

Care Quality Commission

Inspection Evidence Table

Orient Practice (1-4829977217)

Inspection date: 5 and 7 February 2019

Date of data download: 25 January 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	
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).	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Partial
There was a risk register of specific patients.	Partial
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.	Y

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>The joint adult and children's' safeguarding policy did not contain a named local lead or deputy lead for safeguarding, However, staff knew who the lead was, but they said there was no deputy to cover periods of absence.</p> <p>The practice held a list of 22 children on the safeguarding register. We viewed a sample of four and found there were no alerts on the clinical system to highlight these patients.</p> <p>There was no system to follow up at risk children that had not been seen within a given period of time at the practice. For example, we saw a 16-year-old newly registered at-risk patient who did not attend their initial appointment and the practice did not follow this up. A looked after children nurse contacted the practice for information on this patient and the practice told them they have not attended for their appointment and the practice attempted no further contact with this patient.</p> <p>We saw a 14-year-old patient who had not been seen since June 2018, a letter was received from the multi-agency safeguarding HUB with concerns in January 2019 and the practice had not made efforts to contact this patient.</p> <p>The practice did not have a list of vulnerable patients, a search was run on the clinical system to find these and seven patients were found, however we were told that there were more suggesting a coding issue. Two out of seven of these patients had alerts on the system identifying them as vulnerable and one patient aged 35 had an alert stating they were on the child protection register. The lead GP showed us a list of vulnerable patients but this was a personal list that he had created and was not shared with the wider team.</p> <p>We gave the provider two days post inspection to provide us with evidence of completion of mandatory training for all clinical staff members and this was not sent, therefore, we were unable to confirm that all clinical staff members had received safeguarding training appropriate to their role.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were no systems in place for the provider to check that salaried GPs were on the performers list. However, the deputy practice manager had a system to check this for locum GPs.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: December 2018</p>	Y
<p>There was a record of equipment calibration. Date of last calibration: December 2018</p>	Y
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	N
<p>There was a fire procedure.</p>	Y
<p>There was a record of fire extinguisher checks. Date of last check: August 2018</p>	Y
<p>There was a log of fire drills. Date of last drill: 29 November 2018</p>	Y
<p>There was a record of fire alarm checks. Date of last check: 5 February 2019</p>	Y
<p>There was a record of fire training for staff. Date of last training: unknown</p>	Partial
<p>There were fire marshals.</p>	Partial
<p>A fire risk assessment had been completed. Date of completion: July 2017 review date July 2018</p>	Partial
<p>Actions from fire risk assessment were identified and completed.</p>	unknown
<p>Explanation of any answers and additional evidence:</p> <p>The fire procedure and other fire related documentation did not indicate who the fire marshals were and. We were told that there were three fire marshals, but there was no documentation or evidence supporting this.</p> <p>The practice was unable to provide evidence that all staff had completed fire training.</p> <p>There were fire evacuation signs at the back of the building which directed people to a fire exit that was locked. This was rectified by the second day of inspection.</p> <p>Only three staff members were in the practice during the last fire drill and there were no patients in the premises. Learning from the fire drill was not discussed with staff members.</p> <p>Property services arranged the fire risk assessment and the building was rated moderate risk as a fire evacuation plan had not been developed and the five yearly NICEIC inspection had not been carried out. The practice was unaware of whether an updated risk assessment had taken place or whether any actions had been completed. For example, outstanding action from 2016 relating to the electrical installation, request an investigation into a fault in the fire alarm panel.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 28 January 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The security company carried out a risk assessment in relation to the violent patient scheme (SAS), which resulted in the security guard being stationed outside the room whilst a consultation with a patient is taken place. However, the risk assessment did not address the safety of reception staff members in the waiting area or non-special allocation scheme patients attending the practice to book an appointment or pick up prescriptions. The risk assessment also did not consider that SAS patients sometimes attended the practice against the conditions of their contract on days where they were not allowed to do so and did not consider that there was very rarely an experienced manager on the premises when SAS clinics were taking place.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: 29 January 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The infection prevention and control audit identified issues such as wall surfaces and skirting boards painting and damage. However, the report was only received on the day of inspection, therefore the practice had not had the opportunity to address them.</p> <p>We saw that non-clinical staff had completed infection prevention and control training, however the provider did not send evidence of infection prevention and control training for clinical staff members.</p>	

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.	Partial
There was an effective induction system for temporary staff tailored to their role.	N
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	Not inspected
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 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	N

impact on safety.

