

Care Quality Commission

Inspection Evidence Table

Steeple Bumpstead Surgery (1-1951605021)

Inspection date: 26th February 2019

Date of data download: 07 February 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

We rated the practice as inadequate for providing safe services. This was because checks of premises and equipment were not reliable and prescriptions and medicines were not held securely. Whilst there was a reliance on clinical locum staff, there was not a consistent and safe approach to managing absences of these clinicians. Locum staff were not provided with support or supervision.

There had not been a multi-disciplinary meeting involving other healthcare professionals since September 2018, despite this being identified as a required action following concerns raised at the end of 2019.

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Partial
There were systems to identify vulnerable patients on record.	Y

Safeguarding	Y/N/Partial
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N
<p>Explanation of any answers and additional evidence:</p> <p>The child safeguarding policy had been ratified by the provider's head of safeguarding. Staff that we spoke with knew where to find policies and who they would contact if they had any concerns.</p> <p>The Safeguarding Adults' policy had been reviewed in 2018 by the Quality and Safety team. Whilst this did not identify a lead member of staff for adult safeguarding, it provided an email address to copy safeguarding alerts to. The provider informed us that they had identified and assessed this as the most effective means of raising safeguarding concerns.</p> <p>We found no evidence of active and appropriate engagement in local safeguarding processes. Whilst safeguarding was a standing matter at the weekly practice meeting, we saw no evidence of safeguarding concerns being raised, shared or discussed externally as there had been no meetings with other healthcare providers to discuss patients of concern since September 2018. There had not been a practice meeting since January 2019.</p> <p>After the inspection, the provider informed us that the Advanced Nurse Practitioner attended childrens' safeguarding conferences as these arose and that monthly reports were prepared and made available for the providers' Strategic Safeguarding Group.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
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.	Y
Staff had any necessary medical indemnity insurance.	Y

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:	Partial
There was a record of equipment calibration. Date of last calibration:	Y 28.11.2018
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:	Partial
There was a log of fire drills. Date of last drill:	N
There was a record of fire alarm checks. Date of last check:	Y 30.10.18
There was a record of fire training for staff. Date of last training:	Y Various
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y December 2018
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>PAT testing had not been completed for all relevant equipment. After the inspection, the practice confirmed that testing had taken place.</p> <p>The fire risk assessment indicated that all fire extinguishers had been maintained. We were told these had all been replaced in the last year. However, we identified a fire extinguisher that had not received an annual service. The practice advised us after the inspection that this issue had been resolved.</p> <p>We were advised that fire marshals were appointed but one out of the two fire marshals had not received fire marshal training. The fire risk assessment incorrectly stated that all fire marshals had been trained.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y 13.02.2019
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 13.02.2019

Explanation of any answers and additional evidence:

A legionnaires risk assessment had been completed on 23.11.2016. It was noted that this should be reviewed before 24.11.2017. There was no evidence that this had been reviewed, nor had the risk assessment been updated to reflect whether the 12 high risk actions, four moderate actions and five low-risk actions identified as part of the risk assessment had been completed.

There had been no fixed wire testing completed in the last 5 years. After the inspection, the practice sent us evidence that this had been completed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	09.01.2019
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: On-site infection control training had been provided on 13.02.2019.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems 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.	Partial
Explanation of any answers and additional evidence: The practice relied on locum GPs, locum dispensary staff and a locum advanced nurse practitioner. They had secured long-term locum staff with a view to providing continuity of care, however, there had been occasions whereby no clinical staff were available on the premises and so appointments had to	

be cancelled at short-notice.

Whilst the practice had taken steps with a view to mitigating the risk of the absence of clinical staff, including contacting other providers for support, advice and assistance, the terms in which clinical staff were engaged meant that there was not a consistent and safe approach to managing the absence of clinical staff.

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence: There had not been a multi-disciplinary meeting involving other healthcare professionals since September 2018. After the inspection, the provider advised us that they regularly shared information with community nurses when they attended the surgery and with health visitors and social workers as required.	

