Care Quality Commission

Inspection Evidence Table

Orton Bushfield Medical Practice (1-6876103607)

Inspection date: 4 June 2019

Date of data download: 24 May 2019

Overall rating: Inadequate

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

Safe Rating: Inadequate

At the previous inspection, the practice was rated as requires improvement for providing safe services. At this inspection, the practice was rated as inadequate for providing safe services because:

- We found the practice's system for managing test results was ineffective. We found 122 outstanding test results on the practice's system, some dating back to 13 May 2019 but the majority from 29 May 2019 onwards. 86 of these test results had not been opened, therefore the practice had no assurance of any urgent concerns that needed to be addressed.
- We found the practice's system for managing patient and drug safety alerts was ineffective. We found the practice had not actioned two alerts, one of which affected three patients. There was no evidence to show the practice had taken action to protect those patients from avoidable harm.
- The practice's safeguarding processes and systems were unclear. We found one example of a safeguarding concern raised by a member of staff and the practice could not evidence any actions were taken in response to it.
- We found out of date medicines; four vials of prochlorperazine, a medicine stored in a GP bag, and one flu vaccination, all of which had expiry dates of 31 May 2019, despite a stock check having been recorded as completed after this date. This issue was previously raised as a concern at our inspection visit in February 2019.
- We found the practice had taken no action to mitigate risks identified during building and safety risk assessments. A fire risk assessment was completed in January 2018 and one action was marked for completion 'as soon as possible' as it posed a fire risk. On the day of our inspection this was still incomplete. In addition to this, the practice had completed a health and safety risk assessment but taken no action to mitigate the risks identified.
- The process for recording and handling and learning from complaints and feedback was not effective. This was raised as a concern at our July 2018 and February 2019 inspection visits.

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.	N[1]
There were policies covering adult and child safeguarding.	Partial[2]
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial[2]
Policies were accessible to all staff.	Partial[2]
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.	N[3]
There were systems to identify vulnerable patients on record.	N[4]
There was a risk register of specific patients.	N[4]
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Explanation of any answers and additional evidence:

1 – During the inspection visit, we asked to see evidence of safeguarding processes such as adult and child safeguarding policies and safeguarding registers. Members of staff we spoke with were either unable to access the information or did not know the practice's processes.

2 – We requested to see copies of the adult and child safeguarding policies. On the inspection in February 2019, we were shown a policy that lacked detail and was not practice specific. At this inspection, we found the policy had not been updated. Following this inspection, the practice provided a copy of a child safeguarding policy which was more practice specific, however, the practice did not provide us with an updated adult safeguarding policy.

3 – We identified an example of when an administrative member of staff had raised a safeguarding concern. However, there was no accompanying information on the staff member's report, in the patient's clinical record or in meeting minutes to evidence the practice had taken any action in relation to this concern. The practice did not provide any information following the inspection in relation to this.

4 – We asked to see the practice's adult and child safeguarding registers. We were told that the only member of staff who was able to access these registers was on annual leave and nobody else in the practice, including the lead GP, was able to access them. We were not provided with a copy of the registers on the day of the inspection.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y[1]
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
Explanation of any answers and additional evidence: 1 – During previous inspections visits, we found the practice had not completed Disclosure and Barring Service checks (DBS) when recruiting new members of staff. However, we found at this inspection the practice had made changes to their recruitment systems and when we reviewed the personnel files of two new members of staff, both had appropriate recruitment checks in place.	

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: January 2019	Y
There was a record of equipment calibration. Date of last calibration: January 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: August 2018	Y
There was a log of fire drills. Date of last drill: October 2018	Y
There was a record of fire alarm checks. Date of last check: August 2018	Y
There was a record of fire training for staff. Date of last training: Ongoing training as per staff requirements	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2018 with a suggested review date of January 2020.	Y
Actions from fire risk assessment were identified and completed.	N[1]
Explanation of any answers and additional evidence: 1 – During our previous inspection visits, we found the practice did not have oversight of fire risk assessments. On this inspection visit, we found the practice had obtained a copy of the fire risk assessment; however, we found actions arising from the assessment had not been completed. For example, one action which was required to be completed 'as soon as possible', involved the removal of combustible waste from the practice's boiler room. On the day of the inspection, we viewed the boiler room and found that combustible waste was still in situ.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: March 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2019	Partial[1]
Explanation of any answers and additional evidence: 1 – During previous inspection visits, we found the practice had not completed a health and safety risk assessment. On the day of this inspection we found the practice had completed a health and safety risk assessment in March 2019. The practice had identified a number of areas which required improvement, such as doors and glass in windows being damaged. However, there was no action plan in place and when we asked the practice if they had completed these actions, they told us they did not view it as their responsibility to do so.	

Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	July 2018[1]
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.	N[2]
Explanation of any answers and additional evidence: 1 – The practice had completed an infection prevention and control audit in July 2018, and we saw actions had been completed. The practice were in the process of completing a new infection prevention and control audit, which was commenced six weeks prior to our inspection but remained incomplete on the day of the inspection. 2 – On the morning of our unannounced inspection, we found clinical rooms including treatment rooms were all unlocked and open despite key pads on all of the doors. One of the treatment rooms contained all of the discarded clinical waste which was awaiting collection for disposal.	

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[1]
There was an effective induction system for temporary staff tailored to their role.	Partial
Comprehensive risk assessments were carried out for patients.	N[2]
Risk management plans for patients were developed in line with national guidance.	N[2]
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[3]

Explanation of any answers and additional evidence:

1 – We reviewed a number of staff rotas covering the weeks leading up to our inspection and found the practice was operating with small numbers of staff on some occasions. The practice told us they had struggled to recruit and retain clinicians. We found on a number of occasions, the only clinical staff available at the practice were a locum GP and locum nurse. Staff told us they were aware the practice was short-staffed, and it was difficult to meet patient demand.

2 – We reviewed care records and found patients did not always have risk management plans in place. In addition to this, patients diagnosed with mental health conditions did not always receive adequate support or reviews.

3 – The provider was aware of staffing difficulties within the practice and utilised a high number of locum staff. The practice did not provide evidence they had assessed or monitored the impact on safety.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial[1]
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.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Partial[2]
There was a documented approach to the management of test results and this was managed in a timely manner.	N[3]
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:

1 – We reviewed clinical records as part of our inspection and found records were not always written in line with current guidance. For example, we found instances where medicine review codes were added despite no evidence of a comprehensive or structured medicines review.

2 – We spoke with members of staff who were responsible for monitoring two-week wait referrals. Staff told us they only monitored referrals where patients did not attend and would not routinely follow up on referrals which may have been delayed.

3 – On the day of the inspection, we found 122 outstanding test results on the practice's system, some dating back to 13 May 2019 but the majority from 29 May 2019 onwards. 86 of these test results had not been opened, therefore the practice had no assurance of any urgent concerns that needed to be addressed. We reviewed three of these results from the 13, 14 and 17 May 2019 and found all of these results required some action, for example either a repeat test or prescribing of a medicine. The practice did not provide any information following the inspection to assure us these results had been actioned.

Appropriate and safe use of medicines

The practice did not always 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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.96	0.94	0.88	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). (01/04/2018 to 31/03/2019) (NHSBSA)	9.4%	11.3%	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 (01/10/2018 to 31/03/2019) (NHSBSA)	5.96	5.86	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.91	2.08	2.07	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[1]
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[2]
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

Medicines management	Y/N/Partial
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[3]
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N[4]
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.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial[5]
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.	Partial[6]

Explanation of any answers and additional evidence:

1 – The practice told us they did not complete any audits or monitoring of the prescribing of non-medical prescribers. The practice told us there was no formal method of clinical supervision or peer review of non-medical prescribers. However, GPs were available during the day to discuss any concerns they had.

2 – The practice had completed 1,022 medicine reviews in the preceding 12 months. We reviewed five clinical records and identified that medication review codes had been added to records with no accompanying information to demonstrate a comprehensive and structured review had taken place to ensure the prescribing was safe and appropriate.

3 – At the previous inspection in July 2018 we found the practice did not have complete oversight of the monitoring of patients prescribed high risk medicines. At our December 2018 and February 2019 inspections and at this inspection, we found the practice had made improvements to ensure they had oversight. All patients we reviewed had appropriate monitoring in place prior to prescribing.

4 – The practice told us they did not complete any audits or monitoring of the prescribing of controlled drugs.