Explanation of any answers and additional evidence:

There was a system for logging staff absence and although the provider had a human resources department details of how to manage staff absence was not shared with the deputy manager. We saw that when concerns were raised about the lack of staff especially during busy periods this was not acted on, there were no risk assessments carried out and when new staff members were recruited work load and impact of work was not monitored.

Patients were not effectively risk assessed. For example, we were told that due to SAS appointments not being held for over five weeks patients that had not been seen for over eight weeks were reviewed/audited. We looked at the records of these 14 patients and found no documentation to support that a notes review or risk assessment had taken place.

There were two agency staff members, only one of who had completed an induction. However, the induction was not role specific and did not go into any detail. The induction stated that the staff member was shown how to access policies, but the policies were password protected and the staff member did not have a login or password.

Information to deliver safe care and treatment

Staff did not have 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.	Partial
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.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	partial
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.	partial
<p>Explanation of any answers and additional evidence:</p> <p>We were shown a document which showed that on 17 January 2019, 687 old patient records required summarising, this had reduced to 410 as of 5 February 2019. However, a clinical search found there were also 531 newly registered patient notes that had not been summarised, bringing the total number of un-summarised patient notes to 941. We viewed minutes of a practice meeting on 28 September 2018 where administration staff raised this issue with the provider highlighting that summarising had not been done in over 9 months, with the deputy manager stating that she had been sending emails to the provider and had not received a response. This had not been actioned until these records were found at the warning notice follow up inspection in December 2018. The provider failed to effectively risk assess this issue as they had not recognised that a plan needed to be put in place to keep on top of the summarising for newly registered patients. We were told that a new summariser would be in place the week after the inspection but the provider had not reviewed their risk register to analyse how long it would take two summarisers to complete the backlog of summarising as they had reported to the Care Quality Commission that this would be done by Mid-February, but admitted on this inspection that this was now not possible.</p> <p>During the inspection we were told by an administration staff member that there was an issue that Living Care had inherited where a summariser was falsifying on the clinical system that notes had been summarised. We were told during the feedback session that the Director of Operations for Living Care ran a search under that staff members name and found that they had summarised 400 patient records, a random search of 5 of these patient records were looked at and found to have been correctly summarised. The provider did not then carry out a risk assessment to establish how many more records would need to be checked to gain assurance that all clinical records had been appropriately summarised.</p> <p>There was a spreadsheet to monitor two week wait cancer referrals, however this was not adequately completed and did not always note whether an appointment had been given. The practice was unable to</p>	

demonstrate through this that all patients that had been referred for an appointment had received one, we saw five examples which demonstrated this.

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) <small>NHS Business Service Authority - NHSBSA</small>	0.23	0.74	0.94	Significant Variation (positive)
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) <small>(NHSBSA)</small>	7.1%	9.7%	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.	Partial
Staff had the appropriate authorisations 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.	Partial
There was a process 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.	N
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 unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS	Y