Appropriate and safe use of medicines

Not all systems were effective in ensuring the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	0.97	1.06	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	9.0%	10.0%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	5.54	6.18	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	2.36	1.68	2.22	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N
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.	N
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

Medicines management	Y/N/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.	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 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
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 See below
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 door to the dispensary was open during the inspection. This door led into the reception area, where the desk hatch to the dispensary was open. This area could be accessed by patients and visitors. There was no risk assessment for this.</p> <p>On the day of our inspection, we found that the nurse's room was unlocked and vacant. The fridge where vaccines and insulin were stored was unlocked. Whilst there were some systems to ensure the safe storage of prescription stationery, prescription stationery was not held securely in this room.</p> <p>The anaphylaxis packs in the nurse's room did not have a tamper evident seal on them.</p> <p>We were informed that there was an informal review of the advanced nurse practitioners' prescribing practice. As they were a long-term locum, there were no systems of clinical support or supervision of their prescribing. There were no documents to define their prescribing remit.</p> <p>The controlled drugs cabinet was not compliant with the relevant regulations and requirements for the safe storage of controlled drugs. After the inspection, we were sent evidence to confirm that this had been purchased and was awaiting installation.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	N
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>Whilst all dispensary staff had the required level of qualification, there was no structured ongoing training or continuing professional development program for dispensary staff. One of the dispensers was engaged on a long-term locum basis and we were told that therefore, they were responsible for completing their own training. Whilst all mandatory training had been completed, there were no systems to review and check their performance and additional training requirements.</p> <p>There was limited space in the dispensary to dispense safely. All the available work surface space for dispensing was full of either items that were awaiting labelling and dispensing or stock. Baskets with prescription items were stacked on top of each other awaiting labelling and checking. The practice manager informed us that they had submitted a request to refit the dispensary to the provider.</p> <p>Although there was remote GP oversight of the dispensary, staff were unclear about the systems in place. Staff believed the locum GPs were responsible. If a GP was not on the premises, staff told us that they would not hand prescription items to patients.</p> <p>Dispensary staff were aware of systems to report near-misses, although none had been raised in the 12 months prior to our inspection.</p>	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	2
Number of events that required action:	2
<p>Explanation of any answers and additional evidence:</p> <p>In addition to significant events, the practice recorded 'incidents' such as aggressive patients and computer systems failures, for example.</p> <p>Significant events were a standing item at the practice meeting. Whilst we were informed these meetings were held weekly, none had taken place since January 2019.</p> <p>The learning from one significant event in December 2018 was to improve engagement with other healthcare providers. Despite this, there had been no multi-disciplinary meeting held since September 2018. There was a multi-disciplinary meeting scheduled to take place in March 2019, although minutes from the January 2019 practice meeting evidenced that previous meetings had been arranged and subsequently cancelled. The provider sent evidence that they had scheduled monthly meetings and that in the event that these needed to be cancelled, the Assistant Director was to be informed.</p>	

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

Event	Specific action taken
No GP available to work at the practice.	The practice was aware of the lack of GP cover prior to the afternoon in question and had contacted other providers in the locality to ascertain whether they could offer support, yet no GP was available. Patients who required urgent GP assistance were redirected to other services.
Lack of contact with palliative care patient.	Investigation carried out, plan to discuss with community matron and improve communication in the future. See above.

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

Effective

Rating: Inadequate

We rated the practice inadequate for providing effective services and for all the population groups, as the breaches of regulations we found at inspection, impacted on these groups. This was because performance was below average in respect of diabetes, asthma, COPD, cancer and mental health. Identified improvements had not been made following our 2017 inspection. Information about patients was not shared with other health professionals to ensure continuity of care and information cascades were not effective.

There was a lack of quality improvement processes in place; there had been no clinical audits completed in the last two years. The learning and development needs of staff were not assessed.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was not consistently 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
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>As all clinical staff were engaged on a locum basis, the provider relied on them to ensure that they were up to date with evidence-based guidance. There were no regular clinical meetings or supervision processes in place where GPs and nurses could discuss current evidence based guidance. As part of their action plan, the provider told us that they would be implementing clinical supervision for the locum GPs which would take place bi-annually. There was no reference made to clinical supervision of the locum advanced nurse practitioner.</p> <p>The provider intended to add a case-study review into the weekly clinical meeting to promote professional discussion and review.</p> <p>QOF performance, which measures the practice's performance in relation to various indicators and health checks, was poor in relation to some health checks and therefore, patients' needs were not being effectively assessed and reviewed.</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>	0.46	0.60	0.81	No statistical variation

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> Information about patients was not shared with other health professionals to ensure continuity of care. The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks were offered to patients over 75 years of age. 69 health checks for patients aged over 75 had been completed in the last year.

