

# Care Quality Commission

## Inspection Evidence Table

**Dr Christopher John George Wright (1-506336798)**

Inspection date: 13 February 2019

Date of data download: 30 January 2019

## Overall rating: Inadequate

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

## Safe

## Rating: Inadequate

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

- The practice did not have appropriate systems in place for the safe management of medicines as there was no effective system in place to ensure prescriptions were securely stored and their use monitored and patients taking high risk medicines were not consistently being monitored in line with current guidance and legislation. The provider submitted details of an action plan to address concerns around high risk drug monitoring after our inspection.
- There were no systems in place to monitor indemnity arrangements or the professional registrations of clinical staff.
- Staff had not all completed safeguarding, fire and infection control training.
- Safeguarding arrangements and the mechanisms for reporting significant events were not clear.
- The practice did not have a GTN spray within their emergency medicine storage. The practice told us that they had purchased this medicine after our inspection.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding.	Partial
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	N

Safeguarding	Y/N/Partial
Policies were accessible to all staff.	Partial
The lead GP 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.	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Three members of non-clinical staff spoken to were not sure who the practice safeguarding lead was. The identity of the lead was not documented in any of the safeguarding policies we reviewed.</p> <p>There were a number of safeguarding policies in the practice and it was not clear which policy the practice was currently using.</p> <p>There was no centralised oversight of staff training including safeguarding training. The practice was unable to confirm on the day of the inspection that all staff had completed safeguarding training to the appropriate level. Evidence was provided after our inspection which indicated that all staff whose files we reviewed, with the exception of the healthcare assistant, had completed the appropriate level of safeguarding training prior to our inspection. The healthcare assistant completed this training after our inspection.</p> <p>We reviewed the files of five staff members. Four of these staff members had been employed prior to 2014. All four staff members had DBS checks completed in 2014 but no subsequent checks had been completed for these members of staff and no policy which detailed how often checks should be conducted.</p> <p>We were told that regular meetings were scheduled with the health visitor team but were rarely attended by health visitors. We saw minutes of meetings from multidisciplinary team meetings to show that the practice had attempted to hold engagement meetings with these services. Staff told us that they had access to contact information for the health visiting team and health visitors were located in the attached health centre.</p>	

Recruitment systems	Y/N/Partial
---------------------	-------------

Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Staff had any necessary medical indemnity insurance.	N
Explanation of any answers and additional evidence:	
<p>There was no system in place to monitor the professional registrations for clinical staff employed at the service and ensure that these were up to date. Staff told us that they knew the professional registration of the lead GP was valid as they had paid their annual retention fee. Staff could not confirm that the practice nurse or the locum GP employed at the service were currently registered with their professional bodies.</p> <p>There were no systems in place to oversee the medical indemnity arrangements for clinical staff including for the long-term locum and the practice nurse. We were told by staff at the surgery that each clinician was responsible for their own medical indemnity arrangements and confirmed that there was no system in place to ensure that all clinical staff were indemnified. We were provided with confirmation that the healthcare assistant was a member of the Royal College of Nursing. However, the information detailed in the confirmation of membership letter indicated that the healthcare assistant would not be entitled to cover as she was employed directly by the practice. The practice provided evidence after our inspection that they had obtained medical indemnity insurance for the healthcare assistant and that all other staff had appropriate insurance in place.</p> <p>The staff whose files we reviewed had received the required immunisations but there was no record of this in their personnel files. The practice pulled this information from staff member's clinical records.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 2/8/18	Y
There was a record of equipment calibration. Date of last calibration: 2/8/18	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 17/1/19	Y
There was a log of fire drills. Date of last drill: 7/3/18	Y
There was a record of fire alarm checks. Date of last check: tested weekly and system checked 8/10/18	Y

There was a record of fire training for staff. Date of last training: Various	N
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: October 2018	Y
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence:  Not all staff whose files we reviewed had completed fire safety training.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Disability access audit Date of last assessment: October 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2018	Y
Explanation of any answers and additional evidence:	

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met but not all staff had completed infection control training.**

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control. Date of last infection prevention and control audit: February 2019	N Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:  Staff spoken to during the inspection were unclear on who acted as the infection control lead. The practice nurse told us that their responsibilities around infection control had not been clearly outlined. There was a lack of oversight of staff infection control training and some staff had no record of infection control training. The infection control lead was not designated in the practice policy and the CCG infection control lead named in the policy was not correct.  The practice had completed an infection control audit in February 2019. There were a number of issues identified as requiring action including that a number of staff had not completed infection control updates.	

