

Care Quality Commission

Inspection Evidence Table

Ryalls Park Medical Centre - Yeovil (1-553822687)

Inspection date: 1 and 25 July 2019

Date of data download: 26 June 2019

Overall rating: Inadequate

The practice was rated as Inadequate as the areas of Safe, Effective, Responsive and Well Led, and all of the patient population groups.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18. The practice had opted out of fully using the national Quality and Outcomes Framework (QOF) and were using some indicators to provide a baseline or register of patients identified as being at higher risk and need for support. (QOF is a system intended to improve the quality of general practice and reward good practice). The practice used an alternative quality improvement scheme implemented by Somerset Clinical Commissioning Group, the Somerset Practice Quality Scheme (SPQS). The practice from April 2019 was now participating in QOF.

Safe

Rating: Inadequate

We rated the practice as inadequate for providing safe services as the arrangements in respect of staff training and the sharing of information. Learning from significant events and incidents required strengthening to ensure risks were mitigated.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	NA
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
<p>We reviewed records and systems relating to the handling of safeguarding concerns. This included how information was received in, triaged and acted upon. Correspondence, such as letters from secondary care alerting that children had not attended appointments, was received in by administration staff and then seen by clinical staff. Assessments were made with decisions made for the next step, such as sending a letter to the parents or guardians or no action to be taken. Records were maintained to show what actions and activities were undertaken including referrals to safeguarding.</p> <p>DBS checks had not been carried out on all staff who undertook a chaperone role. We were informed the chaperone policy and procedure had been reviewed and updated following the inspection which included restricting chaperone duties to those with a suitable DBS check and training.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>On the first day of the inspection we found records for recruitment and employment were not comprehensive or clear to support that a safe process was in place. Information was stored either in paper form or electronically and although a system for monitoring the overarching training and information regarding staff this was incomplete. Not all clinical staff records had evidence of their qualifications or training. On the second day of inspection we saw that the provider had addressed some of these issues and had organised the paper records effectively to show that appropriate recruitment processes were in place for the samples recruitment/employment records we reviewed.</p> <p>Details of staff vaccinations had just been commenced being obtained and had to be collated. Information regarding clinician's vaccination status was included in the sample of records we reviewed, however central oversight did not have sufficient information about all of the other clinical staff immunisation status.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 18/009/2018	Yes
There was a record of equipment calibration. Date of last calibration: 18/09/2018	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 05/12/2018	Yes
There was a log of fire drills. Date of last drill: 24/07/2019	Yes
There was a record of fire alarm checks. Date of last check: 15/01/2019 (external company) Weekly checks by practice staff.	Yes
There was a record of fire training for staff. Date of last training: Variable – new training programme to be commenced	Partial
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 12/07/2018	Yes
Actions from fire risk assessment were identified and completed.	Partial
<ul style="list-style-type: none"> On the first day of inspection we found PAT and Calibration of equipment was carried out by an external company. However, the provider did not have a comprehensive asset list to ensure that all the equipment held or used by the service was checked. Doctors were requested to bring equipment in, however there was no system to monitor this. We were told that locums were required to bring their own equipment for home visits and there was not a system to check, procedures and record keeping that these were PAT and calibrated. At the second day of inspection the provider had commenced an audit of equipment and electrical goods at the practice to have an accurate asset list. Following the inspection, the provider told us they had amended their procedures and had instigated a home visit bag with equipment to use ensuring that it was suitable and safe for clinical staff to use. On the first inspection day there was no system to ensure that all staff had participated in an annual fire safety drill as the names of participants was not recorded. On the second inspection day we were provided with information of the improvements made in the overall fire safety procedures at the practice. This included evidence that a fire safety risk assessment had been completed by an external professional (last carried out 07/11/2018), a fire drill had been carried out 24/07/2019 and a programme of drills was planned to ensure that all staff participated at least twice a year. Minor improvements were required following the fire risk assessment. These actions were in progress, for example a new fire evacuation chair had been purchased and was waiting to be fitted. 	

