

# Care Quality Commission

## Inspection Evidence Table

### West Street Surgery (1-540962306)

Inspection date: 22 May 2019

Date of data download: 15 May 2019

## Overall rating: Requires Improvement

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

### Safe Rating: Requires Improvement

At the September 2018 inspection, we rated the practice as inadequate for providing safe services because:

- The practice had not completed risk assessments for fire or health and safety. For risk assessments that had been completed, such as for legionella, the practice had not completed any remedial actions.
- The practice had ineffective systems to manage risk. When incidents did happen, the practice did not share learning from them or improve their processes.
- There was a lack of oversight of complaints, significant events and safety alerts. This led to a lack of learning from these events.
- Not all staff had completed the required mandatory training. Reception staff had not been trained regarding the 'red flag' symptoms of sepsis.
- There were gaps in the system used for prescribing certain medicines that required additional monitoring. The practice could not provide evidence to assure us that blood test results were always reviewed prior to prescribing.
- There was a delay in dealing with correspondence into the practice.
- Staff immunisations were not recorded for both clinical and non-clinical staff.
- We found gaps in record keeping to support appropriate monitoring of the cold chain, as vaccination fridge temperatures were not consistently recorded.
- There was lack of evidence concerning the cleaning of the building.

At the May 2019 inspection, we rated the practice as requires improvement for providing safe

services because:

- The practice had systems in place to assess risk. However, these were not always effective and remedial works were not consistently being completed.
- There was clearer oversight of significant events and safety alerts. However, actions discussed were not always reviewed or completed to ensure learning and improvement.
- The system to monitor medicines that needed additional monitoring had been reviewed. Records we looked at confirmed that the appropriate monitoring was now completed and recorded.
- The process of receiving correspondence into the practice had been reviewed and we saw that there was no evidence of delay in clinician review.
- All staff had received safeguarding and fire training.
- The systems to ensure infection prevention and control had improved and an audit had been completed and acted upon. However, there were no records of cleaning non-single use items of equipment.
- Weekly fire extinguisher checks had not been completed since November 2018 in line with their own policy.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Partial
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection, we found:</p> <ul style="list-style-type: none"> <li>• Safeguarding policies and procedures had not been shared with staff due to a lack of staff meetings.</li> <li>• Not all staff had completed appropriate safeguarding training.</li> <li>• Safeguarding registers were not up to date and these were not shared with staff or discussed at clinical meetings.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Safeguarding policies had been discussed in staff meetings. Additional policies and procedures were in place and accessible to all staff on the shared drive. All policies had been updated in April 2019. However, not all key changes had been disseminated to staff and staff were unaware of the contents of the new policies.</li> <li>• All staff had completed the appropriate safeguarding training.</li> <li>• Safeguarding registers were kept, and vulnerable patients were discussed regularly at multi-disciplinary (MDT) meetings with both adult and children's community workers present.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• Appropriate DBS checks had not been completed for staff working as chaperones.</li> <li>• Records of staff immunisations were not held.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Clinical staff and those who were required to act as a chaperone had completed DBS checks and staff immunisation records were held.</li> <li>• The practice regularly relied on locum GP's however, the practice did not check to ensure they had medical indemnity in place. Following the inspection, we received evidence that work was being completed to ensure the appropriate recruitment documentation was in place for recruitment staff.</li> </ul>	
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: 06/09/2018	Y
There was a record of equipment calibration. Date of last calibration: 06/09/2018	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: 02/11/2019	Partial
There was a log of fire drills. Date of last drill: 16/05/2019	Y
There was a record of fire alarm checks. Date of last check: 18/03/2019	Y
There was a record of fire training for staff. Date of last training: Ongoing as per staff need	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 08/11/2018	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: At the September 2018 inspection we found: <ul style="list-style-type: none"> <li>Regular weekly fire extinguisher checks were being completed.</li> <li>Regular fire drills had not taken place and not all staff had received fire safety training.</li> <li>Actions from a legionella risk assessment had not been completed.</li> </ul> At the May 2019 inspection we found: <ul style="list-style-type: none"> <li>Weekly fire extinguisher checks had not been completed since November 2018.</li> <li>Actions that had been identified from the fire risk assessment had not been completed. For example, the fire risk assessment had highlighted that the building required more smoke alarms, but these had not yet been fitted. The practice told us this had been assessed as a low risk and was due for completion in September 2019.</li> <li>All staff had received training and regular fire drills were being conducted.</li> <li>Remedial works identified from the legionella risk assessment, such as repairing the cold-water storage tank, had been completed since our last inspection.</li> </ul>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: 14/02/2019	Y