--

## 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
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 impact on safety.	Y
Explanation of any answers and additional evidence:	
<p>Although all staff we spoke with on the day of the inspection said that the service would benefit from having additional GPs on site, there was nothing to suggest that limited clinical staffing impacted on the safety of patients. Although some patients raised concerns around access, no patient raised any issues about staffing impacting on the safety of the service. A review of the appointment systems indicated that an emergency appointment was available the day of the inspection and that a routine appointment was available 25 February 2019</p>	

## 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.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
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.	Partial
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.	N
<p>Explanation of any answers and additional evidence:</p> <p>From reviewing the records of patients who had required regular blood monitoring and from discussions with staff; we found that there was a lack of formal processes for reviewing patients prescribed high risk medicines and that there were no shared care agreements in place for the patients who were being monitored in secondary care. We reviewed the record of three patients prescribed high risk medicines whose care records indicated that they were either not having regular monitoring in accordance with recommended guidance or that the practice was not ensuring that monitoring was being completed by a secondary care service prior to prescribing these medicines.</p> <p>We reviewed records of other patients on high risk medication including lithium, methotrexate and azathioprine. Although their blood monitoring did seem up-to-date this there was no clear process in place to ensure that the prescriber checked the blood results before issuing a prescription and there was no evidence that they were doing so. The presence or absence of such blood results would not have been easily accessible to the prescribing doctor and in several cases, there was no evidence the results had been consulted before issuing the prescription for the drugs.</p> <p>The provider submitted a response after our inspection in response to the warning notice issued. The provider confirmed that they would implement a system of six monthly medication reviews and three monthly monitoring, In addition the provider told us that they intended to implement a system of audit so that they could check that monitoring was being completed as required.</p> <p>From discussions with clinical staff we found that there was a lack of formal systems in place for sharing information with other services. For example, there was no system in place to highlight vulnerable children to out of hours services. We were told that this was done on an ad-hoc basis and that there had been difficulty engaging other services in structure multidisciplinary working. Staff were not completing care plans for patients other than the ones required as part of QOF or other incentive schemes. We were told by staff that they did not have time to complete care plans for patients.</p> <p>Staff confirmed there was no failsafe log in place to monitor two-week wait referrals.</p>	

### Appropriate and safe use of medicines

**The practice did not have systems for the appropriate and safe use of medicines,**

## including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>NHS Business Service Authority - NHSBSA</small>	0.94	0.62	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) <small>(NHSBSA)</small>	9.5%	8.7%	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.	N
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures 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

Medicines management	Y/N/Partial
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.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems 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>The practice did not have effective systems in place to securely store and monitor the usage of prescriptions. We saw that boxes and pads of printer and controlled drug prescriptions were stored in a locked room. However, this room was accessible to contract cleaning staff. Staff confirmed that printer prescriptions were not locked away at the end of each day. Although the rooms were lockable they were accessible to contract cleaning staff. We saw that there was a log of controlled drug prescriptions once the box were opened but there was no log of the number of boxes of these prescriptions or printer prescriptions. We were told after the inspection that the practice had placed a lockable cabinet in the prescription storage room and ensured that the key for this cabinet was inaccessible to cleaning staff.</p> <p>The concerns raised from reviewing the prescribing of high risk medicines in the practice showed that the systems for managing repeat issues of these medicines were not safe. The provider submitted a response after our inspection in response to the warning notice issued which detailed actions taken to ensure that regular monitoring of patients on high risk medicines would be completed going forward.</p> <p>We reviewed the practice's supply of emergency medicines and found that there was no GTN spray (a medicine used to treat cardiac pain) held or Glucagon or Glucogel (to treat low blood sugar levels). There was no risk assessment in place to consider the need for or justify the absence of these medicines. The practice nurse confirmed that staff would give hypoglycaemic patients sweets as an alternative which would not have been appropriate in an emergency. The practice told us after our inspection that they had purchased Glucagon and a GTN spray after our inspection.</p>	

