

Care Quality Commission

Inspection Evidence Table

Dr Iftekhar Majeed (1-504364823)

Inspection date: 17 and 18 April 2019

Date of data download: 14 April 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

Safety systems and processes

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

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

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff demonstrated awareness of their responsibilities around reporting incidences if they suspected a concern. We were told the practice had policies in place to support staff. We were obstructed in reviewing the policies by the management team and were told they were being updated. The practice had a safeguarding register, however we found that the register was not up to date. For example: The domestic abuse register contained a total of 11 patients. On reviewing a sample of the records, we found children of these patients had no alerts on their records to highlight to practice staff the history of domestic abuse in the household, which placed the children at risk. The practice were not flagging other family members registered at the same address as vulnerable children on the safeguarding register. This highlighted the lack of accurate information the practice held on vulnerable patients. Patients who had undergone female genital mutilation (FGM) were not flagged on the clinical system and we found no evidence to confirm patients had been offered the appropriate support. We were told by the lead GP that monthly multidisciplinary meetings were held, however we were not provided with any minutes of meetings to confirm this. We reviewed a sample of patients' records we found no evidence to confirm that they had been discussed as part of a multidisciplinary meeting with the health visitor. 	

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.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff had any necessary medical indemnity insurance.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was unable to demonstrate that they had carried out the appropriate checks for newly employed clinical staff or that appropriate indemnity was in place. There was no documentation available of training completed by some clinical staff. 	

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: 25 June 2018	Y
There was a record of equipment calibration. Date of last calibration:	N
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 11 March 2019	Y
There was a log of fire drills. Date of last drill: 29 November 2018	Y
There was a record of fire alarm checks. Date of last check: 17 April 2019	Y
There was a record of fire training for staff. Date of last training: Various in the past 12 months	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 16 January 2019	Partial
Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had not carried out risk assessments and relied on the assessments completed by the landlords. However, the practice had gained no assurances that appropriate assessments had been carried out and that risks had been mitigated. We were told that there were no hazardous substances kept at the practice, therefore there was no COSHH (control substances that are hazardous to health) risk assessments in place. The practice had a range of products on site including oxygen and cleaning products none of which had been risk assessed. There was no record of equipment calibration available. We were told this would be sent after the inspection. This was not received. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had completed no risk assessments for health and safety. We were told these were the responsibility of the landlords, however the practice had gained no assurances that these had been completed, or that risks had been mitigated. Copies of the risk assessments were to be sent after the inspection. We have not received any documentation. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	N
Date of last infection prevention and control audit:	N
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice did not demonstrate appropriate measure were in place for the management of infection prevention and control. We were told that all policies were being updated and were not given access to review the infection control policy to ensure it contained all the necessary information to support staff. The provider was unable to provide evidence to confirm that all staff had completed the relevant training in infection control. There was no evidence available to support that an infection control audit had been completed for the premises. However, the practice nurse carried out monthly audits of the clinical rooms to ensure they were well stocked and clean. On inspection the rooms appeared clean. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	N
Comprehensive risk assessments were carried out for patients.	N

Risk management plans for patients were developed in line with national guidance.	N
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.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> When we arrived at the inspection we were told that the GP (provider) was away on annual leave. We found a member of the clinical nursing team, new to the practice, an advanced nurse prescriber (ANP) had been given overall responsibility of the practice in the absence of the lead GP. They had received no induction, including information regarding local safeguarding policies and processes and had commenced work without any checks, discussions, or consideration to assessing clinical competencies. There was no protocol outlining what the scope of an ANP included. We were informed that the ANP saw all patients except children under one year of age. As there was no GP on site we asked who was responsible for patients with pregnancy related issues, children under the age of one and patients requiring Fit Notes. We were told the ANP would see these patients, we saw evidence which confirmed this. The management team were unaware of the scope of the role of an ANP. The GP was on annual leave for one week, there had been no arrangements made for clinical support or supervision for the ANP during this time. The practice did not have an effective system to ensure all patients were adequately investigated. There were no arrangements in place to ensure test results were reviewed and abnormal results responded to. 	