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14/02/2019	Y
Explanation of any answers and additional evidence:  The health and safety risk assessment identified actions for completion, for example, the removal of paper shredding cabinets from staff areas. These actions had appropriate timescales and were reviewed on completion.	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met however, there was a lack of cleaning records for some equipment.**

	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:22 Jan 2019	Y
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:	
At the September 2018 inspection we found:	
<ul style="list-style-type: none"> <li>The practice had ineffective infection prevention and control procedures (IPC) and an audit had not been completed.</li> <li>There was no evidence of cleaning being completed or a cleaning schedule for the building. The practice was visibly clean and tidy.</li> </ul>	
At the May 2019 inspection we found:	
<ul style="list-style-type: none"> <li>The practice had an IPC lead in place who had reviewed IPC policies and completed an infection control audit. Actions had been identified and remedial work was being undertaken.</li> <li>There was good communication with the cleaning agency. We saw evidence of cleaning sheets to ensure appropriate cleaning, according to the created schedule, had been completed.</li> <li>Not all non-single use equipment, such as ear syringing machines, had cleaning logs.</li> </ul>	

## Risks to patients

**There were systems to assess, monitor and manage risks to patient safety however, there was not an appropriate induction process in place for locum staff.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	N
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted, and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely	Y

unwell patient and had been given guidance on identifying such patients.	
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

At the September 2018 inspection we found:

- Staff reported that GP absences were not managed appropriately, for example, if locum GPs did not arrive for sessions booked. Some GP partners would often arrive up to an hour late to start clinical sessions.
- Receptionists had not received training to recognise acutely unwell patients or patients showing 'red flag' signs of sepsis.

At the May 2019 inspection we found:

- GP sessions continued to start late on a regular basis. Patients told us that appointments were often late, and they were not informed of how long the delay would be. The waiting area had a board to detail how late clinics were running but it was not updated regularly. The practice informed us that they had installed a screen that would inform patients of late running clinics. However, management teams were unaware if this was being used.
- The practice had provided internal training for reception staff to recognise the signs of sepsis. The reception staff understood how to escalate patients who were acutely unwell.
- A locum pack had been developed to induct new locum staff however, it was not being used in the practice. Locums did not sign to agree the practices policies and procedures.

**Information to deliver safe care and treatment**

**Staff had the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	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.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>The system to manage referrals and correspondence into the practice was unclear and staff told us there could be a delay of up to two weeks for referral letters to be seen by a clinician.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>Clinical records and referral letters we looked at showed accurate and detailed clinical detail. However, we saw some examples where patients who were being referred for urgent investigation had not been told that this would be to exclude a cancer diagnosis.</li> <li>We saw that there was no delay in clinicians reviewing referral letters.</li> </ul>	



## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) <small>(NHS Business Service Authority - NHSBSA)</small>	0.86	0.94	0.91	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). (01/01/2018 to 31/12/2018) <small>(NHSBSA)</small>	7.3%	8.4%	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 (01/07/2018 to 31/12/2018) <small>(NHSBSA)</small>	6.32	5.95	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) <small>(NHSBSA)</small>	3.23	2.20	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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had not completed the appropriate monitoring for patients on high risk medicines prior to prescribing.</li> <li>• We saw no evidence of prescribing audits being completed.</li> <li>• We saw gaps in the records of fridge temperature checks to support the appropriate use of the cold chain.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had reviewed the system for monitoring high risk medicines. Records we checked showed all patients had received the appropriate monitoring prior to prescribing.</li> <li>• The practice monitored and audited antibiotic prescribing and discussed this at clinical meetings. Posters displayed in the practice aimed to educate patients in the appropriate use of antibiotics.</li> <li>• All emergency medicines were held in a cupboard behind a locked door. All were within their</li> </ul>	

**Medicines management****Y/N/Partial**

expiry dates and there were systems in place to ensure regular checks were completed. The practice held oxygen and a defibrillator that were checked daily. Vaccines were stored in locked fridges. Temperature checks were completed daily to ensure that vaccines were stored within the recommended range.