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

**The practice learned and made improvements when things went wrong but there was a lack of awareness among staff of the practice's significant event processes.**

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.	N
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and	N



externally.	
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	2
Number of events that required action:	2
Explanation of any answers and additional evidence:	
<p>The practice did not have effective systems in place to monitor the prescribing of high risk medicines appropriately.</p> <p>We spoke with two members of staff who were not familiar with the practice's significant event process and neither staff could provide an example of a significant event and Were not able to explain the criteria for identifying such an event.</p>	

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

Event	Specific action taken
Needlestick injury	A member of staff accepted a sharp's box from a patient which was overflowing. The member of staff was injured and the practice followed their needlestick injury policy. Practice policy reiterated to staff, confirmed that practice nurse was the only staff member to accept patient sharps boxes.
Boiler Failure	Practice purchased heaters in response and ensure appropriate signage was available to prevent patients/children injuring themselves on the heaters.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
<p>The practice manager confirmed that they cascaded patient safety alerts by email. These were then printed and kept in a folder in the practice. There was nothing to document the action taken in response to safety alerts. We reviewed two safety alerts. For an alert related to sodium valproate we saw entries in the clinical systems which implied discussion about the implications of the risk associated with taking sodium valproate during pregnancy, including reference to the patient's preferred method of contraception, though the entries for two patients did not explicitly state that risks had been discussed.</p>	

## Effective

## Rating: Inadequate

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

- There was an absence of care planning for staff.
- The practice did not have systems to review and monitor the quality of care provided by locum staff and not all staff were being regularly appraised.
- Staff had not all completed required training.
- Performance indicators for patients with COPD, dementia, childhood immunisation and bowel screening were below the local and national averages. However, the practice had taken action in response to some of this data and unverified data for 2018/19 indicated improving performance in these areas.
- The practice did not always undertake effective joint working with other organisations.

### Effective needs assessment, care and treatment

**Patients' needs were not consistently assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
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
Explanation of any answers and additional evidence:	
There was an absence of formal care planning for patients aside from those that required completion as part of local and national target initiatives. We were told by staff that they did not have time to complete care planning for patients.	
The practice's lack of effective oversight of patients prescribed high risk medicines demonstrated that patients were either not consistently having their treatment reviewed regularly or receiving assurance that reviews were regularly occurring. The provider submitted a response after our inspection in response to the warning notice issued which detailed actions taken to ensure that regular monitoring of	

patients on high risk medicines would be completed going forward.

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>	1.17	0.45	0.81	No statistical variation

## Older people

## Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services and the effectiveness of care for people with longer term conditions, families children and young people and people experiencing poor mental health. However, this population group was rated as requires improvement for providing effective services because the concerns regarding training, oversight of staff performance and lack of effective joint working arrangements impacted all population groups.

- There were no formal processes in place or tools used to identify older patients who were living with moderate or severe frailty.
- There were no formal systems in place within the practice to follow up on older patients discharged from hospital. However, we were told that all correspondence from secondary care was reviewed by the lead GP who would ensure changes were made to medicines where necessary.
- The practice provided Local Care Co-ordination (LCC) assessments for older patients. The practice had surpassed all targets set for these assessments in 2017/18 except for one target related to case reviews where they were one patient short of meeting their target.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

- QOF data from 2017/18 indicated that the number of patients with COPD who had received an annual review was lower than the local and national average.
- Patients with long-term conditions who were being prescribed high risk medicines did not all have 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 tailored package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

- There were no formal systems for GPs to follow up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- 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>	65.8%	74.8%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.7% (29)	10.0%	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>	78.7%	75.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	5.2% (13)	7.7%	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>	74.2%	78.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	10.9% (27)	10.0%	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>	71.2%	78.5%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.8% (4)	2.3%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an	63.4%	92.1%	89.7%	Significant Variation (negative)

assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	6.8% (3)	5.8%	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)	80.8%	80.5%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.8% (17)	4.1%	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)	81.8%	88.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.3% (2)	7.4%	6.7%	N/A

#### Any additional evidence or comments

We were provided with unverified data for QOF year 2018/19 (April 2018 to 31 March 2019) which indicated that, year to date, the practice had increased the percentage of patients with COPD who had received a review in the last 12 months to 79% through more proactive recalling by the practice nurse.

