

Care Quality Commission

Inspection Evidence Table

The Boulevard Medical Centre (1-3169167634)

Inspection date: 27th June 2019

Date of data download: 26 June 2019

Overall rating: Inadequate

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

Please note: Some standard lines of the evidence table have been removed as these were not inspected on 27th June 2019.

Safe

Rating: Inadequate

We found that the practice was not providing safe services to the patients because:

- There was a lack of clinical oversight of staff working at the practice
- The premises were not fit for purpose and there was not effective infection prevention and control measures.
- Equipment and medicines were out of date and put patients safety at risk
- There was limited monitoring of patient safety.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	NA
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	N ¹
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	N ²

Safeguarding	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We saw evidence that the practice manager and practice nurse had completed level three safeguarding training in 2017 and the practice policy stated this was to be repeated annually. There was no safeguarding training documented for the healthcare assistant and some administration staff. The practice could not show us that all locum staff had safeguarding training. 2. We reviewed the practices safeguarding register and found that not all children with safeguarding concerns had an alert on their record. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N ²
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice told us that recruitment was managed at one of the other locations. We were not supplied with evidence around recruitment. 2. Staff vaccination was held centrally at one of the other locations. When this was inspected there were gaps in staff vaccination records. 	

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:	N
There was a record of equipment calibration.	N ¹
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 training for staff. Date of last training:	Partial ²
Actions from fire risk assessment were identified and completed.	
<p>Explanation of any answers and additional evidence:</p> <p>1. We found evidence of medical equipment which had did not have up to date calibration records. For example, we saw an ECG machine which was due to be calibrated in July 2018 but had not been, the nebuliser on the emergency trolley was last calibrated in 2017 and the ear syringe was last calibrated in November 2017.</p> <p>There were also two doppler machines found in the nurse's room. One required calibrating in 2017 however there was no evidence this had been done. The other doppler machine failed its calibration in October 2015 and had a red sticker on identifying it had been condemned from use in 2015 but was still located in a clinical room.</p> <p>We found glucose monitors which did not have the necessary correction fluid equipment for calibration. The fluid located in one machine had expired. We asked staff for records of the machines being tested, which is required before every reading however staff told us they did not do it before using the machines.</p> <p>2. Fire training was an annual mandatory training course that staff were required to complete however there was not up to date training records for the practice manager and the practice nurse.</p> <p>The doctor's room indicated that there was a fire exit to the rear of the room with a sign in the room. However the exit door was locked with no key available. The door was also partially obstructed by glass doors, blinds and old cupboards. We were told by staff that this was not used as a fire door as there was another fire exit outside the room.</p>	

Health and safety	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>The doctors clinical room had blinds on the windows which had two cords which had not been secured. There was no risk assessment for these and therefore was ligature risk. One was located next to a baby change mat.</p> <p>We found 39 patient's confidential data in an unsecured cupboard which was accessible to patients. Practice staff were not aware that it was there.</p> <p>The building was not secure to patients as they could access all areas.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	N ¹
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2019	Partial ²
The practice had acted on any issues identified in infection prevention and control audits.	N ³
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	N ⁴
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. There was no evidence of infection control training for the practice nurse. The practice records for infection control training for administration staff highlighted that some training was overdue. It was not clear how often training should be completed as there were contradictory dates on the training matrix when compared to the policy. 2. The practice had external companies carry out infection control audits every two years which had been completed the week of our visit, however the audit did not include many areas which required work. We found four vaccinations in the fridge which had expired in May 2019 and six further vaccinations which were due to expire at the end of June 2019 however these had not been effectively stock rotated. We found that the sink in the doctor's room was dirty and contained an overflow. This had not been picked up as part of the infection control audit. The staff toilet was located upstairs in the building however there was no sink in the same room. Staff were expected to wash their hands in the adjacent kitchen sink which had a washing up bowl in. We found a number of out of date items in clinical rooms including three out of date sample bottles, 15 out of date wound swabs, a box full of out of date ECG electrodes and two out of date peak flow metres. We found two dressings in the cupboard of the nurse's clinical room which had been issued to a specific patient in 2017 however these had not been administered to the patient and had not been removed from the stock. The practice had two spill kits for spillages on carpeted floor and one spill kit for spillages on a hard surface however the two spill kits for carpeted floor had expired in January 2019. Furniture in the doctor's clinical room was ripped with the padding exposed. This meant it could not be effectively cleaned and kept free from infection. This had not been picked up by the infection control audit. 3. There was evidence of infection control risks which had been highlighted in the 2017 audit had not been rectified. For example, the audit suggested that the grouting needed completing as there was infection control risk. This had not been completed. 	