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.	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.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We were told by the management team that multi-disciplinary team (MDT) meetings had been held on the 30 April 2018, 26 June 2018, 25 September 2018, 30 October 2018 and 29 January 2019. The management team was unable to provide the minutes for these meetings. The inspection team was told these would be provided following the inspection. These have not been received. We reviewed 12 patients' consultations from the morning clinic on the day of inspection and found a lack of contemporaneous documentation during consultations to support delivery of the appropriate care and treatment. This included a lack of detail in the recording of history, examination and investigation. This did not provide assurance that adequate care and treatment had been provided. Staff told us that urgent referrals to secondary care were completed online, we asked staff what safety netting was in place to ensure appropriate action was taken, we were told that no checks were made once the referral was submitted. This demonstrated ineffective systems to ensure patients who required urgent reviews, were tracked through the referral system appropriately. We asked to see patient correspondence that had been received the previous week, we were told these had been scanned onto patient's records. We were handed over 90 letters and 30 pages of blood test results, which had been received by the practice between 8th and 12th April 2019. We were told by the management team that the correspondence or test results had not yet been reviewed or actioned by a GP. There was no clinical oversight to ensure urgent correspondence was identified and actioned. We saw a letter that had been sent from secondary care advising the practice of a possible safeguarding concern, no action had been taken. The patient's notes had not been summarised and there was no safeguarding alert on the computer record. 	

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) (01/01/2018 to 31/12/2018) <small>(NHS Business</small>	0.82	0.96	0.91	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Service Authority - NHSBSA)				
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). (01/01/2018 to 31/12/2018) (NHSBSA)	4.2%	5.7%	8.7%	Variation (positive)
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 (01/07/2018 to 31/12/2018) (NHSBSA)	5.27	5.16	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	1.47	1.70	2.13	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations 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.	N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
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	N/A

Medicines management	Y/N/Partial
written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> On reviewing notes from patient consultations, we found examples of inaccurate prescribing. We found antibiotics had been prescribed inappropriately, and an example of prescribing an incorrect dose. There was no system in place for clinical supervision or reviewing prescribing practice. We identified patients having medication reviews via telephone without any prior face to face contact, or appropriate examination to ensure patients medicines were adequate for their needs. We looked at a selection of records for patients on high risk medicines and found there was no effective system to ensure appropriate monitoring had taken place, and we saw examples where monitoring was overdue, however prescriptions continued to be issued. For example; A search was completed to identify patients who were taking Angiotensin converting enzyme inhibitors (ACE) inhibitors. These medicines require regular monitoring of potassium levels and renal function as they have the potential to raise potassium levels and impair kidney function. It is usual for monitoring to be done at least every 12 months. We identified 187 patients who had been prescribed this category of medicines in the last 12 months. We found 53 of these patients had not had blood test monitoring performed in the last year. This placed them at risk of developing raised potassium levels and impaired kidney function which would not be identified without the appropriate monitoring being completed. We reviewed patients who were on a medicine which required six monthly blood testing in line with national guidance. We identified eight patients who had been prescribed this medicine in the last 12 months. We found six of these patients had not had a blood test done in the last six months and two patients had not had a blood test done in the past 12 months. 	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N

Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	17
Number of events that required action:	17
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us they reported all incidents and significant events on an incident reporting system to share learning with the clinical commissioning group. The practice were unable to demonstrate they used information to review safety processes within the practice. The landlords were relied on to do all the safety reviews; however the practice gained no assurances that these had been done. A number of incidents recorded related to letters received from other services for patients not registered at the practice. 	