#### Families, children and young people

#### Population group rating: Inadequate

- .

#### Findings

- Childhood immunisation uptake rates were below 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 no formal arrangements for following up failed attendance of children's appointments following an appointment in secondary care. If children failed to attend the practice for immunisations the practice nurse would contact the patient's guardian by phone and issue a letter if they could not reach them. Health visitors would be contacted where necessary.
- Young people could be referred to local services for sexual health screening and contraception methods not provided by the practice.

- The practice, in association with three other practices, hosted consultant led clinics for children with asthma, eczema, constipation, epilepsy and general paediatric conditions. The lead GP also attends the clinics. Clinics occur monthly at one of the participating practices and patients from these surgeries could be booked into the clinic held at any of the three participating practices.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	57	64	89.1%	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) (NHS England)	53	63	84.1%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	54	63	85.7%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	53	63	84.1%	Below 90% minimum (variation negative)

#### Any additional evidence or comments

We spoke with the practice nurse who was not aware that the practice was currently below target for childhood immunisations. The practice was unable to source contemporaneous data for childhood immunisations. The practice nurse told us that there were a number of reasons that the practice found it difficult to immunise more children on their list. We were told that there were a number of children whose families refused and that the practice's annual turnover was approximately 20%. We were told that the practice was now receiving support from someone from their GP federation who would assist with coding and recalls.

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

**Population group rating: Requires Improvement**

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services and the effectiveness of care for people with longer term conditions, families children and young people and people experiencing poor mental health. However, this population group was rated as requires improvement for providing effective services because the concerns regarding training, oversight of staff performance and lack of effective joint working arrangements impacted all population groups.

## Findings

- 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)	66.6%	66.4%	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)	62.9%	62.4%	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)	41.6%	42.6%	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)	88.9%	77.3%	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)	88.9%	52.5%	51.9%	No statistical variation

## Any additional evidence or comments

The practice told us that one of the priorities within the CCG was to improve the uptake of bowel screening. The practice said that the IT support from the federation would be focusing on contacting patients to encourage them to have bowel screening.

**People whose circumstances make them vulnerable**

**Population group rating: Requires Improvement**

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services and the effectiveness of care for people with longer term conditions, families children and young people and people experiencing poor mental health. However, this population group was rated as requires improvement for providing effective services because the concerns regarding training, oversight of staff performance and lack of effective joint working arrangements impacted all population groups.

**Findings**

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice would vaccinate 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 signposting to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients suffering from poor mental health could be referred to local talking therapy services. The practice hosted a counsellor who offered cognitive behavioural therapy or counselling to patients in the local area.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and	88.6%	92.5%	89.5%	No statistical variation



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)				
Exception rate (number of exceptions).	5.4% (4)	5.7%	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)	76.4%	90.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (2)	5.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	0.0%	82.4%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	0 (0)	4.2%	6.6%	N/A

#### Any additional evidence or comments

The practice attributed last year's QOF figures for the face to face care plan review for patients with dementia indicator to a coding issue. The practice was receiving support from the federation to ensure that they were coding patients correctly.

#### Monitoring care and treatment

The practice had undertaken some quality improvement activity aimed at reviewing the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	449.5	540.5	537.5
Overall QOF exception reporting (all domains)	5.0%	5.0%	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 saw that the practice had completed a two-cycle audit which reviewed antibiotic prescribing in relation to urinary tract infections. We saw that in the first cycle of 22 patients reviewed the practice had complied with the Public Health England UTI diagnostic guide in 79.5% of cases and had complied with PHE antibiotic care guidance in 90.9% of cases. The actions from the audit were to Review correct use of use of urine dipsticks and improve the recording of symptoms. The second cycle showed that the compliance with diagnostic guide was 78% and the antibiotic care guidance was 91%.

