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
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.	Y
<p>Explanation of any answers and additional evidence: There was a lack of risk assessments specific to the practice.</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
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Patient views were acted on to improve services and culture.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence: There were limited arrangements in place to seek and act on feedback from staff and patients. This included a lack of clinical meetings and no mechanisms in place such as a patient participation group to facilitate patient feedback about the practice.	

#### Feedback from Patient Participation Group.

Feedback	
The office manager had approached some patients to form a patient participation group and two had shown interest. During the inspection one patient was interviewed about the intended patient participation group, however there was no time frame for setting up the group.	

### Continuous improvement and innovation

#### There was little evidence of systems and processes for learning, continuous improvement and innovation.

		Y/N/Partial
There was a strong focus on continuous learning and improvement.		N
Learning was shared effectively and used to make improvements.		N
Explanation of any answers and additional evidence: The training system for staff had not been implemented. There was no evidence of previous training.		

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 ≤ -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.