5 – We found four vials of out of date prochlorperazine, which expired on 31 May 2019 in the emergency drug bag. This was despite a stock check having been recorded as completed on 3 June 2019. This was previously raised as a concern on our inspection in February 2019.

6 – We found one out of date flu vaccination which also expired on 31 May 2019 in a vaccine refrigerator. This was despite a stock check having been recorded as completed on 3 June 2019.

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[1]
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.	N[2]
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial[3]
Number of events recorded in last 12 months:	5[4]
Number of events that required action:	-[4]

Explanation of any answers and additional evidence:

1 – We found the practice did not always monitor and review safety. For example, we found the practice had taken no action in relation to building and fire safety risk assessments. In addition to this, not all significant events in the practice were logged or managed appropriately.

2 – The practice's significant event log detailed that no significant events had occurred since our inspection in February 2019. However, the significant events folder contained two pieces of paper with brief details in relation to two events. The significant events log was also incomplete and did not contain details of the significant events that were recorded. This was previously raised as a concern on our July 2018 and February 2019 inspections.

3 – We were able to see through meeting minutes that some significant events were discussed with staff. However, this was not a complete approach and we found examples where some events had not been discussed.

4 – As we were unable to ascertain the accurate number of significant events which had occurred in the last 12 months, it was also not possible to review how many of them needed to be actioned.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A statement from an administrative member of staff advising of a safeguarding concern.	The statement included that it was reported to the lead GP and safeguarding lead. However, there was no accompanying information to suggest any actions were taken.
A cold chain breach resulting in the loss of vaccines.	This significant event file contained no information as to actions that were taken. The practice told us they would provide details of the actions taken as they were held elsewhere. This information had not been received.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N[1]
Staff understood how to deal with alerts.	N[2]

Explanation of any answers and additional evidence:

1 – We reviewed three recent patient safety alerts for; carbimazole, sodium valproate and tapentadol.

Carbimazole: The practice had completed a search prior to our inspection and found that no patients were affected by the alert.

Tapentadol: The practice could not evidence a search had been completed prior to our inspection; although, when we completed the search we found no patients were affected by the alert.

Sodium Valproate: The practice could not evidence a search had been completed prior to our inspection. When we completed the search on the day of the inspection we found three female patients of child bearing age who would be affected by the alert. Clinical records did not evidence any consultations or discussions where the alerts were discussed with the patients. One of the three patients visited the practice shortly prior to our inspection and had a routine appointment with an Advanced Nurse Practitioner, but there was no evidence the safety alert had been discussed during the consultation. When sodium valproate is taken during pregnancy, it can affect how the baby develops in the womb and cause birth defects. Therefore, it is imperative that female patients of child bearing age are made aware of the risks.

2 – Members of staff we spoke with on the day of the inspection gave a mixed view on how the practice dealt with alerts. Some members of staff told us that all alerts were reviewed and actions taken where appropriate, whereas other members of staff did not know the practice's process for handling safety alerts.

Effective Rating: Inadequate

At the previous inspection, the practice was rated as requires improvement for providing effective services. At this inspection, the practice was rated as inadequate for providing effective services because:

- We found patients were not receiving full assessments of their clinical needs and patient care was not regularly reviewed and updated. The practice's recall system was ineffective. We reviewed the patient records system and found patients diagnosed with long-term conditions had alerts attached to their records advising a review of their conditions was overdue. However, there was no evidence that these reviews took place, and this meant we could not be assured these patients were receiving effective care and treatment.
- The practice's Quality Outcomes Framework (QOF) performance had significantly deteriorated in 2018/2019 data submitted by the practice. The practice did not have any plans in place to improve this at the time of the inspection.
- The practice's childhood immunisation uptake was below the 90% World Health Organisation minimum target and had deteriorated since our July 2018 inspection.
- We found the practice did not have a quality improvement program in place to monitor and improve the quality of care provided to patients.
- The practice did not have a system in place for monitoring the competence of clinical staff employed. We found examples where a clinician's consultations were not completed or recorded in line with NICE guidelines and this had not been identified by the practice.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N[1]
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N[2]
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

Explanation of any answers and additional evidence:

1 – We reviewed the clinical records of one patient diagnosed with a mental health condition and found that the practice had not monitored the patient's blood pressure or weight since 2017 despite the patient attending the practice on a number of occasions for routine appointments. It is important to monitor patients diagnosed with mental health conditions to ensure any deterioration is identified at the onset. In addition to this, we found two examples of patients attending the practice for regular dizziness who did not receive a full assessment of their clinical needs.