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

**The practice had some systems to learn and made improvements when things went wrong however this was not always effective.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
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: (log commenced in Dec 2018)	19
Number of events that required action:	19
Explanation of any answers and additional evidence:	
<p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>There was no oversight of significant events and the management teams were unable to provide evidence that incidents had been dealt with appropriately or learning taken from them.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>The practice had implemented a system to record significant events and incidents. We saw evidence that these were discussed in clinical meetings and actions to improve practice were created. However, there were no records of the actions being completed and these were not reviewed. We saw evidence that some actions had been completed.</li> <li>We also saw evidence of complaints that met the criteria for a significant event, such as a missed diagnosis, however, these were not being managed as a significant event.</li> </ul>	

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

Event	Specific action taken
Incorrect blood result added to a patient records by a receptionist.	Actions identified included further training and resources for the reception staff. However, there was no evidence this had been completed.
Breach of patient confidentiality as incorrect letter was sent to a patient.	Actions identified included discussion with administration staff and the correct letter being re-sent. This error was not disclosed to the patient whose information was sent incorrectly. There is no evidence that the actions had been completed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• Safety alerts were sent to individual clinicians however, there was no oversight of actions that had been taken.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had good oversight of safety alerts and had systems in place to ensure they were appropriately actioned. Records we looked at showed that clinical care was being given in line with recent safety alerts.</li> </ul>	

## Effective

## Rating: Inadequate

At the September 2018 inspection we rated the practice as inadequate for providing effective services because:

- There was no evidence of health checks being completed.
- Limited numbers of care plans were being completed.
- Not all staff had received mandatory training.

At the May 2019 inspection, we rated the practice as inadequate for providing effective services because:

- There was evidence of health checks being completed, however low numbers of patients had received health checks.
- There were limited numbers of care plans being completed for those in vulnerable groups.
- All staff had received training required by the provider and management teams had oversight of training needs. There was no evidence of appraisal processes for salaried GP's.
- There was high exception reporting in some areas however, shortly after the inspection we received unverified data indicating that this had decreased in the last year.

### Effective needs assessment, care and treatment

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

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

deteriorated.

Explanation of any answers and additional evidence:

Clinical records we looked at showed patients were being appropriately assessed and managed in line with recent guidelines and alerts.

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) <small>(NHSBSA)</small>	1.27	0.87	0.79	No statistical variation

### Older people

### Population group rating: Requires Improvement

#### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice 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.
- Older people received regular structured medicine reviews.

### People with long-term conditions

### Population group rating: Inadequate

#### Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with diabetes, asthma and COPD were involved in creating personalised care plans and were prescribed rescue medicine for use in a crisis where appropriate.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.9%	79.3%	78.8%	Variation (positive)
Exception rate (number of exceptions).	22.7% (148)	15.8%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.6%	76.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	32.5% (212)	13.7%	9.8%	N/A



	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	90.7%	82.2%	80.1%	Variation (positive)
Exception rate (number of exceptions).	27.8% (181)	15.6%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	78.1%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (21)	8.0%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.3%	90.1%	89.7%	No statistical variation
Exception rate (number of exceptions).	17.9% (40)	13.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.5%	82.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.6% (127)	5.1%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	91.0%	92.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.8% (13)	5.0%	6.7%	N/A