People with long-term conditions

Population group rating: Inadequate

Findings

- Performance was below or significantly below average for checks for patients with diabetes, asthma and COPD.
- Information about patients was not shared with other health professionals to ensure continuity of care.
- 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>	67.3%	75.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	12.5% (14)	14.3%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	52.8%	74.8%	77.7%	Variation (negative)
Exception rate (number of exceptions).	5.4% (6)	11.4%	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>	69.1%	77.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	1.8% (2)	15.5%	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>	61.1%	72.9%	76.0%	Variation (negative)
Exception rate (number of exceptions).	3.2% (6)	8.4%	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>	62.0%	89.2%	89.7%	Significant Variation (negative)
Exception rate (number of exceptions).	2.0% (1)	15.3%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	86.5%	81.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.2% (8)	4.7%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	96.0%	90.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	5.2%	6.7%	N/A

Any additional evidence or comments

Unverified data from April 2018 to the date of our most recent inspection, being 26th February 2019 showed the following:

- 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 was 70%. This did not evidence improvement.
- 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 was 63%. This did not evidence improvement.
- 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 was 67%. This did not evidence sufficient improvement.

In the provider's action plan sent after the inspection, we received unverified data which evidenced some improvements from the date of the inspection to 15 March 2019, although this was did not demonstrate consistent satisfactory achievement across all above indicators.

There was no lead member of staff responsible for QOF performance and the practice manager was unable to extract relevant data. The practice manager was due to attend a course on QOF in the weeks following our inspection.

Findings

- There were not effective systems to share information with other healthcare professionals about children and young people.
- Childhood immunisation uptake rates were now found to be in line World Health Organisation (WHO) targets for 2018 and sufficient improvements had been made.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	30	31	96.8%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	22	25	88.0%	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)	22	25	88.0%	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)	22	25	88.0%	Below 90% minimum (variation negative)

Any additional evidence or comments

Unverified data for 2018 showed that sufficient improvements had been made:

- 92% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)
- 92% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)
- 92% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR)

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)	77.9%	74.2%	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)	73.0%	71.8%	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)	62.7%	55.6%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	25.0%	63.9%	70.2%	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)	55.0%	49.9%	51.9%	No statistical variation

Any additional evidence or comments

Unverified data from April 2018 to the date of our most recent inspection, being 26th February 2019 showed that 28% patients with cancer, diagnosed within the preceding 15 months, had a patient review recorded as occurring within 6 months of the date of diagnosis.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- End of life care was not delivered in a coordinated way. Whilst it had been identified that improvements were required to ensure effective engagement with other health care professionals, action was not taken.
- Data evidenced that patients with cancer were not receiving a timely review of their care.
- The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- Data showed that the practice did not assess and monitor the health of people with mental illness and severe mental illness.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	20.0%	89.9%	89.5%	Significant Variation (negative)
Exception rate (number of exceptions).	0 (0)	15.6%	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)	50.0%	87.1%	90.0%	Variation (negative)
Exception rate (number of exceptions).	0 (0)	12.5%	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)	83.3%	81.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	25.0% (2)	8.4%	6.6%	N/A

Any additional evidence or comments

Unverified data from April 2018 to the date of our most recent inspection, being 26th February 2019 showed the following:

- 0% 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. This represented a significant deterioration in already poor performance.
- 22% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months. Again, this represented a significant deterioration in already poor performance.

As the QOF year ends in March 2019, there was a month left until the end of the relevant year. In their action plan, the provider sent us evidence to indicate some improvements.

The exception rate for percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was higher than average. Exception reporting is the means by which patients can be excluded from the data because of certain characteristics or because they decline invitations. On the day of our inspection, we found that this data appeared higher than average due to the low numbers of patients identified, which adversely affected the data.

In reviewing the exception reporting, it became apparent that there had been a significant deterioration

in performance for this indicator. Unverified data from April 2018 to the date of our most recent inspection, being 26th February 2019 showed:

- 38% of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.

Monitoring care and treatment

There was limited or no monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	424.9	529.9	537.5
Overall QOF exception reporting (all domains)	2.7%	5.8%	5.8%

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

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

There had been limited quality improvement activity over the last two years:
<ul style="list-style-type: none"> • There had been no clinical audits in the last two years. In the action plan submitted after the inspection, the provider gave details of the clinical audits they would be completing. • The medical advisor for the provider periodically carried out a review of the clinical records of the locum GPs and advanced nurse prescriber. Whilst this was not carried out routinely, this considered clinical record keeping, monitoring of long-term medicines and management plans.