2 – The practice's recall system was ineffective. We reviewed the clinical record of one patient who had been prescribed a new medicine. We found they were due to be reviewed within one week, however, the patient did not book an appointment and the practice failed to recall them. We reviewed the patient records system and found patients diagnosed with long-term conditions had alerts attached to their records advising a review of their conditions was overdue. However, there was no evidence that these reviews took place, and this meant we could not be assured these patients were receiving effective care and treatment.

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) (01/04/2018 to 31/03/2019) (NHSBSA)	1.17	0.82	0.77	No statistical variation

Older people — Population group rating: Inadequate

Findings

The issues identified in effective affected all patients including this population group, however, there were some areas of good practice such as:

- 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.
- All patients had a named GP, including those patients in a residential care home.
- The practice attended fortnightly Multidisciplinary Team meetings which was attended by representatives of social services, community matrons, mental health team and district nurses.
- 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.

People with long-term conditions Population group rating: Inadequate

Findings

The issues identified in effective affected all patients including this population group, however, there were some areas of good practice such as:

- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The practice's performance for diabetes indicators was higher than CCG and England averages, however, due to high levels of exception reporting in these indicators it was not possible to ensure all of the patients included in this data were receiving appropriate care.

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)	85.9%	80.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	26.9% (73)	15.7%	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)	90.3%	74.4%	77.7%	Variation (positive)
Exception rate (number of exceptions).	31.7% (86)	11.9%	9.8%	N/A
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)	93.3%	79.3%	80.1%	Variation (positive)
Exception rate (number of exceptions).	28.4% (77)	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) (QOF)	72.8%	76.2%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.1% (9)	7.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.7%	90.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	13.6% (15)	13.6%	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)	81.6%	82.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.3% (27)	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)	82.5%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.6% (4)	7.6%	6.7%	N/A

Any additional evidence or comments

- On the day of our inspection, we reviewed unverified but submitted 2018/2019 Quality and Outcomes Framework (QOF) data. These results evidenced deterioration in outcomes for patients with large numbers of patients not getting recommended interventions for their specific condition, we could not be assured these patients were receiving effective care and treatment:

  Clinical indicators for Asthma had reduced from 72.8% (2017/2018) to 59.9% (2018/2019).

  Clinical indicators for Atrial Fibrillation had reduced from 82.5% (2017/2018) to 80.3% (2018/2019).

  Clinical indicators for COPD had reduced from 93.7% (2017/2018) to 58.5% (2018/2019).

  Clinical indicators for Diabetes had reduced from 85.9% (2017/2018) to 62.2% (HbA1C) (2018/2019).
  90.3% (2017/2018) to 47% (blood pressure) (2018/2019).
  93.3% (2017/2018) to 72.1% (cholesterol) (2018/2019).

  Clinical indicators Hypertension had reduced from 81.6% (2017/2018) to 61.2% (2018/2019).

- The practice was aware of this reduced data and told us recruitment and retention difficulties contributed towards the reduced performance. We asked the practice how they intended to improve this data, but we were not provided with any information.
- The submitted 2018/2019 data we reviewed did not include information in relation to the patients who were excepted from the data by the practice. Therefore, we were unable to ensure all patients included in the above data had received appropriate care and treatment.

Families, children and young people Population group rating: Inadequate

Findings

The issues identified in effective affected all patients including this population group, however, there were some areas of good practice such as:

- 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.
- Antenatal clinics were provided at the practice by the local midwifery team.
- Health visitors were able to offer appointments at the practice.
- 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)	63	69	91.3%	Met 90% minimum (no variation)
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)	56	65	86.2%	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)	57	65	87.7%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	56	65	86.2%	Below 90% minimum (variation negative)