The doctors clinical room had a number of blinds in the room which were dirty and had no evidence of any cleaning record.

The doctors clinical room had no handwash in the mounted dispenser, however there was a bottle of handwash on the sink which had expired in 2003.

4. Both clinical rooms had a clinical waste bin which was not foot operated and were overflowing. The clinical waste bin in the doctor's room was located under a counter and so was not easily accessible. It is not clear when these bins were last emptied.

We found a sharps bin in the doctor's clinical room which had been opened in February 2018. National guidance suggests that sharps bins are to be discarded after being open for three months.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N ¹
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N ²
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.	N ³
There was a process in the practice for urgent clinical review of such patients.	N ⁴
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N ⁵
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We saw evidence of clinics which had been cancelled due to staff sickness however there had not been any attempt to cover the clinic or arrange more cover for the practice in the future. 2. The emergency trolley did not have a paediatric pulse oximeter or thermometer. There was no paediatric pulse oximeter or thermometer within the building. There were no needles or syringes available on the emergency medicines trolley. 3. Reception staff were unaware of patients in the waiting room as the room was obstructed from view of the receptionists. Receptionists were also unaware of patients who could be accessing other parts of the building. 4. There was not always a clinician available in the practice to assist in emergencies. There were regular times where there was only a nurse available in the practice due to the practice relying on locum GPs. There was an on call system for urgent assistance for the practices within the Beechdale Medical Group which was either the GP partner or the ANP partner, however this clinician would not always be immediately available as they may be in consultation's or completing home visits. The practice staff did not have direct phone numbers to the on call clinician, they were expected to phone the surgery that the on call clinician was working at to contact them. 5. The practice had not increased the number of doctors appointments following concerns which were raised at previous inspections within the practice. There were often times when there was no clinician, doctor or nurse, available at the practice. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N ¹
There was a documented approach to the management of test results and this was managed in a timely manner.	N ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N ²
Explanation of any answers and additional evidence: <ol style="list-style-type: none">1. Care records we reviewed showed a lack of information in documentation and did not provide full audit trail of patient care. For example, we found that consultation records did not always contain information regarding examinations and treatment that patients received, and there was not always complete records of telephone encounters with patients regarding treatment and advice.2. On the day of our inspection we saw there were 111 outstanding correspondence documents on the computer system which had not been filed which dated back to the 21st December 2018. There were also 32 tasks outstanding which had not been filed. There was not always evidence that these had been acted upon. We were told that this 'hub' of administered assigned the documents and tasks to clinicians to action. There was no system of oversight to ensure that these had been completed.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.98	0.79	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)	7.7%	7.5%	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)	5.78	5.29	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.22	1.82	2.07	Tending towards variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N ¹
Blank prescriptions were kept securely and their use monitored in line with national guidance.	P ²
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N ³
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N ⁴
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N ⁵
There was a process for monitoring patients' health in relation to the use of medicines	N ⁶