Any additional evidence or comments

Unverified data from April 2018 to the date of our most recent inspection, being 26th February 2019 showed that overall QOF performance had deteriorated. 335 points had been awarded to the date of our inspection.

After the inspection, the provider sent us an action plan and more up to date unverified data. This identified that the practice had achieved 407 points. Whilst this indicated that the practice had made a concerted effort to make improvements, this was not consistent across all indicators and continued action was needed.

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.	Partial
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>As the GPs, advanced nurse practitioner and dispensary staff were engaged on a locum basis, the provider relied on them to ensure that they were up to date with their training and learning needs. There were no systems to assess clinicians' training needs through one to ones, supervision and appraisal.</p> <p>As part of their action plan, the provider told us that they would be implementing clinical supervision for the locum GPs which would take place bi-annually. We were not informed of any plans to offer appraisal and support for the advance nurse prescriber.</p> <p>After the inspection, the provider informed us that they were intending to add a case-study review into the weekly clinical meeting to promote professional discussion and review.</p> <p>Whilst it was evident that the medical lead did review clinicians' notes, this was not a systematic review at regular intervals.</p> <p>Permanent staff had completed required training and attended regular appraisals.</p>	

Coordinating care and treatment

Staff did not work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
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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) <small>(QOF)</small>	N
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	N
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	N
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>The provider did not have regular multi-disciplinary case review meetings to discuss patients on the palliative care register or patients with complex needs.</p>	

Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.7%	94.4%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (3)	1.0%	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
Explanation of any answers and additional evidence: The practice did not carry out minor surgery and we found no other incidents where written consent was required. We saw that consent was appropriately obtained when children attended for their immunisations.	

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

CQC comments cards	
Total comments cards received.	4
Number of CQC comments received which were positive about the service.	0
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
NHS Choices	<p>There had been seven reviews posted from patients who had visited the practice in the 12 months prior to our inspection. Four of these reviews were 5-star reviews, with patients writing that staff were professional and helpful. Three patients gave the practice one star. One patient commented that staff were rude, another stated that there was no privacy at reception. The final negative comment was not relevant to this key question.</p> <p>The provider or practice manager responded to a majority of patients, to either thank them for their feedback or explain how negative feedback has been escalated to the provider.</p>
Comment cards	In two out of the four comment cards, patients praised the clinicians. There was no reference to the care provided in the other two comment cards.

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
2519	222	111	50%	4.41%

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)	87.4%	88.0%	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)	83.3%	85.9%	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)	95.3%	94.6%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	83.3%	80.5%	83.8%	No statistical variation

Any additional evidence or comments
Whilst feedback received in the GP patient survey was positive, the practice had devised an action plan to make further and continued improvements; this included exploring training in customer experience training.

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
<p>Explanation of any answers and additional evidence:</p> <p>There were posters displayed in clinical and waiting areas encouraging patients to be involved in decisions about their care.</p> <p>Patients were able to access their record electronically so that they could view the up to date information held by the practice.</p>	

Source	Feedback
Interviews with patients.	Both patients we spoke with were positive about the care they received from the clinical staff and receptionists.

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)	89.1%	92.9%	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.	Partial
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Information with pictorial aids was available for patients with learning disabilities when they attended for their annual review.</p> <p>As it had been identified that there were no patients who accessed the practice who were not able to communicate in English, information leaflets were not available in other languages.</p>	

Carers	Narrative
Percentage and number of carers identified.	36 patients identified (1.4% of the practice population).
How the practice supported carers.	Offered flu vaccinations.
How the practice supported recently bereaved patients.	There were no systems whereby the practice would routinely contact or support recently bereaved patients.

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
<p>Explanation of any answers and additional evidence:</p> <p>The reception desk was positioned in such a way that minimised the risk of conversations being overheard.</p>	

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services. This was because there had been occasions where appointments had to be cancelled by the practice at short notice due to a lack of clinicians. As this issue affected all populations groups, they were also rated as requires improvement.