Any additional evidence or comments
• Childhood immunisation uptake rates for three of the four immunisations were below the World Health Organisation (WHO) targets of 90% with a range of 86% to 91%. This was lower uptake than our previous inspection in July 2018. The practice was aware of this but could not explain any specific actions they had taken to improve. One member of staff told us immunisations were only provided in one clinic on a Thursday, this was disputed by the lead GP who told us clinics were provided on different days. The practice told us they believed this performance had improved and supplied us with details of patients who had recently received their immunisations; however, was not a complete list of patients.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The issues identified in effective affected all patients including this population group, however, there were some areas of good practice such as:

- 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.
- 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)	67.5%	70.9%	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)	67.7%	73.4%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	49.3%	56.9%	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)	58.8%	63.0%	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)	56.3%	60.6%	51.9%	No statistical variation

Any additional evidence or comments

- The practice's uptake for cervical screening was 68%, which was below the 80% coverage target for the national screening programme but comparable with the local and national averages. This had previously been raised as a concern at our April 2016 and July 2018 inspection visits.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings
The issues identified in effective affected all patients including this population group, however, there were some areas of good practice such as: • End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice held a register of patients living in vulnerable circumstances including those with a learning disability. We requested information from the practice in relation to the number of learning disability health checks completed, but this was not provided. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings
The issues identified in effective affected all patients including this population group, however, there were some areas of good practice such as: • There was a system for following up patients who failed to attend for administration of long-term medication. • A PRISM (Primary Care Mental Health Service) worker facilitated appointments at the practice. • 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)	72.9%	91.0%	89.5%	Tending towards variation (negative)
Exception rate (number of exceptions).	9.4% (5)	13.1%	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)	87.5%	89.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.4% (5)	11.7%	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)	72.7%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	8.3% (2)	6.6%	6.6%	N/A

Any additional evidence or comments

- On the day of our inspection, we reviewed unverified but submitted 2018/2019 Quality and Outcomes Framework (QOF) data. These results evidenced deterioration in outcomes for patients with large numbers of patients not getting recommended interventions for their specific condition, we could not be assured these patients were receiving effective care and treatment:

  Dementia had reduced from 72.7% (2017/2018) to 61.1% (2018/2019).

  Schizophrenia, bipolar affective disorder and other psychoses care plans had reduced from 72.9% (2017/2018) to 66% (2018/2019) and alcohol consumption had reduced om 87.5% (2017/2018) to 58.8% (2018/2019).

The practice was aware of this data and told us recruitment and retention difficulties contributed towards the reduced performance. We asked the practice how they intended to improve this data, but we were not provided with any information.

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)	539.9	543.0	537.5
Overall QOF exception reporting (all domains)	9.8%	6.5%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
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

- Audits provided on the day of the inspection did not demonstrate improvements to the quality of care provided.
- One audit provided by the practice was a safeguarding audit which had been completed by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and not the practice.
- Another audit provided by the practice was an audit in relation to the storage of vaccines following a cold chain breach. The practice told us they would send examples of completed audits following the inspection, these were not received.

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.	Partial[1]
The learning and development needs of staff were assessed.	N[1]
The practice had a programme of learning and development.	N[1]
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	N[2]
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A[3]
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[4]
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[5]
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N[5]

Explanation of any answers and additional evidence:

1 – The practice's programme of learning and development was unclear. We found two nurses who were providing childhood immunisations but had no record of completing anaphylaxis training to ensure patients were safe in the event of a medical emergency. The registered provider told us they would provide this evidence following the inspection, this evidence has not been received.

2 – We reviewed the personnel files of two newly appointed members of staff. We found neither member of staff had completed a full induction program; one of these members of staff had no record of any induction program at all.

3 – The practice had not employed any new Health Care Assistants since the introduction of the Care Certificate.

4 – The staff appraisal and supervision system was unclear. We found that some members of staff had not received a full induction process and there was no evidence of any supervision or appraisal meetings for these members of staff.

5 – We reviewed three clinical consultation records of a locum clinician and identified a number of concerns such as; consultations were lacking in detail and were not of sufficient quality and therefore did not meet NICE guidelines. These records could not demonstrate patients seen by this member of staff received safe and effective care and treatment. The lead GP reviewed these consultations on the day of the inspection and agreed with the inspection team that these did not meet standards for record keeping. We asked for evidence of how the practice could demonstrate the competence of staff employed, and the practice were unable to do this.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

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[1]
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: 1 – We reviewed the medical records of patients who were in the last 12 months of their lives and found the practice used a co-ordinated approach with other agencies and services to ensure support was provided.	