## Families, children and young people

## Population group rating: Requires Improvement

### Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets. There had been an increase in uptake of immunisations since the September 2018 inspection.
- The practice nursing team gave immunisations and advice opportunistically to patients who had not attended for specific immunisation appointments.
- Any child who had not attended for immunisation was referred to the health visitor.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	125	134	93.3%	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)	142	149	95.3%	Met 95% WHO based target (significant variation positive)
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)	142	149	95.3%	Met 95% WHO based target (significant variation positive)
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)	141	149	94.6%	Met 90% minimum (no variation)

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

Population group rating: Inadequate

### Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. However, low numbers of patients had received health checks and patients we spoke to had not received invites to attend the practice for a health check. The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.
- 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)	78.7%	74.0%	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)	79.2%	73.2%	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)	58.8%	56.3%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	33.3%	60.9%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	55.2%	55.8%	51.9%	No statistical variation

### Any additional evidence or comments

The nursing team had recently commenced a programme of telephoning patients who had not attended for cancer screening, including smear tests.

At the September 2018 inspection we found:

- The practice was unable to provide evidence of health checks completed and there was no system in place for inviting eligible patients to attend.

- There were 401 patients on the cancer register and 16 of these had care plans.

At the May 2019 inspection we found:

- Low numbers of eligible patients had received health checks. Patients we spoke to told us they had not been invited for health checks.
- There were 425 patients on the cancer register and 45 of these had care plans.

## People whose circumstances make them vulnerable

## Population group rating: Inadequate

### Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. However, care plans were not completed. The practice held regular MDT meetings with community teams to discuss these patients.
- 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 and signposted these patients to local specialist services.

At the September 2018 inspection we found:

- There were 52 people with a learning disability on the practice register and none of these had care plans.
- The practice did not hold a register of people in vulnerable circumstances including homeless people and travellers.
- There were 42 patients with palliative care needs on the practice register and two of these had care plans.

At the May 2019 inspection we found:

- There were 59 patients with a learning disability on the practice register and 27 of these had care plans.
- A register of patients in vulnerable circumstances such as homeless people or travellers had not been developed.
- There were 49 patients receiving palliative care and six of these had care plans.

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

**Population group rating: Inadequate**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice was due to commence a system of identifying patients with early signs of dementia by using an electronic tool.
- Not all staff had received dementia awareness training in the last 12 months.

At the September 2018 inspection we found:

- There were 105 people on the register of those suffering from a mental health condition and none of these had care plans.
- There were 76 people with dementia on the practice register and three of these had care plans.
- There were 1038 patients with a diagnosis of depression and none of these had care plans.

At the May 2019 inspection we found:

- There were 105 people on the register of those suffering from a mental health condition and seven of these had care plans.
- There were 89 people with dementia on the practice register and four of these had care plans.
- There were 1049 patients with a diagnosis of depression and four of these had care plans.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.9%	90.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	47.6% (20)	20.0%	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)	92.3%	91.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	38.1% (16)	17.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.0%	83.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.8% (6)	8.3%	6.6%	N/A

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543.6	538.7	537.5
Overall QOF exception reporting (all domains)	7.7%	6.4%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
<b>Any additional evidence or comments:</b>	
The practice had completed clinical audits however was not reviewing the consultations of all clinicians, such as the clinical pharmacist. There was also evidence of poor coding of patients and high exception reporting with no plans to improve processes.	

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

- Following an incident where a patient had been prescribed incorrect hormonal medicine after a hysterectomy, the nursing team had completed an audit of patients on these medicines and adjusted any treatment regimens as necessary.
- An audit had been completed regarding antibiotic use within ear infections and sinusitis. The results of the first audit were shared with the staff and the second cycle showed improvement in appropriate prescribing.

**Any additional evidence or comments:**

At the September 2018 inspection we found:

- Exception recording was above the local and national averages. The practice suggested that not all staff were following the exception reporting policy, and this was reviewed shortly after the inspection.

At the May 2019 inspection we found:

- Exception reporting was still above local and national averages in some areas. The practice told us that this was due to the heavy reliance on locum GPs and they often did not code patients and consultations appropriately. There was no administration support to ensure this had been completed correctly. Appropriate coding for patients was not included in the locum induction booklet.



## Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles however there was limited oversight of appraisals and supervision and no embedded induction for locum staff.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice did not complete regular appraisals with staff and training needs had not been assessed.</li> <li>• There were unclear induction procedures for new staff and locums.</li> <li>• Staff told us they had to complete training in their own time.</li> <li>• There was no clear approach for managing staff whose performance was poor or variable.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• There was limited oversight of staff appraisals and supervision. However, staff we spoke with told us they had received appraisals in the last year. We did not see evidence of internal or external appraisals completed for locum or salaried GPs.</li> <li>• The practice had developed competency assessments for clinicians. However, there was no competency programme for reception or administration staff.</li> <li>• GP's completed ad-hoc reviews of the consultations completed by the clinical pharmacist, however, this was not done on a formal basis and did not feed into appraisals data.</li> <li>• The practice had developed an induction pack for locum staff. However, this had not been embedded into practice and locum staff were not asked to sign documents to ensure their</li> </ul>	

knowledge of the practices policies and procedures. The locum pack was provided in a paper copy for locums and contained electronic links to key documents that were unable to be accessed.

- There was oversight of staff training and all staff had completed training required by the provider. There were no records of the training that locum staff had received.
- There was still no clear approach for the management of staff performance.

## 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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice held regular MDT meetings with community teams, including safeguarding and child health teams. We saw evidence that patients with complex needs or in vulnerable circumstances were discussed and referred to other services appropriately.</p>	

## Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	95.3%	94.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (17)	1.0%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: Records we looked at showed that consent was sought and recorded appropriately. Staff had good knowledge of Gillick and Fraser guidelines. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.	

At the September 2018 inspection we rated the practice as requires improvement for providing caring services because:

- The practice did not hold a register of carers
- The practice did not offer additional support or services for those identified as carers.

At the May 2019 inspection we rated the practice as requires improvement for proving caring services because:

- The practice held a carers register and had begun identifying carers however, the number of identified carers was lower than 0.5% of the practice population. The practice was signposting carers to appropriate community support.
- We saw staff treating patients with kindness and compassion.

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Staff we spoke with showed compassion and care for patients. Patients we spoke with told us that staff were friendly and caring.	

CQC comments cards	
Total comments cards received.	40
Number of CQC comments received which were positive about the service.	32
Number of comments cards received which were mixed about the service.	8
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards	Patients told us that they were happy with the service and that staff were kind and helpful.
Patient feedback	Patients we spoke with told us that staff were compassionate and they felt involved in their care and treatment plans.

## 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
12405	262	109	41.6%	0.88%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	87.2%	88.7%	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)	80.1%	85.7%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	95.8%	95.7%	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)	76.5%	82.0%	83.8%	No statistical variation

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

#### Any additional evidence

The practice reviewed the NHS Family and Family test (FFT) scores and discussed these at clinical meetings. There was no evidence of changes made to the service in response to these comments. The practice provided a plan of how to review the FFT scores shortly following the inspection.

#### 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
Interviews with patients.	Patients told us that changes to their treatment was explained to them in a way they could understand, and they had enough time in consultations to ask any questions. They told us they felt involved in any decision making.

#### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	90.2%	92.7%	93.5%	No statistical variation

#### Any additional evidence or comments

The practice had not made or planned any improvements following the GP patient survey.



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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 47 carers which was less than 0.5% of their practice population. However, this was an increase since the September 2018 inspection.
How the practice supported carers.	The practice had posters in reception to signpost carers to signpost to local services
How the practice supported recently bereaved patients.	The practice produces leaflets to support bereaved patients.

## Privacy and dignity

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

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Treatment doors remained closed during consultations and the reception area was away from the waiting area to ensure patients privacy was maintained.</p> <p>However, on two occasions we found computers that had patient records on the screen in unlocked rooms when there was no clinicians present.</p>	

## Responsive

## Rating: Inadequate

At the September 2018 inspection we rated the practice as inadequate for providing responsive services because:

- There was no evidence of learning from complaints.
- There was no evidence of planned improvements in relation to the results from the National GP Patient Survey Results published in August 2018.
- The practice did not tailor services to the needs of the population or effectively care plan for patients.