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

Event	Specific action taken
A breakdown in communication was recorded due to a conflict between the services that used the health centre.	A meeting was scheduled for April 2019. Evidence provided showed the meeting had been held in March 2019, but we found no evidence of actions taken or shared learning.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence: <p>Safety alerts including alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were not managed appropriately and the practice were unable to demonstrate what actions had been taken. On the day of inspection, we found that the practice was not aware of some alerts. For example, updated Valproate Alerts from September and December 2018 which recommended specific actions to be taken for women of childbearing age taking this medicine. There were no records that actions necessary to ensure that patients had received safe care and treatment. In addition, we saw that patients had not been informed of the risks highlighted in recent patient safety alerts, for example the risks associated with prescribing Carbimazole to women of child bearing age and the risk of skin cancer associated with Hydrochlorothiazide.</p>	

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
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.	N
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	N
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
<p>Explanation of any answers and additional evidence:</p> <p>The clinical records viewed did not give assurance that care and treatment was provided in a safe way or that risk to patients health and welfare had been considered and mitigated. Records did not adequately demonstrate the history, examination, safety netting or follow ups or on-going treatment plans.</p> <ul style="list-style-type: none"> On reviewing a sample of patients' records we found evidence-based guidance had not been followed. Patients on high risk medicines had not received the appropriate monitoring, the prescribing of medicines and the possible risks had not been considered. For example: we found a medicine that can cause neurological conditions had been prescribed. The prescriber confirmed they had no knowledge of the potential risks and was unaware of the safety alert that had been issued previously concerning the serious implications with this medicine. Patients treatment was not regularly reviewed. We found numerous examples of patients with multiple conditions who had not been appropriately reviewed or monitored by the GP, but the prescribing of medicines had continued. On reviewing patient's medical correspondence, we found two requests from other services for urgent referrals to specialists for an assessment of the patient. There was no evidence that these referrals had been acted on. On reviewing a sample of patients' clinical records, we found a failure to adequately investigate and respond to abnormal results and prescribe appropriate treatment. This placed patients at risk of having undiagnosed and untreated conditions. 	

- We saw two patients records with suspected cancer. Despite visiting the practice on a regular basis, they had not received the appropriate investigations or referred for specialist investigation and treatment.
- We found an example of NICE guidelines for a specific medicine not being followed. NICE guidance suggests the medicine should not be prescribed for longer than five days due to risk of serious side effects, the patient was prescribed a nine-day supply. The prescriber was not aware of the MHRA alert relating to the potential risk of serious irreversible side effects associated with this medicine, or the condition which it can cause.

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) (01/01/2018 to 31/12/2018) (NHSBSA)	0.87	0.73	0.79	No statistical variation

Older people

Population group rating: Inadequate

Findings

- Staff did not have the appropriate knowledge of treating older people including their psychological, mental and communication needs. On reviewing a sample of patient records, we found patients had been seen by clinical staff employed by the practice who had not completed the relevant training.
- The practice was not responsive to the needs of older people. A search of the clinical system showed seven requests for home visits had been made between January and March 2019. Three home visits had been made, however the other four had received a telephone consultation including the prescribing of medicines without an appropriate examination of the patient having taken place.
- Records identified a housebound patient with multiple conditions who had not had a home visit carried out in recent years. All contacts with the patient were done as telephone consultations. We found the lead GP had prescribed treatment on many occasions without examining the patient or taking an adequate history.
- We were told on the day of inspection by the management team that there were no patients on the palliative care register. On carrying out a search of the clinical system we found 11 patients on the register, however patients who were terminally ill had not been included. This demonstrated that the palliative care register was inaccurate and did not demonstrate a true reflection of the practice population. We were unable to confirm that multi-disciplinary team meetings were held with community teams, including district nurses to discuss patients' ongoing care.

People with long-term conditions

Population group rating: Inadequate

Findings

- We found patients with long term conditions routinely received telephone reviews without being seen by the GP. There was no examination or adequate review of their condition and medicines.