- We were told that there were always two fire marshals on duty each day. Staff responsible for this role undertook e learning training and these were in date.
- There was information to show that emergency lighting was checked by a trained professional.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Variable dates/ assessment divided into different areas.	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Variable dates	Partial
On the first inspection day staff provided information to show that there were individual health and safety risk assessments that were developed and reviewed regularly. Although the information was stored in various locations and the records were not comprehensively kept. On the second day of the inspection visit this had been rectified and records were centrally held and there was a more coordinated approach to managing health and safety.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21/06/2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Areas highlighted in the infection control audit such as pedal bins requiring replacement had been acted upon. There was no information to show that GPs had undertaken infection control training.	

Risks to patients

There were some 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis)	Yes

and staff were suitably trained in emergency procedures.	
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial
<ul style="list-style-type: none"> The practice had some processes in place to respond to aspects of ensuring clinical cover was in place. We were told that two GPs were usually on duty everyday (one duty doctor and one doctor for routine appointments) but when this could not be accommodated through leave, training or sickness alternative actions were put in place and was covered by two ANPs (Advance Nurse Practitioners). When only one GP was on duty they dealt with on the day appointments, telephone consultations and home visits. There were also occasions when there were no GPs present in the practice to respond to medical emergencies. We were told the GP was contactable by phone. We were told that ANPs carried out home visits where necessary. The rotas we reviewed for July 2019 did not show any situation when this occurred. There was no risk assessment for this. The provider was not able to say how often GPs had not been on site in the past 12 months nor could they confirm if advanced nurse practitioners had been on site in the absence of a GP. The practice had some processes in place to ensure clinical cover was in place. We were told that two GPs were on duty everyday (one duty doctor and one doctor for routine appointments) but when this could not be accommodated through annual leave, training or sickness, alternative actions were put in place and cover was supplied by two advanced nurse practitioners (ANPs). When there was only one GP on duty, they dealt with on the day appointments, telephone consultations and home visits. We were told that where necessary, ANPs carried out home visits. The rotas we reviewed for July 2019 did not reflect 	

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.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was	Yes

managed in a timely manner.	
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes
<ul style="list-style-type: none"> Practice staff told us that there were gaps in the patients records due to possible ineffectual coding of patient's needs, such as long-term conditions. This included when new patients joined the practice. We were told there was a programme of audit in place to rectify these concerns. However, the practice could not provide sufficient evidence that it had an effective oversight of volume or depth of the issue or that they had sustainable actions in place to rectify the concerns. Feedback from secondary care services indicated that at times appropriate information was not always shared with them when patients were referred to them. 	

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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.88	0.87	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)	6.2%	4.8%	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)	5.57	5.85	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)	3.10	2.35	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> • There was no recorded information to support that prescribers' competencies and decision making was checked by GPs. • We saw records that high risk medicines processes and checks were in place but a sample of patient records for medicines for the treatment of high blood pressure showed that two patient reviews had not taken place in the last 5 years. 	

Track record on safety and lessons learned and improvements made

The practice had 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	4
Number of events that required action:	3
The practice investigated significant events and had systems to share and disseminate the learning from these events. There were records, minutes of meetings to show how this information was shared. However, they had not yet formalised a system to link issues to complaints or issues within complaints to significant events.	

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

Event	Specific action taken
A prescription for a CD was raised but went missing when faxed to the pharmacy. Not dispensed. A second prescription was raised.	Arrangements for not faxing prescriptions and the use of an order book were reiterated to staff.
Epilim – prescribing error when switched from liquid medication to tablets by the Clinical Commissioning Group clinical pharmacist. Error identified before given to patient when received in by care staff.	Arrangements for checks for repeat prescribing changes discussed with staff who were responsible for prescription processes. Changes to prescribing checked and reiterated to staff to recheck with the original prescriber before issuing.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
We saw examples of actions taken on recent alerts. However, there was no evidence of older alerts from around 2012 being revisited to check appropriate actions were in place, such as simvastatin.	

Effective

Rating: Inadequate.