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)	95.5%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.9% (21)	0.9%	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.	N[1]
Explanation of any answers and additional evidence: 1 – Whilst we did not find any examples where consent had not been obtained from the patient records we reviewed, the practice did not audit or review the process for seeking consent.	

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

Source	Feedback
Patient comment cards	Due to the inspection being unannounced, the practice did not receive CQC patient comment cards to display in the waiting area.
NHS choices	Since the previous inspection, in February 2019. One review has been posted on NHS Choices with the rating of one star. NHS choices overall had an average of two and a half stars out of a possible five and a mixture of positive and negative feedback. Some patients advised of a positive, caring attitude amongst staff whilst others made references to negative experiences received at the practice in relation to how patients are treated.
Patient consultations	Patients we spoke with on the day of the inspection were positive about the way staff treated people.

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
5220	344	115	33.4%	2.20%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	85.6%	90.5%	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)	84.9%	89.1%	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)	95.6%	96.3%	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)	74.2%	85.6%	83.8%	No statistical variation

Any additional evidence or comments
• The practice was aware of low patient satisfaction in relation to the overall experience of their GP practice. The practice believed this was down to accessing the practice rather than the caring nature displayed by the practice team. The practice pointed out this was reflective of the other indicators in the National GP Patient Survey which highlighted results in line with the CCG and England averages for caring indicators.

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

Any additional evidence
The practice's Patient Participation Group (PPG) undertook an annual survey in collaboration with the practice. As this was an unannounced inspection, we were unable to speak to the practice's PPG, however, on our previous inspection in February 2019, we spoke with the PPG and reviewed their latest patient survey exercises.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Patient consultations	Patients we spoke with on the day of the inspection told us they felt involved in decisions about care and treatment. This was reflective of the National GP Survey results where 92.5% of patients felt they were involved as much as they wanted to be in decisions about their care and treatment.

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)	92.5%	94.6%	93.5%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	We asked to review the practice's carers register to ascertain the number of carers the practice had identified and supported. We were told the only member of staff able to access the register was on annual leave and no other member of staff in the practice was able to access the register. During our previous inspection visits, we had been told the register was not up-to-date due to coding issues.
How the practice supported carers.	The practice provided information for carers on noticeboards within the practice; this included support groups and services.
How the practice supported recently bereaved patients.	The practice informed us that they would contact recently bereaved patients or families to offer their condolences and any support that may be required.

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[1]
There were arrangements to ensure confidentiality at the reception desk.	Y[1]

Explanation of any answers and additional evidence:

1 – The practice had installed signage at the reception desk asking patients to stand a distance away from the desk whilst waiting to be seen. In addition to this, members of staff we spoke with told us they were aware a private room could be utilised if patients were distressed or wanted to discuss sensitive issues.

Responsive Rating: Inadequate

At the previous inspection, the practice was rated as inadequate for providing responsive services. At this inspection, the practice remained rated as inadequate for providing responsive services because:

- Patient feedback through the National GP Patient Survey, NHS Choices and feedback on the day of the inspection was negative in relation to accessing the practice. The practice had installed a new telephone system to create further telephone lines but continued to only use one member of staff to answer the lines. The new telephone system had also not been evaluated by the practice to monitor any improvement.
- The practice was due to implement a new appointment system from 17 June 2019, however staff we spoke with told us they had no information or training on this system and did not know what it entailed. No information was made available to patients.
- The process for recording and handling and learning from complaints and feedback was still not effective. This was raised as a concern on our July 2018 and February 2019 inspection visits.