- We found examples of asthma reviews being completed via a telephone consultation.
- The practice could not demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Where patients had been identified we saw examples of where they had been treated inappropriately, which could cause risk to patients' health.
- We carried out a search of the clinical system for patients who had been prescribed ACE inhibitors (ACE inhibitors are used primarily for the treatment of hypertension (elevated blood pressure) and congestive heart failure). National guidance recommends that these medicines require regular monitoring. The search highlighted 187 patients on these medicines, 53 patients had not received the appropriate monitoring in the past 12 months.
- We identified two patients who were diabetic that had not been appropriately referred for diabetic eye screening. We also saw examples of patient correspondence from the retinal screening service which stated that their systems had identified patients as possibly having diabetes, but the screening service did not have any record of the patients being referred by the practice for retinal screening. This placed these patients at risk of visual problems associated with diabetes, which left undetected and untreated could lead to blindness.

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) (QOF)	74.7%	79.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	12.7% (23)	11.2%	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) (QOF)	72.4%	78.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.9% (18)	8.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	66.9%	78.7%	80.1%	Variation (negative)
Exception rate (number of exceptions).	14.9% (27)	11.4%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England	England
----------------------------	----------	-------------	---------	---------

			average	comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	42.0%	77.5%	76.0%	Significant Variation (negative)
Exception rate (number of exceptions).	1.7% (2)	4.5%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	50.0%	90.5%	89.7%	Significant Variation (negative)
Exception rate (number of exceptions).	6.7% (2)	12.7%	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)	83.9%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.8% (20)	4.3%	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)	93.3%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.3% (1)	5.4%	6.7%	N/A

Any additional evidence or comments

- On reviewing the clinical indicators for the practice, we found statistically significant negative variation from the national and local averages for indicators associated with COPD and asthma, we also found statistically negative variation for indicators related to diabetes. On reviewing these indicators with the previous year's results, we found that performance had significantly declined. We found long term condition management was poor with patients not receiving the monitoring, care and treatment they required.
- We found that patients had been exception reported inappropriately. Patients can be exception reported if the practice has actively tried to contact them on three occasions and the patient has not responded, if the patient declined to attend or participate in monitoring, if the patient was on the maximum number of medicines or was unsuitable in another way, for example, terminally ill.

However, on reviewing a sample of patients records we found patients had been exception reported because they required a home visit or had poor control of their condition.

Families, children and young people

Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were well below the World Health Organisation (WHO) targets. The practice provided no evidence of action taken, monitoring or of how they encouraged patients to attend for their immunisations.
- The practice had no arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. We were unable to confirm that the practice had arrangements in place to share information with community teams.
- On reviewing a sample of patients' consultations', we found two children had been seen by an advanced nurse prescriber without having completed the relevant training or competencies in assessing and managing paediatric patients. A detailed history had not been taken for these patients, they had been prescribed inappropriate medicines.

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)	34	44	77.3%	Below 80% (Significant 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)	39	53	73.6%	Below 80% (Significant 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)	41	53	77.4%	Below 80% (Significant 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)	40	53	75.5%	Below 80% (Significant variation negative)

Any additional evidence or comments

- On reviewing the clinical indicators for the practice, we found statistically significant negative variation from the national and local averages for indicators associated with childhood immunisations. On reviewing these indicators with the previous year's results, we found that performance had significantly declined.
- On speaking with the lead GP, we asked if he was aware of the low immunisation rates and what the practice was doing to address it. The lead GP was unable to provide any evidence of what was being done to encourage patients but told the inspection team that the practice nurse followed up on patients not attending.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The practice's uptake for cervical screening was below the target for the national screening programme. The practice was unable to demonstrate how they were encouraging patients to attend for screening.
- On reviewing the appointment system, we found days when there was no appropriate clinical cover available, therefore patients had no access to clinical staff.
- The practice was unable to demonstrate that patients received the appropriate health assessments and checks and were followed up where abnormalities or risk factors were identified.