At the May 2019 inspection we rated the practice as inadequate in providing responsive care because:

- The practice had more oversight of complaints however, was not consistently learning from them.
- There was a lack of identification of significant events from some complaints received and a lack of actions taken.
- The practice did not have an action plan in place or improvements made to address areas of low patient satisfaction in the national GP patient survey. The practice did not carry out its own patient surveys to collect feedback.
- Patients told us that some GP sessions often started late.

This affected all population groups and therefore they have all been rated as requires improvement.

### Responding to and meeting people's needs

#### The practice organised and delivered services to 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.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

<b>Practice Opening Times</b>	
<b>Day</b>	<b>Time</b>
Opening times:	
Monday	8am – 7.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 7.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	Pre-bookable and on-the-day
Tuesday	Pre-bookable and on-the-day
Wednesday	Pre-bookable and on-the-day
Thursday	Pre-bookable and on-the-day
Friday	Pre-bookable and on-the-day

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12405	262	109	41.6%	0.88%

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)	97.0%	94.0%	94.8%	No statistical variation

### Older people

### Population group rating: Inadequate

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- There was no plan in place for GPs to respond quickly or outside of normal working hours in recognition of the religious and cultural observances of some patients, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. The practice told us this situation had not been encountered.
- A named GP provided home visits to five local care homes and one home for people with a learning disability. They described the practice as effective and responsive to the needs of the residents.

### People with long-term conditions

### Population group rating: Inadequate

#### Findings

- Patients with multiple conditions were currently unable to have their needs reviewed in one appointment due to clinicians having different specialised skills. Consultation times and length was flexible to meet the patients' needs.
- 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.
- Diabetic reviews were completed with referrals for retinopathy screening and podiatry services for patients.

## **Families, children and young people**

**Population group rating: Inadequate**

### **Findings**

- 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice hosted a community midwife clinic on a regular basis.

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

**Population group rating: Inadequate**

### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included online booking systems, electronic prescribing and telephone consultations.
- The practice had recently joined with five local practices to create a community interest company and provide an extended access service.

**People whose circumstances make them vulnerable**

**Population group rating: Inadequate**

**Findings**

- The practice held a register of patients living with a learning disability however did not hold registers of homeless people or travellers.
- 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, including offering home visits.

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

**Population group rating: Inadequate**

**Findings**

- The management team were unable to tell us if priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. However, care plans were not consistently used and not all staff had received training in the last twelve months.
- A mental health link worker offered a weekly clinic at the practice. They proactively followed up patients who did not attend their appointments. The mental health link worker was qualified to complete medication reviews.

## Timely access to the service

**People were able to access care and treatment in a timely way, however some GP sessions often started late.**

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Home visits were available from both the GP and nursing team. These were prioritised by a clinician.</p> <p>At the September 2018 inspection we found planned GP sessions often started late as GP partners did not arrive at the practice until up to an hour after the session had begun. This had not improved at the May 2019 inspection.</p>	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	55.3%	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)	56.3%	66.3%	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)	58.5%	61.4%	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)	63.2%	71.8%	74.4%	No statistical variation

### Any additional evidence or comments

At the September 2018 inspection we found:

- The practice was aware of the lower than average GP patient survey results however, had no plans to change systems because of this.
- We saw evidence of up to a two-week delay in clinicians reviewing correspondence which could result in a delay to patients receiving assessment, results or treatment.

At the May 2019 inspection we found:

- Management teams told us that they were unaware of any changes to increase patient access. However, following the inspection we were told that extended access was available at the practice. The website did not indicate when this extended service was available. The practice had reviewed the system of correspondence and there was no evidence of delays when referrals or letters were received.

Source	Feedback
For example, NHS Choices	Patients told us that they had some difficulty contacting the practice by telephone at certain times of the day. Patients also told us that GP appointments often ran late.