Responding to and meeting people's needs

Services did not always meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	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.	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.	N
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	N
<p>Explanation of any answers and additional evidence:</p> <p>Locum GPs were engaged to work in the practice four days a week. One day a week, there were no GPs working and patients would be seen by the advanced nurse practitioner. Whilst the provider took some steps to ensure continuity of care by engaging regular, effective locum GPs, there had been instances whereby appointments needed to be cancelled or rearranged due to clinical staff absence.</p> <p>There had been no meetings with other healthcare professionals since September 2019.</p>	

Practice Opening Times	
Day	Time
Reception & practice opening times:	
Monday	8am – 1pm 2pm – 6.30pm
Tuesday	8am – 1pm 2pm – 6.30pm
Wednesday	8am – 1pm 3pm – 6.30pm

Thursday	8am – 1pm 2pm – 6.30pm
Friday	8am – 1pm 2pm – 6.30pm
Dispensary opening times:	
Monday	8am – 1pm 2pm – 6.30pm
Tuesday	8am – 1pm 2pm – 6.30pm
Wednesday	CLOSED
Thursday	8am – 1pm 2pm – 6.30pm
Friday	8am – 1pm 2pm – 6.30pm

Explanation of any answers and additional evidence:
 Appointments could be made at reception with a GP or nurse at the local GP Alliance. This was available on the weekends and on a Wednesday evening.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2519	222	111	50%	4.41%

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)	96.0%	94.1%	94.8%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Health checks were offered to patients aged over 75.

People with long-term conditions

Population group rating: Requires improvement

Findings

- The practice did not liaise 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 not effectively coordinated with other services.

Families, children and young people

Population group rating: Requires improvement

Findings

- We found there were some systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day

appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice.
- 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: Requires Improvement

Findings

- The practice was a Dementia Friendly practice which meant that services were accessible to patients who had dementia.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

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

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)	85.9%	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)	77.3%	63.5%	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)	62.2%	59.7%	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)	84.3%	70.6%	74.4%	No statistical variation

Source	Feedback
NHS Choices	<p>There had been seven reviews posted from patients who had visited the practice in the 12 months prior to our inspection. Four of these reviews were 5-star reviews, with comments relating to the caring domain. Three patients gave the practice one-star reviews. Two patients said that they experienced difficulty accessing appointments. The remaining one-star review did not relate to access.</p> <p>The provider or practice manager responded to a majority of patients, to either thank them for their feedback or explain how negative feedback has been escalated to the provider.</p>

Comment cards	In two out of the four comment cards, patients raised concern about accessing appointments. One patient told of delay they had experienced in obtaining their medicines.
Patient participation group	The PPG told us that day to day services were good and that they were able to access appointments, although they had concerns about the continuity of care due to the lack of permanent clinical staff. They told us that the practice was not responsive to queries they had raised.
Friends and family test	<p>There had been five responses received in the last year. All patients indicated that they would be extremely likely to recommend the practice to their friends and family.</p> <p>Patients praised the clinical and non-clinical staff.</p>

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.	10
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.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Complaints were either managed by the practice manager or referred to the provider, as detailed in the practice's complaints leaflet.</p> <p>We were informed that 10 complaints had been raised in the last 12 months, but the complaints folder that we viewed only held records of only two complaints and a request for further information; however, these evidenced a timely response in accordance with the practice's policy.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Request for repeat prescription not generated.	Investigation completed into why the repeat prescription had not been generated and systems updated with a view to ensuring problem did not occur again.
Appointment not available at a time convenient to patient.	Practice Manager called patient and explained appointment system. Advised to contact Provide should they not be happy with response.

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing well-led services. We found that the leadership and governance was not effective at practice level and there was limited oversight by the provider who was not aware of challenges to safety and effectiveness.

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
Explanation of any answers and additional evidence:	
The leaders at the practice were unaware of the challenges to safety and effectiveness and there was a lack of oversight by the provider to ensure that there was effective leadership at the practice. In their presentation, the provider's representatives told us that QOF was good although there was room for improvement. This was not the case, as inspectors identified significant negative variations in QOF performance and improvement was required.	
Following our inspection of 27 July 2017, we identified that the practice should continue to improve outcomes for patients and at that inspection, underperformance was identified with diabetes related indicators. The practice failed to make the improvements identified by inspectors as we found the QOF performance had significantly deteriorated between our 2017 and 2019 inspections.	
The practice did not have quality improvement processes in place and there had been no clinical audits completed in the past two years.	