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) (PHE)	59.3%	65.8%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	57.6%	64.2%	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)	34.0%	42.1%	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)	60.0%	65.8%	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)	0.0%	50.0%	51.9%	Variation (negative)

Any additional evidence or comments

- On reviewing the clinical indicators for the practice, we found statistically significant negative variation from the national and local averages for cervical screening and cancer detection. On reviewing these indicators with the previous year's results, we found that performance had significantly declined.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The practice was unable to demonstrate that end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The management team that there were no patients on the palliative care register. On carrying out a search of the clinical system we found 11 patients on the register, however patients who were end of life had not been included. This demonstrated that the palliative care register was inaccurate and did not demonstrate a true reflection of the practice population. We were unable to confirm that multi-disciplinary team meetings were held with community teams, including district nurses to discuss patients' ongoing care.
- The vulnerable adult register had one patient listed on it. When we spoke with the lead GP he told us that the vulnerable adult register contained the names of all patients with learning disabilities and those in care homes. This demonstrated a lack of awareness of the practice population and the inadequate registers in place.
- The practice was unable to demonstrate 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 was unable to demonstrate how they supported the physical health of people with mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was no system for following up patients who failed to attend for administration of long-term medicines. The lead GP carried out telephone consultations and prescribed medicines to patients without the proper reviews and assessments having taken place.
- When patients were assessed to be at risk of suicide or self-harm the practice had inadequate arrangements in place to help them to remain safe. On reviewing a sample of patients' consultations, we found evidence of a patient that required support, however we found no referrals had been made to ensure the patient received the appropriate care.
- We found high levels of exception reporting for patients with dementia. For example: the practice achievement was 18.2% in comparison to the national average of 10%. On reviewing a sample of records, patients who were unable to attend the surgery were exception reported.

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)	100.0%	91.6%	89.5%	Variation (positive)
Exception rate (number of exceptions).	11.5% (3)	13.5%	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)	100.0%	93.1%	90.0%	Variation (positive)
Exception rate (number of exceptions).	11.5% (3)	10.9%	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)	88.9%	83.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.8%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	499.3	538.1	537.5
Overall QOF exception reporting (all domains)	7.1%	6.2%	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

- The practice was unable to demonstrate clinical audits had been completed to demonstrate quality improvements.

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.	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.	N
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found that an advanced nurse prescriber (ANP) had been employed by the provider. They told us they had commenced employment immediately with no induction. Despite only being employed for two weeks the GP went on annual leave and let them as the clinical lead within the practice. There were no arrangements in place for clinical support or supervision during this time. The provider had not considered the role of an ANP and the training requirements in areas such as long-term condition management, gynaecology and treatment of children. There had been no assurance of competency for staff employed in advanced clinical practice, nor was there a plan for one to ones, coaching or mentoring. The management team confirmed they had not checked the qualifications or experience of the ANP before employment or being left as the clinical lead at the practice. 	

Coordinating care and treatment

Staff did not 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)	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.	N
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> <ul style="list-style-type: none"> We were told on the day of inspection that multi-disciplinary team meetings were held regularly, however the management team was unable to provide the minutes of the meetings. Evidence of the meetings was to be provided post inspection, however these have not been received. We found that there had been two requests from other health care professional for urgent referrals for patients to be seen by specialist services. The patients had been seen by the lead GP, however the referrals had not been made. 	

Helping patients to live healthier lives

Staff were not consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	N
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was unable to demonstrate that they had appropriate systems in place to ensure patients received appropriate support where required. The palliative care register was not up to date, the GP was unable to articulate patients appropriate for inclusion and did not demonstrate an awareness of their ongoing needs. The lead GP confirmed that he had completed asthma reviews over the telephone. No examination had taken place, checks of inhaler technique or measurement of peak flow had been completed. Patients had not been provided with a written asthma management plan as recommended by national guidelines. Patients who were unable to attend the practice were offered telephone consultations to discuss their needs with the GP. On reviewing a sample of patients' records we found patients with complex needs were not reviewed in a face to face consultation and medicines were prescribed without a review. 	

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)	99.0%	95.7%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0.8% (4)	0.7%	0.8%	N/A

Consent to care and treatment

The practice 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.	N
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On reviewing a sample of patients' records we found a lack of contemporaneous documentation during consultations to demonstrate patients were supported in making decisions. This included a lack of detail in the recording of history, examination and investigation. This did not provide assurances that adequate assessments of patients had been completed. 	