The lead GP undertook a review of all patients from the last two years with raised platelet counts after attending a course which highlighted that raised platelet counts could be indicative of cancer.

The search revealed 17 patients who had had raised platelet levels measured over the previous two years. Of these two were known to have tumours, two were discounted as they were young children, two patients had chronic inflammatory disorders to account for the raised level, one was postoperative following myomectomy and four had subsequently had the blood test repeated with normal platelet levels. The remaining six patients were phoned on contacted and asked to have a blood test. Those who could not be contacted by phone were sent letters. As at November 2017. three patients had not responded, two had normal levels of platelets on repeat testing and one had had an increased level and was asked to make an appointment for review. One patient was referred on a two week wait and another patient required further investigation. The practice did an audit to assess the impact of a protected learning event on the uptake of HIV testing. Six months prior to the event 12 patients had received an HIV test and in the six months after the event 17 patients had been tested.

**Any additional evidence or comments**

**Effective staffing**

**The practice was unable to demonstrate that staff had all the necessary 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.	N
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.	Y
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	N

advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
Explanation of any answers and additional evidence:	
<p>The nurse had not completed a cervical screening update course since March 2015 but they were booked to attend an update on 5 March 2019. We were told that the nurse had not had adequate free time to complete this course sooner.</p> <p>Not all staff whose files were reviewed had completed the required mandatory training including safeguarding, infection control, fire and information governance. Some of this training was completed after our inspection.</p> <p>Not all staff whose files we reviewed had received an appraisal within the last 12 months.</p> <p>We were told that the practice frequently employed locum staff but that there were no systems in place to oversee the work undertaken by new locums employed at the service. The practice had one regular locum GP employed but there were no systems to formally oversee their work except for a periodic review of their referrals which the practice was required to do as part of a CCG initiative.</p>	

## Coordinating care and treatment

### Staff did not consistently work 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)	Partial
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.	N
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence:	
<p>We saw minutes from multidisciplinary team meetings where the care of vulnerable patients, including those on the palliative care register were discussed. Although the health visitors were invited we were told that they do not attend these meetings but that district nurses attended on occasion. We were informed that information sharing between the practice and the health visitor team would occur on an ad hoc basis.</p>	

The lack of formalised shared care arrangements for patients prescribed high risk medicines and the lack of information which confirmed monitoring was occurring either at the practice or in secondary care showed that there was a lack of effective working between the surgery and other services where care was being delivered jointly.

## Helping patients to live healthier lives

### Staff were supported patients to live healthier lives.

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	91.8%	95.0%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.8% (6)	0.7%	0.8%	N/A

### Any additional evidence or comments

--

## Consent to care and treatment

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

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

# Caring

# Rating: Good

## Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	39
Number of CQC comments received which were positive about the service.	28
Number of comments cards received which were mixed about the service.	10
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Patient interview	The patient we spoke with was exclusively positive in their comments about the kindness and compassion displayed by staff at the service.
Comment cards	The feedback from patients about the kindness and compassion displayed by staff at the service was wholly positive except for one comment card which said that members of the reception team could be rude.
NHS choices	The practice had only received three reviews on NHS choices. Two of the reviews were positive about the care received by the treatment provided by the nurse and GP. The other comment referred to a GP at the service was under pressure and rude.

## 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	Surveys sent out	Surveys returned	Survey Response	% of practice
----------	------------------	------------------	-----------------	---------------

population size			rate%	population
4570	418	92	22%	2.01%

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)	90.1%	88.6%	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)	87.3%	86.5%	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)	96.1%	94.1%	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)	86.2%	83.8%	83.8%	No statistical variation

#### Any additional evidence or comments

The practice had two members of staff nominated for local awards. One member of staff won an award for going the extra mile. Staff were actively involved in helping patients by providing them with food bank vouchers, assisting them to access local support services and hosting Christmas parties for patients who were older or faced social isolation.