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.	Y
The facilities and premises were appropriate for the services being delivered.	Partial[1]
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence: 1 – We found the practice had not acted upon issues identified in health and safety and fire safety risk assessments. Some of these issues included doors and glass in windows being damaged and there was no evidence to suggest these were due to be repaired.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8.30am to 1pm and 1.30pm to 6pm
Tuesday	8.30am to 1pm and 1.30pm to 6pm
Wednesday	8.30am to 1pm and 1.30pm to 6pm
Thursday	8.30am to 1pm and 1.30pm to 6pm
Friday	8.30am to 1pm and 1.30pm to 6pm
Appointments available:	
Monday	8.30am to 1pm and 1.30pm to 6pm
Tuesday	8.30am to 1pm and 1.30pm to 6pm
Wednesday	8.30am to 1pm and 1.30pm to 6pm
Thursday	8.30am to 1pm and 1.30pm to 6pm
Friday	8.30am to 1pm and 1.30pm to 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5220	344	115	33.4%	2.20%

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)	93.0%	95.5%	94.8%	No statistical variation

Older people — Population group rating: Inadequate

Findings

The issues identified in responsive affected all patients including this population group, however, there were some areas of good practice such as:

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

People with long-term conditions — Population group rating: Inadequate

Findings

The issues identified in responsive affected all patients including this population group, however, there were some areas of good practice such as:

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Inadequate

Findings

The issues identified in responsive affected all patients including this population group, however, there were some areas of good practice such as:

- Additional pre-bookable appointments were available through a network of local GP practices to ensure school children did not need to take time away from school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice told us all parents or guardians calling with concerns about a child were offered a same day appointment when necessary. However, we saw evidence of a complaint which was in relation to same day appointments for children. In addition to this, patients we spoke with on the day of the inspection told us how difficult it was to get an appointment for families with children.

Working age people (including those recently retired and students) — Population group rating: Inadequate

Findings

The issues identified in responsive affected all patients including this population group, however, there were some areas of good practice such as:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Additional pre-bookable appointments were available through a network of local GP practices to ensure patients did not necessarily need to take time away from work.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings
The issues identified in responsive affected all patients including this population group, however, there were some areas of good practice such as: • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings
The issues identified in responsive affected all patients including this population group, however, there were some areas of good practice such as: • Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff we spoke with had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when 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)	30.2%	N/A	70.3%	Significant Variation (negative)
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)	43.9%	74.1%	68.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	50.2%	69.3%	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)	65.7%	79.7%	74.4%	No statistical variation

Any additional evidence or comments
• The practice was aware of negative feedback from patients in relation to accessing the practice. Since the previous inspection in July 2018, the practice had installed a new telephone system in the practice. This system was installed after the above National GP Patient Survey was conducted. • The practice had not yet completed any evaluation of the new telephone system which was installed in August 2018. In addition to this, whilst the new telephone system allowed for two lines, the practice continued with only one member of staff answering the telephone. This had been raised during our February 2019 inspection. • The practice told us a new appointment system was to be launched on 17 June 2019 and posters in the waiting room notified patients of this. However, when we spoke with staff they told us they had received no information or training on the new appointment system and did not know what it was. They also told us there was no information available to patients who asked what the new system would be.

Source	Feedback
Patient comment cards	Due to the inspection being unannounced, the practice did not receive CQC patient comment cards to display in the waiting area.
NHS choices	Reviews on NHS choices had an average of two and a half stars out of a possible five and a mixture of positive and negative feedback. The majority of the negative feedback included comments in relation to difficulty accessing appointments and getting through to the practice by telephone.
Patient consultations	Patients we spoke with on the day of the inspection told us they had difficulties when trying to access appointments.

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.	N/A[1]
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	0[1]
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	N/A[1]

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N[2]

Explanation of any answers and additional evidence:

1 – We found that not all complaints were recorded and where they were, they were not always appropriately managed. We found one complaint in the file from March 2019 with no acknowledgement or response; and one complaint acknowledgement from May 2019 but no details of the complaint or final response. The practice's complaints log was blank, so we were unable to ascertain the number of complaints which had been received. This had been raised as a concern during on July 2018 and February 2019 inspections.

2 - The practice was unable to evidence how complaints were used to drive improvement.

Well-led Rating: Inadequate

At the previous inspection, the practice was rated as inadequate for providing well-led services. At this inspection, the practice remained rated as inadequate for providing well-led services because:

- We found the practice had not made improvements to address all of the concerns noted in our previous inspection reports. Where the practice had made improvements, some of these had not been sustained.
- During this inspection we identified a number of new concerns relating.
- We found a lack of leadership capacity and capability to successfully manage challenges and implement and sustain improvements.
- We found the governance systems and management oversight did not ensure that services were safe or that the quality of those services was effectively managed.