Caring

Rating: Inadequate

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	N
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On reviewing a sample of patients' records we identified numerous concerns in the management of patients' conditions. For example: we found delayed referrals for patients with suspected cancer and patients with poor mental health that had not been referred for ongoing support of their conditions. Patients personal needs were not supported by the practice. On reviewing a sample of patients' records we found patients who were housebound had not received the appropriate care and had been excluded from clinical registers and home visit requests were not acted on with telephone consultations being carried out in place of the GP visiting the patient at home. 	

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
2933	408	76	18.6%	2.59%

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)	83.3%	83.4%	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	80.7%	81.3%	87.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)				
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)	81.0%	93.0%	95.6%	Variation (negative)
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)	84.3%	75.5%	83.8%	No statistical variation

Any additional evidence or comments
The practice was unable to demonstrate any actions they had taken to improve on patient satisfaction. The management team told us that the survey results had been discussed at a practice meeting in July 2018; however, the manager was unable to recall any action plans to address areas where satisfaction was below local and national averages. We were told that a copy of the minutes would be forwarded post inspection. These were not received.

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

Involvement in decisions about care and treatment

Patients were not 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.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found some patients with complex health needs were not seen in person by the GP; but reviewed through telephone consultations. On reviewing a sample of patients' records, we found examples where information and support had not been provided. For example: patients with mental health concerns had not been referred for support. 	

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)	81.4%	89.4%	93.5%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found no leaflets available in other languages within the waiting room. 	

Carers	Narrative
Percentage and number of carers identified.	17 carers registered at the practice. This represented 0.57% of the practice population.
How the practice supported carers.	The practice provided no evidence of how carers were supported at the practice.
How the practice supported recently bereaved patients.	No evidence was provided of how the practice supported bereaved families.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Inadequate

Responding to and meeting people's needs

Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	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.	N
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	N
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On arrival at the inspection we found that the GP had gone on annual leave for a week without ensuring appropriate clinical cover being in place. The practice exception reported patients from clinical registers if they were unable to attend the practice, for example, patients who were housebound. On reviewing a sample of patients' records we found a lack of effective care for patients with complex needs. For example: a patient with multiple conditions had not been seen by the GP in recent years. All contacts were done as telephone consultations. Treatment had been prescribed on numerous occasions without the patient being seen. Long term condition reviews had also been completed through telephone consultations. The practice was unable to demonstrate they had regular meetings with other services to ensure patients' care was co-ordinated effectively. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	9.30am to 12pm / 4pm to 6pm
Tuesday	9.30am to 12pm / 4pm to 6pm
Wednesday	9.30am to 12pm
Thursday	9.30am to 12pm / 4pm to 6pm
Friday	9.30am to 12pm / 4pm to 6pm

--	--

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2933	408	76	18.6%	2.59%

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)	88.2%	92.4%	94.8%	No statistical variation

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice was not responsive to the needs of older patients. On reviewing a sample of patients' records we found several examples of patients or relatives requesting home visits but none being undertaken, instead prescriptions had been issued, and annual reviews completed during telephone consultations.

People with long-term conditions

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice was unable to demonstrate that regular discussions were held with the local district nursing team and community matrons to manage the needs of patients with complex medical issues. Patients with long term conditions, who were housebound, did not receive a review of their condition or medication. We saw examples of where they had been exception reported to remove them from the appropriate registers.

Families, children and young people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> Nurse appointments outside of school hours were not available for children so that they did not need to miss school. We found there was no system 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.