This area was identified as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

Any Quality Outcomes Framework (QOF) data relates to 2017/18. The practice had opted out of fully using the national Quality and Outcomes Framework (QOF) and were using some indicators to provide a baseline or register of patients identified as being at higher risk and need for support. (QOF is a system intended to improve the quality of general practice and reward good practice). The practice used an alternative quality improvement scheme implemented by Somerset Clinical Commissioning Group, the Somerset Practice Quality Scheme (SPQS). The practice from April 2019 was now participating in QOF.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	No
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<ul style="list-style-type: none"> Staff had already identified gaps in effective coding in records of patients' needs and there was a degree of uncertainty of the precise numbers/specific needs and a programme of checks was being implemented to address the concerns. Information from secondary care indicated that at times appropriate assessment of patients' needs had not occurred. A sample of five patient records were reviewed which showed one patient had attended the practice with chest pains and was deferred to the emergency department (ED) without being seen by a clinician. A second patient had attended the local hospital with an acute infection leading to sepsis without being seen by a clinician at the practice. Two records had not been completed appropriately and coding not recorded. One patient had attended the ED with a condition that could have been assessed at practice level and as they couldn't access an appointment they went elsewhere. 	

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) <small>(NHSBSA)</small>	0.48	0.66	0.77	No statistical variation

Older people

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

- 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. Patients' needs were discussed and reviewed at the staff daily meetings (huddles) so that patients need were acted upon.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

- The practice had reviewed and redeveloped a new system for patients with long-term conditions to be offered a structured annual review to check their health and medicines needs were being met. This was in the process of implementation and there was information that this would be sustained. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Some staff responsible for reviews of patients with long-term conditions within their job description had received specific training and others were in the process of completing training to do so. Interim measures were in place to meet these patients needs until the training for these staff was completed such as patients with a diagnosis of asthma. A temporary locum nurse with the specialist skills had been employed for two days per month.
- GPs followed up patients who had received treatment in hospital or through out of hours

services for an acute exacerbation of asthma.

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could not fully demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. This was because the coding of patients' needs was not correct and there was a programme of remedial review to ensure that patients' needs were not being missed.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- When identified patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.

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)	52.9%	70.0%	78.8%	Significant Variation (negative)
Exception rate (number of exceptions).	4.9% (17)	7.3%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	51.1%	67.4%	77.7%	Significant Variation (negative)
Exception rate (number of exceptions).	4.3% (15)	6.2%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	50.0%	75.5%	80.1%	Significant Variation (negative)
Exception rate (number of exceptions).	6.9% (24)	10.8%	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	16.9%	61.3%	76.0%	Significant Variation (negative)

(01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	1.9% (7)	7.0%	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) (QOF)	18.4%	68.8%	89.7%	Significant Variation (negative)
Exception rate (number of exceptions).	2.8% (3)	7.2%	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)	58.6%	76.2%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	1.9% (14)	3.7%	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)	84.3%	86.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.8%	6.7%	N/A

Any additional evidence or comments

The practice provided unverified data for 2018/2019. For the year 2018/2019 they had identified that in some areas they had improved but not met the QOF targets. For example:

- 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 was 55%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 59%.
- 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 was 66%.
- 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 was 20%.
- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 46%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less was 72%.
- 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 at 85%.

Families, children and young people

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

- Childhood immunisation uptake rates were at or slightly above the minimum level of World Health Organisation (WHO) targets. See below the practice unverified data.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had some 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.
- 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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)	53	58	91.4%	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)	72	80	90.0%	Met 90% minimum (no variation)
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)	73	80	91.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	71	80	88.8%	Below 90% minimum (variation)

(01/04/2017 to 31/03/2018) (NHS England)				negative)
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

Two members of the nursing team were trained to provide child immunisations. A third member of staff was in the process of being trained to administer immunisations.

The practice provided unverified data for 2018/2019.

- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) 92%.
- 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) 92%.
- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) 92%

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

- 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 practice.

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)	69.3%	73.9%	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)	74.1%	73.9%	69.9%	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)	60.9%	61.1%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	26.3%	45.1%	70.2%	N/A

occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)				
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)	41.4%	54.8%	51.9%	No statistical variation

Any additional evidence or comments

Only one member of the nursing team was trained to carry out cervical screening.