## Listening and learning from concerns and complaints

**Complaints were listened and responded to however, they were not consistently used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	24*
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>*The practice had received 24 complaints since the log was commenced in December 2018</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• There was no oversight of complaints and complaints were not analysed for trends or learning</li> <li>• Complaints were not discussed or shared with staff to drive improvements.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had developed systems to monitor complaints and analyse for trends.</li> <li>• Complaints were discussed with staff at clinical meetings were actions were created.</li> <li>• There was inconsistent follow up and monitoring of these actions to ensure they had been completed and were effective.</li> <li>• We saw evidence that some complaints could also have been dealt with as significant events, such as a potentially missed diagnosis.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
There was a delay in identifying an abnormal blood result for a patient being diagnosed with diabetes.	We saw evidence that this was discussed at clinical meetings and the abnormal results policy was reviewed. The practice diabetic nurse now reviews all blood results for these patients.
The symptoms of urinary retention were not diagnosed, and the patient was prescribed antibiotics.	There was no evidence that this had been discussed at a clinical meeting or what learning had been taken from this event.
A trend in complaints regarding receptionists had been identified.	The practice had discussed reception staff completing additional training in customer service however this had not been actioned.

## Well-led

## Rating: Inadequate

At the September 2018 inspection, we rated the practice inadequate for providing well-led services because:

- There was inadequate leadership capacity.
- Governance systems were not being operated effectively. Some staff felt unsupported and gave examples of occasions where they felt unsupported by the management team.

At the May 2019 inspection we rated the practice as inadequate for providing well-led services because:

- There was ineffective leadership, governance and management structure.
- Some staff told us they felt disempowered and unsupported in their roles. Some staff told us that although support and communication had improved, it was still not sufficient.
- Staff were unaware of the practice vision and values.
- Policies and procedures had been reviewed however, these had not been communicated to all staff.

### 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.	Partial
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: At the September 2018 inspection we found: <ul style="list-style-type: none"><li>• Leaders did not have the capacity to deliver high quality, sustainable care.</li><li>• Staff told us there was poor communication between the management and staff teams.</li><li>• There was disjointed working within the practice with staff supporting each other in small teams.</li></ul> At the May 2019 inspection we found: <ul style="list-style-type: none"><li>• Management teams had changed and there was an interim management team in post. The practice had employed an outside business consultancy to assist with the management of the practice however, this had caused some disjointed working.</li><li>• The GP partners had completed a management restructure which had caused anxiety in some staff members.</li></ul>	

- Some staff members told us they continued to feel unsupported and lacked motivation due to the practice instability.
- Staff told us that communication had improved and that there had been a recent full practice meeting. However, some staff told us they felt further improvements with staff communication were needed.
- GP partners were attending nurses' meetings and were involved in increased patient discussion with nursing teams.

## Vision and strategy

**The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence:	
At the September 2018 inspection we found:	
<ul style="list-style-type: none"> <li>• Staff were unaware of the vision and values of the practice and had not been involved in its development.</li> <li>• Staff told us they worked to their own values in providing high quality care but there was minimal oversight of this from practice management.</li> <li>• There was poor governance and leadership from the provider.</li> <li>• The practice strategy was in line with health and social care priorities across the region however, this was not embedded within the practice.</li> </ul>	
At the May 2019 inspection we found:	
<ul style="list-style-type: none"> <li>• Staff remained unaware of the practice vision and values. Management teams felt disempowered, we were told this was because of the use of a business consultancy service.</li> <li>• Staff groups continued to work to their own personal values to provide good quality care to the patients.</li> <li>• The practice management team showed instability and ineffective strategies to ensure the practice was working towards their strategy.</li> </ul>	

- The practice planned its services to meet the needs of the practice population.

## 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.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• Staff we spoke with felt unsupported and undervalued by management teams.</li> <li>• Staff we spoke with told us that concerns raised were often dismissed.</li> <li>• There was no system to ensure staff had regular appraisals or their training needs were met.</li> <li>• There were no systems to ensure staff well-being and support.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Staff we spoke with told us that they felt more supported, however, some staff told us they still felt undervalued and more support was needed.</li> <li>• Staff told us that they could raise concerns and felt these would be dealt with.</li> <li>• Staff had received appraisals and felt supported with their training needs.</li> <li>• There were some systems in place to ensure staff-wellbeing, such as increased staff communication, however, these were not always effective.</li> </ul>	

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

Source	Feedback
Staff interviews	The culture and communication from management teams had improved since the September 2018 inspection. However, improvements to communication and support were still needed. Some staff told us they felt undervalued by GP partners. Staff continued to prioritise patient care.