- Safeguarding registers were inaccurate and had not been updated to reflect the current practice population.
- In the absence of the lead GP, the advanced nurse prescriber (ANP) was the clinical lead for the practice. We were told the nurse was unable to see children under the age of 1 year of age as this was not part of the ANP's role. Reception staff would direct all children in this age group to the walk-in centre to be seen. On reviewing a sample of consultations carried out by the ANP, we found children had been seen without the ANP having completed the appropriate training for this age group. This demonstrated a lack of clinical oversight by the lead GP in not providing adequate or appropriate cover for the practice population in his absence.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The needs of this population group had not been considered. The GP left the practice without any appropriate clinical cover on a regular basis. On the day of the inspection we found that the GP had not been available on the previous Friday and Monday afternoon and when the practice nurse was away on training courses or annual leave no nursing cover was organised.
- Appointments with the GP were not available until 9.30 a.m. Monday to Friday. For patients that worked, extended hours appointments were available at the local hub until 8pm and on Saturday and Sunday from 9am to 12pm.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, however we found the registers to be inaccurate. For example, the lead GP told us that patients with a learning disability and those in care homes would be included in the vulnerable persons register. On reviewing the register, we found one patient. The lead GP was unsure why the register had no other patients listed. The lead GP showed the records of two patients with a learning disability, one had received an annual review.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice was unable to demonstrate how they adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- In the absence of the lead GP, the advanced nurse prescriber had the clinical lead role. We found on reviewing a sample of the consultations that patients experiencing poor mental health had not

been offered the appropriate support.

- The management team was unaware of the new dementia service the clinical commissioning group was implementing to support patients and their families with dementia.
- There was limited knowledge of support groups within the local area.

Timely access to the service

People were not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	N
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Home visit requests were triaged by the lead GP. We found several examples of home visit requests made which had not been acted on; but dealt with as a telephone consultation. This included multiple telephone consultations with the same patient, medicine reviews and long-term condition reviews. • The lead GP had left the practice without clinical cover whilst away on holiday. We found no evidence that locum GPs had been sought to cover the practice during this time. An email had been sent to the CCG requesting support the week before the GP went on holiday, however, the practice had not followed this up once they realised the CCG had not replied. 	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	84.5%	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)	83.3%	58.3%	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)	79.9%	62.0%	65.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)	69.0%	65.8%	74.4%	No statistical variation

Source	Feedback
NHS Choices	The practice had received a total of three comments. The comments were positive about the care received and helpfulness of the staff. The practice had not responded.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On reviewing the complaints folder we found no evidence of the initial complaint letters and the management team was unable to find the letters during the inspection. The responses, which were on file, were dealt with in a timely manner, however they did not demonstrate continuous improvement and monitoring to ensure learning was embedded. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Cancellation of an appointment with the nurse.	<ul style="list-style-type: none"> An investigation was undertaken and identified that improved communication with patients was required to ensure patients were advised if their appointment was cancelled. The management team was unable to provide evidence of the initial complaints letter.
Reception staff rude	<ul style="list-style-type: none"> An investigation was undertaken and the complainant was offered an apology. The management team was unable to provide evidence of the initial complaints letter.

Well-led

Rating: Inadequate

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	N
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	
<p>The practice was unable to demonstrate effective leadership. Systems in place were putting patients at risk and the lead GP and management team did not have the capability to lead effectively and drive improvement. For example:</p> <ul style="list-style-type: none">• The clinical lead lacked capacity to effectively manage the practice and oversee all clinical areas of the practice adequately.• The practice was unable to demonstrate a culture of high-quality sustainable care. For example: Due to capacity issues the lead GP was unable to demonstrate effective clinical leadership and oversight of patient care.• The management team demonstrated a lack of knowledge to ensure effective processes were embedded to drive efficiency and ensure safety in the practice. This included the management of risk, staff development and ineffective governance processes.• We identified significant failings in the care of patients, this included: safeguarding concerns not being addressed, patient medicine reviews not being completed, overall management of patients with long term conditions and a lack of clinical oversight to ensure patients were receiving adequate care and treatment.• The practice was unable to demonstrate how they prioritised care and how clinical work was evaluated to ensure patients had received appropriate investigations, treatment and management of their health needs.	