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.	Y

Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider of GP services at the practice was a community interest company. In addition to the GP practice, the provider offered many other services in the community, such as hospitals and clinics.</p> <p>The providers' vision advocated outstanding services that cared, nurtured and empowered and this vision applied to the GP practice as well as other services provided elsewhere. This was clear, visible and displayed around the practice. Whilst it was evident how the vision was developed and implemented at provider level, it had not been embedded into the day to day running of the practice. We did not find that outstanding services were being offered at the practice.</p> <p>Systems were not effective in cascading the vision to practice staff. Information that was being recorded did not accord with the risks identified by inspectors.</p> <p>Whilst progress against performance was partially monitored by the practice, we found that the leaders at the practice and the provider, were unaware of the true position in respect of risk and the systems to monitor progress were ineffective.</p>	

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>See below.</p>	

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

Source	Feedback
Staff, patients and others	Whilst staff, patients and others told us that they could raise concerns, there was a lack of confidence that these would be dealt with. People told us that when they raised queries, they did not receive an answer.

Governance arrangements

There were clear responsibilities, roles and systems of accountability but these did not consistently support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At provider level, there was a detailed governance structure and information cascade that was not effective at the practice. Staff and leaders were held to account.</p> <p>However, we found that the governance at the practice was ineffective. Risks were either overlooked or not identified, and so mitigating actions were not put in place. Whilst we saw that infection control issues at the practice were discussed at the provider's Quality and Safety meeting, risks identified by inspectors in relation to recruitment and performance were not.</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.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
There were some systems for the provider to review and monitor risks, issues and performance, but these were not structured, regular or supported by an effective action plan.	
An Executor and Governor visit had been undertaken on 8 th January 2019. The subsequent report stated that staff morale was good; however, the findings in relation to perception of the leadership at the practice did not accord with our findings on inspection.	
The report stated there were queries over QOF. Whilst the report did not elaborate on this, it was evident that effective action had not been taken as QOF performance remained poor. The risks presented by this poor performance were not discussed at the provider's Quality and Safety meeting. The practice manager was unable to access QOF information to monitor performance. We were advised they were scheduled to attend a course later in the month.	
It was identified by the executor and governance visit that there was a three week wait for a routine appointment with a GP. Whilst it was apparent that the provider had been advertising to recruit a salaried GP, the staffing issues at the practice were not being discussed at the provider's Quality and Safety meeting, where vacancies within other locations were regularly reviewed. We were advised that this was because of the stability of the locum staff in post at the practice.	
There had been no clinical audits completed in the last two years. In the action plan submitted after the inspection, the provider detailed a plan for future clinical audits.	
We therefore concluded that despite systems being put in place for the identification and management of risks, this was not effective at the practice and there was a lack of general oversight to identify such issues.	

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.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Whilst audits were in place to monitor the premises and equipment, documents were not always accurately completed to reflect the accurate position, for example in relation to PAT and fire checks. One fire marshal had not received training, which was incorrectly recorded as completed on the fire risk assessment.</p>	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<p>In the Summer of 2018, the provider's contract to provide GP services at the practice had been extended for a period of three years. It was apparent that the provider had worked with NHSE and the CCG to try and reach solutions when challenges were identified, namely in relation to the recruitment of GPs.</p> <p>The practice had not devised a survey for patients to give their feedback. The PPG and others told us that they did not feel listened to or valued and that when they raised questions, they did not receive a response.</p> <p>Whilst we were told that staff meetings were held weekly, these had not been taking place. The last meeting was in January 2019.</p>	

Feedback from Patient Participation Group.

Feedback
We spoke with two members of the PPG. They told us that no-one from the practice attended their last meeting. They were advised that locum staff would not attend and the practice manager was unable to attend. They told us that they asked questions, but did not get answers and did not feel valued.

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>We found that due to the transient nature of the clinical team, there were limited opportunities afforded to discuss and review learning, continuous improvement and innovation.</p> <p>In the practice's action plan submitted after the inspection, the provider assured us that there would be effective systems implemented to promote learning and improvement.</p>	

Examples of continuous learning and improvement

Some improvements had been identified in QOF performance since our inspection. Further, a schedule had been agreed for clinical audits to be completed in 2019/20 and it was intended that GP locums would have a formal six monthly clinical supervision.

Other actions had been identified in respect of premises, equipment and information sharing with other healthcare professionals and the patient participation group.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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