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[1]
They had identified the actions necessary to address these challenges.	N[2]
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N[3]

Explanation of any answers and additional evidence:

1 – The practice did not evidence concerns with quality identified during our previous inspection visits had been addressed in full. The practice leadership team were unable to evidence they fully understood the requirements and how to meet them.

2 – We found a lack of leadership capacity and capability to successfully manage challenges and implement and sustain improvements. For example, issues highlighted in our previous inspection visits remained a concern and some improvements the practice had made had not been sustained.

3 – The practice did not have a succession plan in place and had not identified any future planning at the practice.

Vision and strategy

The practice did not have a clear vision or a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	N[1]
There was a realistic strategy to achieve their priorities.	N[2]
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N[1]
Staff knew and understood the vision, values and strategy and their role in achieving them.	N[1]
Progress against delivery of the strategy was monitored.	N[2]
Explanation of any answers and additional evidence: 1 – The practice did not provide us with a vision or set of values. Practice staff we spoke with were unaware of the practice's vision or set of values. 2 – The practice did not have a strategy in place to achieve their priorities. The practice was working towards an action plan which was created following our recent inspection visits; however, beyond this the practice had no future planning or strategy. The practice had recently formed a Primary Care Network (PCN) with other local practices and were working towards plans for future delivery.	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

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

Source	Feedback
Staff consultations	Members of staff we spoke with were happy with working at the practice and felt supported by the management team. Staff reported a good morale in the practice and felt comfortable with the roles and responsibilities they were given.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N[1]
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: 1 – We found there were insufficient governance structures and systems in place. For example, practice systems and processes were unclear and we received contradictory information from different members of staff as to how processes should be followed.	

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[1]
There were processes to manage performance.	N[2]
There was a systematic programme of clinical and internal audit.	N[3]
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[4]
Explanation of any answers and additional evidence: 1 – The practice did not provide evidence to show comprehensive assurance systems were in place. For example, we found the practice had failed to identify risks to patient safety which we found on the day of the inspection. 2 – We found three consultations completed by a locum clinician which were not in line with NICE guidelines. We brought this to the attention of the lead GP who agreed these were not in line with NICE guidelines. However, the practice had not identified this performance issue due to a lack of competency checks and supervision processes. 3 – We found the practice did not have a systematic programme of clinical and internal audit. 4 – The provider was aware of staffing difficulties within the practice and utilised a high number of locum staff. The practice did not provide evidence they had assessed or monitored the impact on safety.	

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[1]
Performance information was used to hold staff and management to account.	N[1]
Our inspection indicated that information was accurate, valid, reliable and timely.	N[2]
There were effective arrangements for identifying, managing and mitigating risks.	N[3]
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:
1 – The practice could not provide evidence to show performance data was used to drive improvement such as Quality Outcomes Framework data, patient feedback through the National GP Patient Survey or our previous inspection reports from July 2018 and February 2019.
2 – During the inspection visit we asked to see a number of documents and information which the practice did not provide or could not provide due to the information being inaccurate or inaccessible. For example, the number of carers identified and supported by the practice was not provided as the practice was aware the data was incorrect and staff could not access safeguarding registers. In addition to this, some documents requested by the inspection team in supporting evidence were not received.
3 – We found the practice had not taken action to mitigate risks identified during building and safety risk assessments, such as health and safety and fire safety. We also found the practice did not have processes in place to identify risk, such as with patient and drug safety alerts.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial[1]
Staff views were reflected in the planning and delivery of services.	N[2]
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: 1 – Whilst the practice had taken action to improve patient experiences through the National GP Patient Survey and NHS Choices by installing a new telephony system; we found this system was not effective and the practice had not evaluated the impact on patients. 2 – We found practice staff were not always aware of changes, or potential changes the practice leadership team were making. For example, changes to the appointment system and the provision of childhood immunisations.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N[1]
Learning was shared effectively and used to make improvements.	N[2]
Explanation of any answers and additional evidence: 1 – The practice was unable to evidence effective systems for learning and improvement to monitor and improve the care provided. 2 – The practice was unable to evidence learning was shared effectively across the staff teams. We found the staff meeting minutes did not always demonstrate learning or actions were shared.	

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 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.