Vision and strategy

The practice had no vision and no 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was unable to provide evidence of a vision and credible strategy to deliver high quality, sustainable care. We found due to the lack of clinical and managerial leadership the practice had been unable to embed a strategy to improve patient outcomes. The practice had limited systems in place to monitor progress and were unable to demonstrate how they planned services to meet the needs of their practice population. We found no evidence of audits being completed to demonstrate quality improvements and improve service delivery. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	N
There were systems to ensure compliance with the requirements of the duty of candour.	N
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During the inspection process we found the management team to be obstructive and unwilling to comply with the inspector's requests. For example: We asked for minutes of meetings, evidence of staff training and development, access to policies and none of this was available for the inspection team to review. Compliance with the duty of candour was not evident. We saw two referral requests that had not been acted on and we found no evidence that patients were aware of the delay in their referrals and treatment due to the lack of clinical oversight. 	

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
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>The governance processes at the practice were inadequate and demonstrated a clear lack of structure to</p>	

ensure risks were mitigated and systems were reviewed regularly. For example:

- The practice did not demonstrate that there were lead roles with clear responsibilities.
- There was no ownership or oversight of governance arrangements to ensure risks to patients were considered, managed and mitigated appropriately.
- There were no business continuity or contingency plans in place to ensure appropriate clinical cover was in place during the providers annual leave.
- We were told that all policies were being updated and were not given access to review them. We were not provided with any assurance that whilst policies were being updated staff had access to existing policies.
- There were significant concerns relating to recruitment of staff, it was confirmed by staff at the practice that recruitment of clinical staff had taken place without appropriate checks being undertaken. The personnel folder we viewed did not include a job description, evidence of training for the extended role, assessment of competencies, assessment of prescribing practices or records of observed practice or clinical supervision.
- A clinical staff member was given overall clinical responsibility for the practice without an induction and no clinical support and supervision. We were told that there was an arrangement in place with the neighbouring practice to cover for the lead GP in his absence. On speaking with the neighbouring practice, we were advised that there was no formal agreement, however if a patient came into the health centre requiring urgent medical attention then the patient would be seen irrespective of where the patient was registered.
- There was no safety netting system in place to ensure patients who were urgently referred had been dealt with appropriately.
- The system for the management of clinical correspondence was not effective. Correspondence, which included blood results, dated between the 8 and 11 April 2019 had not been reviewed by a clinician to establish any urgent action.

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.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
There was an ineffective process to identify, understand, monitor and address current and future risks including risks to patient safety. For example:	

- No practice specific risk assessments had been completed. The practice relied on the assessments of the landlord, however they had gained no assurances that these assessments appropriately covered all areas of their practice.
- The practice did not demonstrate that clinical staff working in advanced roles had received the necessary support and guidance. There was no competency framework in place, therefore no system for assessing performance.
- The practice was unable to demonstrate that clinical audits had been completed to demonstrate quality improvements. There was no evidence of action to change practice to improve quality.

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.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The management team had no oversight in the identifying and management of risk. This included risk assessments to ensure the premises were safe, staff recruitment and training and a lack of systems to ensure risks were mitigated. • Due to the lack of clinical leadership, performance was not monitored effectively to ensure patients were receiving the appropriate care. Clinical staff confirmed that they received no performance reviews of their consultations. • There was a lack of understanding by the management team of their responsibilities and when to make statutory notifications. We found no evidence to confirm they were aware of the processes they were required to follow. 	

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.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We found there was limited engagement with stakeholders to share ideas and discuss improvements for the practice population.• There was a poster in the waiting room advising patients of the patient participation group and a meeting had been organised for March 2019, however we were told that no-one attended. The practice was unable to demonstrate how they encouraged patients to join the group and how they gathered patient feedback.• The management team told us that the results of the last patient survey had been discussed in July 2018, however there was no evidence available of the meeting or any actions that had been discussed.	

Continuous improvement and innovation

There were 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: <ul style="list-style-type: none">• The practice was unable to demonstrate continuous improvement and we saw no evidence of quality improvement.	

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 Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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.