Medicines management	Y/N/Partial
England Area Team Controlled Drugs Accountable Officer.	
If the practice had controlled drugs on the premises there were appropriate systems and written procedures 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 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
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 to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were 14 hand written prescription pads which were locked in the reception area but these were not monitored and there were no logs of their numbers. However, on the second day of inspection, we were told that these had been destroyed. Blank prescriptions were left in printers where the room doors were not locked to mitigate risks against theft.</p> <p>Nurses told us that they had clinical support, but there were no prescribing audits carried out into the prescribing of the advanced nurse practitioner.</p> <p>We saw an example of a medicine being added to the patient repeat medicines list with no documentation from the practice and no discharge summary from the hospital indicating why this medicine added.</p> <p>We saw an example of a patient being prescribed warfarin where 10 days before the practice last issued a prescription there was a hospital letter on the practices clinical system stating that the patient had not been attending for their INR tests. However, the practice still prescribed and there was no documentation to state that this was discussed with the patient or the patient was sent for further testing.</p> <p>We saw examples of patients being issued methotrexate where there was either no evidence of the practice checking the linked hospital system to view the most up-to-date blood results before prescribing or a prescription was issued without an up-to-date blood test being done as advised by NICE guidelines.</p> <p>We saw a patient being prescribed azathioprine with the last blood test being six months prior to the prescription. We also found that whilst there were blood test results for patients on the linked hospital system, there was not always evidence that these results had been checked before prescribing as</p>	

Medicines management	Y/N/Partial
results were not always documented in the patient record.	

Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong, but this was not always effective.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
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.	N
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	12
Number of events that required action:	12
Explanation of any answers and additional evidence:	
There was an incident reporting policy used for significant events, but this did not contain sufficient detail as it did not include information such as a definition of a significant event, there was no named lead and no details on how to raise an event externally.	
The discussion of significant event outcomes and learning was not always noted in practice meeting minutes.	
The significant event log did not include the summarising and scanning issues, this was included in the practices risk register, however it did not take all considerations into account such as the summarising of new patient records and new daily incoming scanning which we saw was behind by three weeks, with no clinical input, and this was not reviewed or updated.	

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

Event	Specific action taken
Key left in the door of the drugs cupboard	The event was discussed at a practice meeting but there was no documented discussion of any outcomes and learning. There was a log of this significant event where the learning outcome stated: 'keys are now locked away safely in key safe'

	when required'.
Patient physically abused two staff and damaged property.	The event was discussed at a practice meeting and is still open on the risk register. Minutes of meeting indicated that a risk assessment was carried.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: There was no documented policy but we saw that there was a process for sharing outcomes and learning with relevant staff members via email.	

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

Patients' needs were assessed, care and treatment was not 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.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Not inspected
There were 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
<p>Explanation of any answers and additional evidence:</p> <p>Due to there being a back log in scanning documentation in the patient record and there being no clinical oversight of the documents that had not been scanned, the practice had no assurance that patient needs were fully assessed. For example, we saw a hospital discharge letter that had not been scanned or seen by a GP, which requested that an urgent referral was made. The patient was seen by the practice after the document was received, but no referral had been made as the request had not been seen.</p>	

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) <small>(NHSBSA)</small>	0.22	0.68	0.81	Significant Variation (positive)

Older people

Population group rating: Inadequate

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 did not have a system to follow up on older patients discharged from hospital. It ensured that their prescriptions were updated to reflect any extra or changed needs, but this was not always the case for their care plans.

- 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: Inadequate

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.
- 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>	66.0%	71.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	7.8% (12)	12.9%	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>	61.6%	76.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.8% (15)	7.2%	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>	68.8%	74.4%	80.1%	No statistical variation
Exception rate (number of exceptions).	9.8% (15)	10.9%	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) <small>(QOF)</small>	80.9%	79.4%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.3% (3)	2.5%	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) <small>(QOF)</small>	100.0%	93.0%	89.7%	Variation (positive)
Exception rate (number of exceptions).	3.6% (1)	9.1%	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)	65.2%	79.9%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	5.4% (17)	3.8%	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)	87.5%	87.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	11.1% (1)	5.2%	6.7%	N/A

Families, children and young people

Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets and the practice did not have plans in place to help to increase this.
- 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 did not have arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- 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>	127	147	86.4%	Below 90% minimum (variation negative)
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>	115	143	80.4%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	119	143	83.2%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	123	143	86.0%	Below 90% minimum (variation negative)

Any additional evidence or comments

Practice staff told us that due to having a migrant population their immunisation rates were low as patients were having their immunisations abroad and not bringing the information to the practice. The practice was unable to demonstrate that any action had been taken to improve immunisation uptake.