## 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.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
At the September 2018 inspection we found:	
<ul style="list-style-type: none"><li>• Staff were able to describe the practice governance structure and were aware of their roles and responsibilities.</li><li>• Practice policies and procedures were available to all staff.</li><li>• There was limited oversight of significant events, complaints or safety alerts.</li></ul>	
At the May 2019 inspection we found:	
<ul style="list-style-type: none"><li>• Due to the introduction of the business consultancy, some management and governance structures were unclear and there was no plan in place for when this consultancy stopped supporting the practice.</li><li>• Policies and procedures had been re-written. However, they had not been shared with all staff and staff were unaware of the content.</li><li>• There was increased oversight of significant events, complaints and safety alerts and these were discussed with staff. However, there was no review of required actions to improve care following these events. There was a lack of identification of significant events from complaints received.</li></ul>	

## Managing risks, issues and performance

There were processes for managing risks, issues and performance, however these were not always effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• There were ineffective processes to identify risk, including risks to patient safety such as fire, security and health and safety.</li> <li>• Some clinical audits had been completed but did not lead to systemic changes in practice.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• There were processes in place to assess risk for fire, security and health and safety. Some remedial actions had been completed however, this was not consistent. For example, the fire risk assessment had shown more smoke alarms were needed and this had not been completed. Regular fire alarm checks had not been carried out since November 2018 in accordance with the practice policy.</li> <li>• A risk assessment had been completed for legionella and mitigating actions such as water temperature checks were being conducted.</li> <li>• There had been management changes to the practice and the provider had not assessed how this would impact on the quality of care or wellbeing of staff.</li> <li>• We saw evidence of clinical audit, such as an audit regarding the hormonal treatment of women, that had led to changes in patient management.</li> </ul>	

## Appropriate and accurate information

**There was a demonstrated commitment to using data and information to drive and support decision making however, there were inconsistencies in coding within the clinical system.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> <li>• The information used to monitor performance and the delivery of quality care was ineffective. We saw examples where patients were exception reported without sufficient attempts to contact them first.</li> <li>• There were no regular whole practice meetings and GP partners did not attend nurses' meetings to discuss the quality of care or individual patients.</li> </ul> <p>At the May 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• We saw that there was ineffective coding in patient care records therefore, information could not easily be searched, patient information be may be incorrect or not up to date and registers of patients were inconsistent.</li> <li>• The practice had held a whole staff meeting to discuss the quality of care. GP partners attended weekly nurses' meetings.</li> <li>• There was no system in place to manage staff performance.</li> </ul>	

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

**The practice involved 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
Staff views were reflected in the planning and delivery of services.	Y
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:	
The practice had an active patient participation group and encouraged feedback from patients. However, there was no plans in place to act on the feedback from the NHS friends and family test.	
At the September 2018 inspection, staff told us that their suggestions were not acted upon. In the May 2019 inspection, staff felt listened to and able to discuss ideas.	
The service was transparent, collaborative and open with stakeholders about performance.	

Feedback from Patient Participation Group.

Feedback
We did not receive any feedback from the patient participation group at this inspection.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
At the September 2018 inspection we found: <ul style="list-style-type: none"> <li>Learning from significant events and complaints was not shared with the staff teams.</li> <li>Staff told us there was no protected time to look at individual objectives and drive improvements.</li> </ul>	
At the May 2019 inspection we found: <ul style="list-style-type: none"> <li>Improvements had been made to the management of significant events, incidents and complaints. These were discussed with staff at clinical meetings and the management team</li> </ul>	



analysed these for trends. Actions to improve practice were recorded, however, there was no review of these actions to ensure they were completed and effective.

- Staff told us there had been allocated time to focus on individual objectives, such as improving infection control processes.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.