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

#### Any additional evidence

The practice's internal survey focused on the content of the practice leaflet and patient awareness of online services. The responses indicated patients did want the leaflet to change and that they were aware of online services. Patients could provide free text feedback and one patient feedback about issues around access, one patient said that they wanted more information about local support service and another provide positive feedback about the care provided by the surgery.

#### 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 patient.	We received only positive feedback from the patient we spoke with about the level of their involvement with decisions about their care and treatment
CQC comment cards	Feedback from CQC comment cards about involvement with patient care and treatment was exclusively positive.

## 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)	91.6%	92.3%	93.5%	No statistical variation

## Any additional evidence or comments

N/A

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y



Explanation of any answers and additional evidence:

Carers	Narrative
Percentage and number of carers identified.	96 – 2.1%
How the practice supported carers.	The practice directed carers to local support organisations and a designated member of staff could speak with carers and direct them to various avenues of support.
How the practice supported recently bereaved patients.	The practice would contact patients who they knew were bereaved and offer them an appointment if necessary. Patients would also be directed to the local bereavement counselling and support service.

### Privacy and dignity

#### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

## Responsive

## Rating: Requires Improvement

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

- Patients did not have regular access to a female GP at the practice.
- The compliant policy was not immediately accessible to patients and policy staff provided to patients was out of date.
- Some patients feedback that care and treatment was difficult to access. The practice had not undertaken any action in response to below average national patient survey results around access.

### Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However, patients who wanted to see a female GP would often need to seek treatment at the local extended access services.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	N
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	
<p>The practice did not employ a female GP. We were told that female locum GPs would be booked occasionally, where possible, but that if patients asked to see a female doctor the practice would arrange for them to be seen at the local extended access hub.</p> <p>The practice was accessible through two electric doors. The inner door was broken. We were told that patients who had accessibility needs could alert reception if they needed assistance using an intercom at the front of the building.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00 am – 6.30 pm
Tuesday	8.00 am – 6.30 pm

Wednesday	8.00 am – 7.45 pm
Thursday	8.00 am – 6.30 pm
Friday	8.00 am – 6.30 pm
Appointments available:	
Monday	8.00 am – 11.50 am then 2.30 pm – 6.00 pm
Tuesday	8.00 am – 11.50 am then 2.00 pm – 2.00 pm – 4.00 pm and 5.00 pm to 6.00 pm or 3.30 pm to 6.00 pm
Wednesday	8.00 am – 11.50 am then 2.30 pm – 7.45 pm
Thursday	8.00 am – 11.50 am then 2.30 pm – 6.00 pm
Friday	8.00 am – 11.50 am then 2.30 pm – 6.00 pm

#### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4570	418	92	22%	2.01%

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)	90.5%	94.1%	94.8%	No statistical variation

#### Any additional evidence or comments

--

#### Older people

#### Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement for responsive because of the concerns regarding access and lack of action taken in response to below average patient survey scores, issues around the complaints process and the lack of access to a female GP. These concerns impacted all population group.

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent

appointments for those with enhanced needs and complex medical issues.

- The practice held annual Christmas parties which was targeted at older patients at the surgery particularly those who were recently bereaved or socially isolated.

### People with long-term conditions

### Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement for responsive because of the concerns regarding access and lack of action taken in response to below average patient survey scores, issues around the complaints process and the lack of access to a female GP. These concerns impacted all population group.

### Findings

- The practice liaised regularly with the local district nursing team and community matrons on an ad hoc basis 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.
- The practice provided in house phlebotomy for patients who did not wish or were unable to travel to the local hospital for this service.

### Families, children and young people

### Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement for responsive because of the concerns regarding access and lack of action taken in response to below average patient survey scores, issues around the complaints process and the lack of access to a female GP. These concerns impacted all population group.

### Findings

- Additional nurse appointments were available until 7.20 pm on a Wednesday 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.
- 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: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led

services. However, the population groups were rated as requires improvement for responsive because of the concerns regarding access and lack of action taken in response to below average patient survey scores, issues around the complaints process and the lack of access to a female GP. These concerns impacted all population group.

## Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7.45 pm on a Wednesday. 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 from this service between 8 am and 8 pm Monday to Friday.

### People whose circumstances make them vulnerable

### Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement for responsive because of the concerns regarding access and lack of action taken in response to below average patient survey scores, issues around the complaints process and the lack of access to a female GP. These concerns impacted all population group.

## 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 temporarily register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability for example the practice used leaflets with pictures to explain the service to patients.
- The practice healthcare assistant/reception manager provided patients in need with foodbank vouchers.

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

### Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement for responsive because of the concerns regarding access and lack of action taken in response to below average patient survey scores, issues around the complaints process and the lack of access to a female GP. These concerns impacted all population group.

## 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

**Feedback indicated that some patients found it difficult to access care and treatment in a timely way.**

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	61.9%	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)	59.2%	71.0%	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)	53.6%	67.8%	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)	78.4%	73.2%	74.4%	No statistical variation

### Any additional evidence or comments

The practice could not outline any action taken in response to this feedback.

On the day of the inspection we reviewed the practice's appointment diary. we saw that there was an emergency appointment still available on the day of our inspection and a pre- bookable routine appointment available on 25 February 2019.

All staff we spoke with said that there was a shortage of clinicians, particularly GPs and that this had been a challenge to delivering sufficient GP appointments. The practice told us that they had posted adverts and applied to NHS England's returning doctor scheme in an effort to recruit a salaried GP but had been unsuccessful.

Source	Feedback
Comment cards	28 of the comment cards received did not mention concerns around access. 10 of the comment cards mentioned that access was an issue of concern.
PPG representative	The member of the PPG that we spoke with told us that they had no concerns about access and that they always booked their appointments in person.

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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.	Y
Explanation of any answers and additional evidence:	
The practice's complaint policy was not immediately accessible in the patient waiting area. Staff informed us that patients would request the complaint procedure from the reception team. The policy in place at reception was dated October 2013 although we were provided with a more up to date version of the policy from 2017 during the inspection.	

Examples of learning from complaints.

Complaint	Specific action taken
Patient complaint about GP manner	Patient apology given and GP reflected on incident that led to complaint.
Patient complaint about delay in receiving result	Practice acknowledged fault in this regard and reiterated process for management of results to staff to ensure that similar delays didn't occur in the future.



## Well-led

## Rating: Inadequate

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

- There was a lack of future planning to ensure sustainability of the services.
- Governance was lacking in key areas including safeguarding, significant event management and the management of medicines which meant that key areas of risk had not been adequately assessed or addressed.
- There was limited action taken in response to below average feedback and limited evidence of continuous improvement or innovation.

### Leadership capacity and capability

Leaders were aware of the challenges the practice faced. However, lack of future planning and limitations of staffing had the potential to impact on the sustainability of the service.

	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.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	
<p>Staff could outline the challenges faced by the service. For example, the practice was aware that the lack of permanent salaried GPs was issue of concern. The practice was actively trying to recruit for salaried GPs. A neighbouring surgery near the practice had recently closed. The practice had absorbed 400 new patients from this service. Staff outlined the challenges that this presented, for example we were told that a significant proportion of these patients had long term conditions and that there had been considerable strain placed on the practice in trying to ensure that the care of these patients was optimised. The practice told us that they had an annual turnover of 20% of patients because the service was in an area of London with a highly mobile population.</p> <p>The practice had a low turnover of staff. However, several key staff members indicated the possibility of potentially retiring. There were no clear plans in place to ensure continuity of the service was sustained if these members of staff retired.</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.	N
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>It was evident that from discussions with staff and feedback from patients that the practice was caring and supportive of a patient's health and social needs. However, there was a lack of a clear strategy for the practice and the lack of available time due to insufficient clinical staff limited the ability of clinical leadership to focus on this area.</p> <p>We were told that staff did not have time to engage with new care initiatives in the local area and undertake care planning for patients.</p>	

**Culture**

**The practice had a culture that was caring but some staff said they felt at times they were not adequately supported. Staff lacked awareness of the practice's significant event processes or whistleblowing policy which limited the practice's ability to be open.**

	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.	Partial
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 had knowledge of the duty of candour. Although no events required compliance with the duty we saw that the practice was open and honest with patients when things went wrong. However, compliance with duty could have been potentially hindered as staff were not aware of the practice's significant event processes.</p>	

Although all staff said that they enjoyed working at the practice, found the working environment pleasant and the ethos of the practice very caring; some staff told us that at times they did not feel adequately supported when they raised concerns about challenges they faced.