Working age people (including those recently retired and students)

Population group rating: Inadequate

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) (01/04/2017 to 31/03/2018) (Public Health England)	69.8%	68.6%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	44.1%	61.0%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	43.5%	46.5%	54.5%	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. (01/04/2017 to 31/03/2018) (PHE)	33.3%	74.2%	70.3%	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)	50.0%	48.2%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The lead GP had begun making a vulnerable patient register, but this was not shared with staff members.
- 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: Inadequate

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 did not always effectively carry out risk assessments 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.
- The practice was unable to identify which staff members had received dementia training in the last 12 months.

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)	90.3%	90.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	11.4% (8)	5.6%	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)	89.7%	92.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (2)	4.2%	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)	77.8%	84.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	3.9%	6.6%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	505.4	519.9	537.5
Overall QOF exception reporting (all domains)	5.4%	5.5%	5.8%

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

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

We asked the practice for copies of all the audits that had been completed in the past two years. We were given one clinical audit based on the management of hepatitis B and one non-clinical audit based on the practice environment.

The clinical audits aim was to review how hepatitis B results are dealt with by the practice. The first audit cycle found that 161 patients were tested for hepatitis B during a six-month period. One hundred and twenty-one patients had a negative result (for surface antigen, core antibody), 28 patients tested positive for core antibody but negative for surface antigen. Three of the 28 were referred inappropriately. Twelve patients tested positively for both surface antigens and core antibodies, of this group eight were appropriately referred and four were awaiting referral.

Following this audit, a new protocol was designed and was discussed at a clinical meeting.

The second cycle of the audit found 51 patients had been tested for hepatitis B during a six-month period, 33 had a negative result, three had a negative hepatitis B result but positive hepatitis A result. Twelve patients tested positive for core antibodies all of which were referred, none of which was an inappropriate referral.

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.	Partial
There was an induction programme for new staff.	Partial
Induction 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.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<p>Explanation of any answers and additional evidence:</p> <p>Some staff we spoke with told us that they did not feel that they had sufficient knowledge, skills and experience to carry out their duties, we saw that staff highlighted their training needs during their appraisal, but subsequent training was not provided.</p> <p>There was an induction checklist, this was not role specific and was used for clinical and non-clinical staff and was not completed by all staff members. The provider was unaware that when recruiting GPs, they had to ensure they were on the NHS national performers list.</p> <p>Non-clinical staff members told us that they were not given protected time to complete training.</p> <p>Staff had access to training, but they were not given the opportunity to complete a self-assessment as part of this process. The appraisal was done with the provider who completed the form and staff members were not given a copy.</p> <p>Our inspection carried out in July 2018 found two significant events relating to the advance nurse practitioners prescribing, during this inspection we found that there were still no prescribing audits for the advanced nurse practitioner or documented supervision or support.</p> <p>The deputy practice manager was unaware of the steps that would need to be taken if a staff member displayed poor or variable performance.</p>	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Not inspected
<p>Explanation of any answers and additional evidence:</p> <p>Due to the backlog in scanning and notes summarising, the practice was not assured that the information that they passed on to other services regarding patients was the most up-to-date</p>	

Helping patients to live healthier lives

Staff were not 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Whilst patients in the last 12 months of their lives were directed to the relevant support services, there were few alerts on the practices clinical systems to highlight patients that required extra support. For example, we looked at a sample of vulnerable patient records and found there were no alerts on them.</p>	

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) <small>(QOF)</small>	97.1%	95.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.2% (8)	0.8%	0.8%	N/A

Consent to care and treatment

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

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

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was generally 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.	19
Number of CQC comments received which were positive about the service.	12
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	3

Source	Feedback
Patient	Stated that GPs don't always listen and the practice does not share information about changes to the practice.
Administration staff	Stated that patients were their priority.
CQC comment cards	A significant number of the comment cards received mentioned kind caring staff members, but some cards also mentioned difficulty in getting an appointment and bad staff attitude.