The practice provided unverified data for 2018/2019.

- 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) 81%.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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 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

This population group was rated as inadequate as the practice had not facilitated a regular programme of reviews of care for all the patient population groups. Data records were not comprehensive and there were errors in coding as to establish correctly patient's needs.

- The practice had some systems to assess and monitor 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. However, data did not support that there were comprehensive care plans for these patients.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term

medication.

- When identified 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.
- Not all staff had received dementia training in the last 12 months.
- When identified patients with poor mental health, including dementia, were referred to appropriate services.

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)	2.9%	39.1%	89.5%	Significant Variation (negative)
Exception rate (number of exceptions).	1.4% (1)	6.6%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	37.7%	47.3%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	1.4% (1)	6.0%	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)	66.7%	52.1%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.0% (0)	6.9%	6.6%	N/A

Any additional evidence or comments

Information to show that patients with mental health needs were met was incomplete. Practice staff had identified staffing levels, coding and not using QOF indicators were the reason true numbers of these patients with a diagnosis of mental health needs were not necessarily picked up. We were provided with information about what actions they had in place to rectify the concerns which included a programme of review of coding, reviews of care and the use of new quality assurance systems to monitor these would be achieved. Since inspection, the provider submitted additional evidence that showed a programme of coding had been undertaken. Following inspection, the practice also sent us unverified data for 2019/2020 QOF year, that showed an improvement in the documented reviews of patients with mental health needs.

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)	303.8	423.2	537.5
Overall QOF score (as a percentage of maximum)	54.3%	75.7%	96.2%
Overall QOF exception reporting (all domains)	3.3%	4.0%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial

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

- No sustained audit programme apart from some medicine's and prescribing audits carried out. Two repeat cycles of audits recently carried out were made regarding treatment for diabetes and atrial fibrillation.

Any additional evidence or comments

The practice since the first inspection day has completed three cycles of Quality Improvement (QI) processes looking at the patients with long-term conditions, including stroke, osteoporosis, epilepsy and mental health needs. The current process had assisted in identifying more patients that have the need for regular reviews of care and treatment. To assist with going forward they had introduced templates for meeting patients' needs with comorbidity (multiple conditions).

Effective staffing

The practice was able to demonstrate they were working on ensuring 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
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes

There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
The practice had recognised that it needed increase their capacity to provide care and treatment for patients with long term conditions, cervical smear screening and immunisations and had recently begun supporting members of the nursing team to have additional training.	
The practice provided one weeks paid study leave for nurse practitioners.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
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.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
Feedback from secondary healthcare professionals indicated that at times information was not shared effectively or in a timely way with other providers. The practice told us they had taken this on board and were looking at how they could improve communication with others in secondary care.	

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.	Yes

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	No
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
The data to support that patients with long term conditions and mental health needs were being met was incomplete as the practice had not used Quality Outcomes Framework (QOF) indicators, comparable data, as they were part of the local monitoring scheme, Somerset Practice Quality Scheme (SPQS) until April 2019. Therefore, it was unclear that these patients had received the necessary health assessments and reviews of their care but a programme of audit of the coding system had been commenced to improve identifying that patients' needs were being met.	
The health coach's role (30 hours per week) had been established at the practice for several years and were actively involved in supporting patients to live healthier lives. They took the lead with communicating with hard to reach patients and those seen at a potential of risk. They were available to provide information, signposting patients to other organisations and provided health walks, supported access to local talking groups for mental health.	

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)	81.3%	89.6%	95.1%	Significant Variation (negative)
Exception rate (number of exceptions).	0.9% (12)	1.1%	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes

Policies for any online services offered were in line with national guidance.	Yes
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Caring

Rating: Requires Improvement

Kindness, respect and compassion

Feedback from patients was mixed about the way staff treated people. GP National Survey results have deteriorated during the last four results.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	12
Number of CQC comments received which were positive about the service.	2
Number of comments cards received which were mixed about the service.	6
Number of CQC comments received which were negative about the service.	4

Source	Feedback
CQC comment cards	General feedback overall was that once patients were able to obtain an appointment they were treated with kindness and respect. Although one patient felt the telephone consultation did not work well for them as they felt the GP did not know them and did not understand their needs and could have been handled better if face to face.