Not all staff were aware of the practice's whistleblowing procedures.

## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
Explanation of any answers and additional evidence:	
<p>Staff we spoke to were not clear about leadership roles within the practice for example in respect of safeguarding and infection control and some processes that staff were unclear about; including the management of significant events. The practice's policy framework was unclear. All policies were accessible to staff in the practice staff room. There were a number of policies in place covering the same area. Some of these policies were out of date and some did not contain accurate or necessary information. There was a lack of effective oversight in several key areas including staff monitoring, training, two-week wait referrals and prescription usage and the prescribing of high risk medicines. The provider submitted a response after our inspection in response to the warning notice issued which detailed actions taken to ensure that regular monitoring of patients on high risk medicines would be completed going forward.</p> <p>Some staff we spoke with generally referred to a lack of clear governance and lines of responsibility which resulted either in delays to action being taken or a lack of action being taken when issues or suggestions were raised.</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 which were regularly reviewed and improved.	Partial
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y

Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
<p>The majority of risks associated with the premises were well managed yet there was a lack of effective systems in place to mitigate risks to patients. For example, there was no effective system in place to ensure high risk medicines were monitored in accordance with current guidance and best practice. The provider submitted a response after our inspection in response to the warning notice issued which detailed actions taken to ensure that regular monitoring of patients on high risk medicines would be completed going forward.</p> <p>The practice had undertaken a staffing risk assessment. However, there were limited plans in place for succession which presented a potential risk to the future sustainability of the service. The lack of oversight of training, professional registrations, prescriptions and medical indemnity arrangements for staff; may have potentially resulted in risks or concerns not being identified or addressed.</p>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>The lack of assessment of clinical work undertaken by locum staff and the lack of structured regular performance reviews for all staff limited the practice's ability to hold staff to account.</p> <p>Staff were not all aware that the practice had not met WHO childhood immunisation targets and they had not identified prior to the end of 2017/18 that they had not completed dementia care plans for any patients in that year. Although there were areas of where performance was below local and national averages the service had not undertaken any assessment or audit with a view to improving quality in these areas.</p>	

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

#### There was limited involvement of the public, staff and external partners in planning the way the service delivered care and treatment.

	Y/N/Partial

Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The most recent patient survey indicated concerns around access at the surgery. The practice had not put any actions in place in response to these results. The practice's own internal survey did not cover issues around access.</p> <p>Some staff we spoke with said that they could raise ideas to improve the service and that these would be acted upon. Other staff told us that the organisation would not act on staff feedback or delay in taking action in response to their feedback.</p>	

#### Feedback from Patient Participation Group.

Feedback
<p>We spoke with one member of the practice's patient participation group (PPG). The PPG member told us that they met every two to three months. They told us that they were still in the process of creating a more formalised structure with assigned roles and a clear remit. We were told that the practice would raise issues that impacted on patients and sought advice from the PPG on what action should be taken. For example, the practice had discussed with the PPG how to reduce the number of patients who failed to attend for their appointments. We were told that the practice had initiated a text reminder service. The practice had also consulted the PPG on the purchase of a wheelchair for the surgery. We were told that the practice had discussed initiatives to reduce unnecessary prescribing and that members of the PPG had helped the practice in their effort to reduce unnecessary prescribing by getting them to hand out leaflets to patients about prescribing.</p>

Any additional evidence

#### 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:	
<p>There was little evidence of continuous improvement, learning and innovation. Staff at the practice told us that they did not have time to engage with new initiatives.</p>	

--

<b>Examples of continuous learning and improvement</b>
--------------------------------------------------------

N/A
-----

## 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.