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
8165	422	65	15.4%	0.80%

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)	85.5%	82.8%	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)	78.7%	79.7%	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)	91.7%	92.9%	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)	78.1%	77.7%	83.8%	No statistical variation

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

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	Two patients told us that they felt rushed during their consultation, but felt that they were included in decisions made about their care. They also mentioned the lack of continuity of care.

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)	90.5%	90.2%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a dedicated website, there was a provider website which gave limited information about the practice, but not all patients were aware of this.</p>	

Carers	Narrative
Percentage and number of carers identified.	0.9% (58)
How the practice supported carers.	The practice offered carers an annual flu vaccination.
How the practice supported recently bereaved patients.	The practice offered these patients an appointment at a time suitable to them to discuss the support that was available to them.

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
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.	N/A
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: We saw that the practice had plans to employ two salaried GPs. However, patients told us there was a lack of continuity of care and the practice did not inform them when changes were being made to the service including when GPs were leaving.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Saturday	9am to 1pm
Appointments available:	
Monday	8am to 12:20pm and 2pm to 5:20pm
Tuesday	8am to 12:50pm and 2pm to 5:50pm
Wednesday	8am to 12:50pm and 2pm to 5:50pm
Thursday	8am to 12:20pm and 2:30pm to 5:50pm
Friday	8am to 12:40pm and 2pm to 5:20pm
Saturday	9am to 12:30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8165	422	65	15.4%	0.80%

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)	98.4%	92.3%	94.8%	No statistical variation

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.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Inadequate

Findings

- Patients with multiple conditions did not have 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: Inadequate

Findings

- Additional nurse appointments were available on a Saturday for school age children so that they did not need to miss school.
- We found there were no 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.
- Parents or guardians calling with concerns about a child were not always able to have 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 and flexible.
- The practice was open on Saturdays. 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. Appointments were available until 10pm on weekdays and on weekends.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The lead GP was developing a vulnerable patient register but had not shared it with staff members.
- 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.

**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 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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	N
<p>Explanation of any answers and additional evidence:</p> <p>We found that the practice did not always cover clinical sessions when there was advanced notice that the clinician would not be available and risk assessments were not carried out to mitigate the risks of not covering these appointments. For example the practice cancelled the SAS clinics for a five week period, they did not risk assess the effect of doing this, they did not look at the impact it would have on patients and they did not follow any procedures to report this action.</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)	84.2%	N/A	70.3%	No statistical variation
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)	71.2%	63.7%	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)	61.6%	65.2%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	68.3%	69.8%	74.4%	No statistical variation

Any additional evidence or comments

The practice demonstrated that they had increased the number of appointments they were providing and were providing more appointments than were required in their contract, which was an improvement on the

inspection in July 2018 where only 40% of the required appointments were being provided.

Source	Feedback
NHS Choices	The practice was rated 2.5 stars on NHS choices, there were mixed reviews ranging from great GPs and reception staff members to rude reception staff and GPs and difficulty getting an appointment.

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.	9 between July 2018 and present
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <p>The complaints policy we were shown did not instruct staff on how to make a complaint or state who the leads were, it was written as a procedure for patients follow when they wanted to complain. We saw no poster or info in the patient area advising patients of how to complain.</p> <p>We found that complaints were not always handled in a timely way, including patients having to contact the practice on more than one occasion requesting a response. We looked at minutes of practice meetings and saw that complaints were noted but there was not always learning as a result.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient upset at the frequency needed for a medicines check	All medicines checks to be carried out six monthly with the nurse.