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.

The practice GP National Survey results have remained below local and national averages with a gradual deterioration in some areas for the last four results. For example:

2018

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
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5955	248	108	43.5%	1.81%
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2019

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5965	267	123	46.1%	2.06%

2018

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)	77.5%	91.5%	89.0%	Tending towards variation (negative)
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)	81.6%	90.3%	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)	88.6%	97.3%	95.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	51.0%	86.0%	83.8%	Significant Variation (negative)

2019

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 (01/01/2019 to 31/03/2019)	79.2%	91.7%	88.9%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the	77.4%	90.6%	87.4%	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)				
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 (01/01/2019 to 31/03/2019)	89.1%	96.9%	95.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	52.2%	85.4%	82.9%	Significant Variation (negative)

Any additional evidence or comments
The practice told us that they were aware of the patient feedback regarding access to the practice and the experience of using the service and had recently put actions in place to improve. This had included telephone access and call back system. These changes had come into effect in May 2019. At the time of inspection, it was too early to determine the impact this had had on the patient experience.

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

Any additional evidence
The patient participation group (PPG) carried out a survey regarding access and appointments approximately one year ago. The feedback generated steps for changes to be made to on line booking for appointments and repeat prescription requests.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Source	Feedback
Interviews with	We spoke with three patients, they told us they were satisfied with the care provided

patients.	by the practice, they felt listened to and treated with dignity and respect.
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National GP Survey results

2018

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	91.9%	96.0%	93.5%	No statistical variation

2019

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 (01/01/2019 to 31/03/2019)	89.1%	95.4%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	171 patients had been identified as carers. (2.8% of the practice population)
How the practice supported carers (including young carers).	Health Coaches, members of staff designated to undertake this role, took the lead with contacting patients, signposting to support groups and other services.
How the practice	Health Coaches contact the relatives to check they have the information

supported recently bereaved patients.	and support they needs.
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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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Partial
The patient waiting area is close by the reception desk and conversations can be overheard in the waiting area. When required patients can be offered the use of a private room should it be required. No telephone calls are taken at the front desk.	

Responsive

Rating: Inadequate

We rated the practice as inadequate for providing responsive services as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction. This affected all patient population groups.

Responding to and meeting people's needs

Some services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	No
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
The practice staff told us that it had struggled to provide clinical cover to meet patients' needs during the last 12 months as clinical staff had left the service and new staff had joined the practice. They had yet to ensure there was adequate clinical cover to provide meeting the needs of patients with long term conditions, cervical screening and childhood immunisations. Training was in place to achieve this as soon as possible. Additional locum staff had been employed for Asthma and COPD annual checks two days per week from May 2019.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30
Appointments available:	
Monday	08:00 – 17:30
Tuesday	08:00 – 17:30
Wednesday	08:00 – 17:30
Thursday	08:00 – 17:30
Friday	08:00 – 17:30
The practice did not provide extended hours. When the practice was not open patients could call NHS	

111 for urgent assistance.

We were informed that changes were proposed going forward when the Primary Care Network was in place (July 2019) for patients to have access to extended hours.

National GP Survey results

The practice GP National Survey results have remained below local and national averages with a gradual deterioration in some areas for the last four results. For example:

2018

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5955	248	108	43.5%	1.81%

2019

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5965	267	123	46.1%	2.06%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	88.7%	95.9%	94.8%	No statistical variation

2019

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 (01/01/2019 to 31/03/2019)	92.6%	95.6%	94.5%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction.

- The practice told us they were implementing a new process so that patients with multiple conditions had their needs reviewed in one appointment.
- The practice was aware that there were improvements required to provide effective care and treatment for patients with long-term conditions. A programme of checks to ensure they had identified these patients effectively and that they had had reviews of care in place had been implemented. Evidence was seen that good progress had been made within the three weeks between inspection visits.
- The practice liaised regularly with the local district nursing team, complex care teams 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

This population group was rated as inadequate as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction.