Well-led

Rating: Inadequate

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, including a succession plan.	N
<p>Explanation of any answers and additional evidence:</p> <p>The provider was unable to demonstrate they had a sound understanding of the challenges to quality and sustainability as they were unable to effectively risk assess known current and future risks the practice faced. When risks were identified, the provider did not always acknowledge them or act on them in a timely way.</p> <p>Staff we spoke with told us that leaders were rarely visible in the practice stating that there were occasions when leaders did not visit the practice for weeks on end. We viewed the visitors log sheets which supported this.</p> <p>The deputy practice manager was promoted from a receptionist role, there was no development plan or formal training to support the transition into the role. We asked the provider for evidence of any training given and they were not able to provide any, we were told that training was informal with no documentation.</p>	

Vision and strategy

The practice had a clear 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.	Partial
There was a realistic strategy 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 provider had a vision to deliver quality care but no values to support this. the provider was unable to demonstrate that they had any documented strategies to achieve any priorities and priorities were not shared with practice staff members. Staff we spoke with were unable to describe the practices' vision and values.</p>	

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Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
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.	Partial
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
Explanation of any answers and additional evidence: The deputy practice manager who oversaw the day to day running of the practice was unaware of or supported on how to deal with behaviour issues. Some staff we spoke with were fearful about reporting concerns and noted negative experiences of when they had done so in the past. Some staff told us that they did not feel that their safety was a priority and gave the example of the special allocation scheme (SAS) where they had little training in how to deal with violent patients, and the security guard that was available on the days where SAS consultations were taking place was situated outside the consultation room and not in the reception area where administration staff would have immediate access to help if required.	

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

Source	Feedback
Staff members	Staff members told us that they did not feel supported by the provider, they were not adequately trained and did not have the resources to carry out the tasks required of them, stating that their requests for help were often ignored or they were made to do extra hours to make up for the lack of staff members.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, however not all of these were effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had put new governance structure in place. However, the new system was not effective and did not allow for the support that staff members required at the practice as management roles were regional and so senior managers spent limited time at the practice premises and the practice did not have a dedicated practice manager. Staff we spoke with were not always clear on who held which lead roles or who to contact if they required help.</p> <p>Some staff we spoke with were unclear of the responsibilities of their roles and felt they were being asked to complete tasks without training to be able to do so efficiently.</p>	

Managing risks, issues and performance

There were not clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Not inspected
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Partial
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>The practice told us they had a process to manage performance, but we were given examples of what providers described as poor performance, but this was not addressed. The deputy practice manager was unaware of any processes to manage performance.</p> <p>When risks were identified they were not fully risk assessed or monitored and there were examples of risks being brought to the providers attention and no action being taken leading to significant events which were not recorded.</p> <p>There was a major incident plan but not all staff members were able to access it.</p> <p>Staff members told us that when changes were made they were not always informed and we saw that the impact on changes was not monitored.</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.	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>With the exception of QOF, the practice was unable to demonstrate how they monitored performance.</p> <p>Due to the lack of scanning and summarising the practice was unable to demonstrate that they were acting on information that was valid and accurate and we saw examples of this being the case.</p> <p>Risk assessments were not detailed enough and did not take into account all the risks associated with a given situation, and the practice did not monitor and update their risk register. For example, the lack of summarising was on the practice's risk register. However, this did not take into account that there would be a delay in newly registered patients records being summarised, or how diverting staff workload would lead not document scanning not taking place. This register was not monitored and updated according to any progress or delay in progress made.</p> <p>The deputy practice manager was unaware of how to make statutory notifications and we saw an example of when a notification was not made.</p>	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with told us that their views were not taken into account or reflected in the service when given.</p>	

Feedback from Patient Participation Group.

Feedback

The patient participation group told us they were not provided with minutes from the meetings and changes made to the practice was poorly communicated.

Any additional evidence

Some staff we spoke with told us they did not feel supported by the provider, explaining that there was a lack of communication and mentioned a bullying atmosphere.

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: There was little attention paid to continuous learning and development, the practice did not keep a training matrix and was unable to demonstrate who had completed what training including mandatory training. We asked for a record of all training to be sent to us post inspection and this was not provided. We saw that whilst practice meetings did take place there was little learning that was shared as a result.	

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.
- 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 uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG 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.