- 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 usually offered a same day appointment when necessary.

Working age people (including those

Population group rating: Inadequate

recently retired and students)

Findings

This population group was rated as inadequate as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice had recently implemented a new service for engage consult, patients could email the practice with their concerns, a clinician reviewed their queries and actions put in place should it be required. Patients had access to an online appointment booking process and repeat prescription request service.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

This population group was rated as inadequate as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- 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

This population group was rated as inadequate as the national patient survey data was below local and national averages for a range of indicators and the practice were unable to demonstrate they had taken effective action to improve patient satisfaction.

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice was aware that there were improvements required to provide effective care and treatment for patients with mental health needs and a programme of checks to ensure they had identified these patients effectively and that they had had reviews of care in place had been implemented. Evidence was seen that some progress had been made within the three weeks

between inspection days.

Timely access to the service

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

National GP Survey results

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

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)	22.2%	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)	33.4%	71.0%	68.6%	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)	40.8%	67.1%	65.9%	Variation (negative)
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)	50.2%	78.2%	74.4%	Variation (negative)

2019

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 (01/01/2019 to 31/03/2019)	15.0%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP	30.2%	70.9%	67.4%	Variation

Indicator	Practice	CCG average	England average	England comparison
patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)				(negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	39.0%	66.3%	64.7%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	59.3%	77.5%	73.6%	No statistical variation

Any additional evidence or comments

The provider told us about the changes in answering the telephone and how appointments were made available to patients. Feedback from patients during the last 24 months had indicated that patients had found it difficult to access the practice by telephone and often the appointments on the day had been taken up already. The provider had recently had changed the process to provide a different process for patients using the online booking process and introducing a seven-day release of appointments in advance. They had also introduced a call back system – where patients who required a planned booked appointment in advance, for a follow up GP consultation for example, were called by a member of staff seven days before an appointment slot was available. The practice had some data to show the improved telephone system, more telephone lines and additional staff taking the calls first thing in the morning had improved access. However, it was too early to show that this improvement would be sustained or that it had an impact on patient's experience.

Source	Feedback
CQC comment cards	Eight patients fed back that obtaining an appointment remained an issue. One patient had found even with the new system it took three weeks to get an appointment booked with multiple attempts at calling in to the practice. Another patient told us it had improved latterly.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	47
Number of complaints we examined.	10
Number of complaints we examined that were satisfactorily handled in a timely way.	10

Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
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	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>There was a system of complaints that looked at themes and trends and complaints were shared with the practice team and there was a system of shared learning to improve. Themes of complaints ranged from aspects of clinical care, staff attitude and the appointment system. The complaints regarding the appointment system had begun to be addressed. However, prior to the inspection the CQC had been provided with copies of a small number of complaints by the complainants giving feedback about how they had felt their concerns had not been satisfactorily handled. We discussed this with the practice manager about how improvements could be made how the practice fed back its investigation of complaints to the complainant. Following the inspection, we were informed of some of the steps the practice was planning to improve complaints handling which included additional training for those staff who were responsible for complaints handling.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Experience of obtaining an appointment	This was used as part of the whole review of the appointment system.
Patient experience of appointment and the receipt of an unacceptable behaviour letter.	Each area of concern identified was reviewed by the practice and the conclusion was that there was a differing opinion of the day and appointment. Aspects of concerns were discussed with the clinician including the use of chaperones. Information from this and the feedback from CQC was used to update the chaperone policy following this inspection.

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing well led services as governance arrangements required strengthening to ensure risks were mitigated and the practice strategy demonstrated sustainability.

Leadership capacity and capability

Leaders could not always 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.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	No
<ul style="list-style-type: none">The structure of governance was still in re-development due to the changes in the practice partnership and new quality assurance process being implemented. However, there was little evidence that the previous governance structures were effective.There was evidence that there had been gaps in the performance monitoring looking at the key areas of patient care in all the population groups including long-term conditions and mental health. The practice had insufficient information to show they had an awareness of the impact this had on patients' needs.The provider was very slow in reporting changes to the registration of new partners who had been working at the organisation for over six months but not registered with CQC. Outgoing partners had not been removed from the partnership in a timely manner.	

Vision and strategy

The practice had a 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.	No
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	No
<ul style="list-style-type: none">The practice told us it had identified that some aspects of providing the service required improvement. The practice shared with the CQC their vision going forward using new systems for	

quality assurance and we could see in the short period that they had been in place it would be a positive step to improve the outcomes for patients. However, we have no assurance this would be sustained.

- Staff we spoke with clearly had understood and were working together to implement this new programme of quality assurance and management of the service.

Culture

The practice was working towards 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was an emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	No
<ul style="list-style-type: none"> • Complaints were managed in line with their complaints policy and procedure and complainants' concerns were responded to. However, improvements in complaints handling and response would enable complainants to feel their concerns were listened to and acted upon. • Feedback from complainants, other health care professionals was that their concerns were not responded to satisfactorily. 	

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

Source	Feedback
Staff	Staff were provided with the opportunity and time to obtain training and qualifications. Staff appear to have embraced the changes going ahead with quality assurance and the aims to improve the outcomes and experiences of patients.

Governance arrangements

There were responsibilities, roles and systems of accountability to support

governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
<ul style="list-style-type: none"> The governance structures in place were evolving with the introduction of the quality assurance processes and new partnership. Therefore, it was too early to evidence that these governance structures were either effective or sustained and embedded. There was no substantive evidence that any previous service wide governance structures had been effectively implemented monitored and responded to, to ensure safe and effective treatment and care was provided to meet patients' needs. The process for updating and of policy and procedures was ad hoc, with some on the practice public website out of date so the wrong information was provided to patients. Policies and procedures were very varied in quality of information and did not always have the correct information for staff and public to understand. For example, where legislation or guidance has change such as Data Protection 1998 now the General Data Protection Regulation. The storage, access and business records were in the process of being uplifted into a business management record system, which will assist in monitoring that the necessary records and documents were available and assist with the programme of maintenance, employment and the day to day delivery of the service. 	

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.	No
There were processes to manage performance.	No
There was a programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<ul style="list-style-type: none"> The practice was in the process of moving from quality assurance system to another and there was no comprehensive information that the previous system was reviewed regularly or that it was effective. 	

- A proposed programme of audit was provided. There was information of four audits including two cycle of audits.

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<ul style="list-style-type: none"> • It was identified that patient's data for monitoring purposes may be incorrect as coding had not been completed effectively. The practice had not been using Quality Outcomes Framework (QOF) indicators as tool to monitor that patients' needs such as long-term conditions or mental health needs was being met. • Statutory notifications to alert the CQC that there had been a change in circumstances such as the provider partnership were not submitted in a timely way. Changes to the registration of the service were not applied for when they had occurred which has led to incorrect information about the provider partnership being on the CQC register. • Patient paper records were on display in the admin office behind reception which was accessible to staff or others visiting the area. Following the inspection, the provider had carried out a risk assessment and informed us of what actions they planned to be carried out to store these records appropriately. 	

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
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>The practice had taken steps to respond and implement changes regarding patients experience of accessing appointments. It was clear from some of the responses from patients (CQC comment cards, NHS Choices, complaints) that there was a mixed opinion of whether the new system was working well. The practice had implemented a call monitoring system, action plans and staff prompt's for assessing patients' needs for appointments to ensure that they go to the right member of staff.</p>	

Feedback from Patient Participation Group. (PPG)

Feedback

PPG told us they had been included in several aspects of the reviews of the service and actions that the practice had been put in place to improve patients experience and the delivery of the service. This had included the repeat prescription process and the appointment system. They had been involved in patient surveys and were proposing the implementation of new innovative patient feedback system that had been adopted from another practice in the area. The PPG met regularly, and members of the staff team attended to share information and update the progress of changes happening at the practice.

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement

The practice had implemented recently a new system for quality assurance. However, it was too soon to see if this new process was effective.

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.