Medicines management	Y/N/Partial
including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N ⁷
For remote or online prescribing there were effective protocols for verifying patient identity.	NA
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial ⁸
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial ⁹
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	N ¹⁰
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. Clinical rooms were unlocked and accessible to patients at all times. 2. Blank prescriptions were in printer trays in unlocked rooms and could therefore be accessed by patients. 3. We were told that not all healthcare assistants had been completing relevant requirements, patient specific directions (PSD's) before administering injectable medicines. This means that the healthcare assistant had been issuing injectable medicines to patients without any appropriate authorisation from a doctor within the practice. 4. There was no system to review prescribing competence of non-medical prescribers or review any consultations. We found evidence of inappropriate prescribing from locum GPs and nurses at the practice. We were told that staff had raised concerns regarding the competency of the nurse to senior management however there was no evidence that any supervision or review had been completed following the concerns. 5. There were 111 documents which had not been actioned regarding patient treatment from other services. 6. The practice could not tell us what the system was to ensure patients taking high risk medicines were kept safe by ensuring the relevant monitoring had been completed. We found patients who were taking high risk medicines did not have blood monitoring completed every three months as per the shared care guideline for administering the medicines in the GP practice. One patient had not attended hospital for 18 months however had been continued to be prescribed methotrexate. We also saw evidence of patients who had been seen in secondary care in April 2019 and recommended to start methotrexate however this had not yet been actioned. Following the inspection, the CCG reviewed patients to ensure they had received the correct monitoring for high risk medicines. 7. We saw evidence of patients being prescribed antibiotics inappropriately. We also saw evidence of antibiotics being prescribed outside of guidance and recommendations. 8. Emergency medicines were located in the Doctor's room however there were no needles or syringes on the trolley to administer emergency medicines. There were also no needles or syringes in the room. There was no record to monitor stock levels and expiry dates of emergency drugs however all medicines were in date. 9. There was no record of checks being completed on the defibrillator to ensure that the battery was still efficient. 10. We saw evidence of the fridge temperature exceeding the maximum temperature and there was no 	

Medicines management	Y/N/Partial
evidence that the secondary thermometer had been downloaded to ensure the vaccines had not been exposed to high temperatures. We also found vaccines which had expired in the fridge. There was no evidence of stock rotation and vaccines which were nearing their expiry date were not highlighted to make clinicians aware of their short date.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had become aware that they were not receiving all relevant safety alerts and the practice could not demonstrate a system for dealing with alerts. They had began to retrospectively search and identify any patients who were at risk from missed safety alerts, however this had not been completed and patients had not all been contacted or followed up. Staff members and management were not aware that they had not been receiving alerts.</p>	

Effective

Please note: we are unable to rate the effective domain as we did not inspect all key lines of enquiries under effective.

- Staff were not always working within their competencies and management were not aware of what care staff were giving to patients.
- Patient care was not delivered in line with current legislation or standards
- Patient records were not accurate or contain information to ensure they were treated appropriately.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N ²
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N ³
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N ⁴
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N ⁵
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	NA
Explanation of any answers and additional evidence: 1. There was no evidence that clinicians were kept up to date with any changes in guidelines or practice changes. There was no evidence of oversight of clinicians working within guidance. We found examples of prescribing outside guidance. 2. We saw evidence of patients who had not had effective consultations with needs being fully assessed. We saw prescribing to patients which required monitoring had not been completed. There was a lack of information documented regarding what discussions had taken place. 3. There was no evidence of follow ups for patients who required medical attention. Patients who presented with urgent symptoms had not always been assessed and treated appropriately. 4. We saw evidence of patients who required reviews and monitoring which had not been completed. 5. There was a lack of information recorded regarding discussions with patients regarding where to seek further help. It was not always clear that risks and symptoms of deterioration had been	

discussed with patients.

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>	0.38	0.67	0.77	Tending towards variation (positive)

Older people

Findings

- The practice offered home visits for patients who were house bound however these were managed and conducted by staff at the other practices. These were not always conducted in a timely manner.

People with long-term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- Equipment in the practice which would be used during reviews of patient's long term conditions were not always calibrated and could have given incorrect readings.

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>	74.4%	71.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	6.4% (11)	11.0%	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>	81.0%	72.8%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.6% (13)	8.0%	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>	76.4%	76.0%	80.1%	No statistical variation
Exception rate (number of exceptions).	8.2% (14)	12.1%	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>	75.3%	74.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.5% (2)	6.6%	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>	82.6%	86.9%	89.7%	No statistical variation
Exception rate (number of exceptions).	28.1% (9)	10.8%	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) <small>(QOF)</small>	89.5%	81.7%	82.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.3% (11)	3.5%	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) <small>(QOF)</small>	82.1%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.7% (2)	9.2%	6.7%	N/A

Families, children and young people

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- 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)	20	21	95.2%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	12	13	92.3%	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)	12	13	92.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	12	13	92.3%	Met 90% minimum (no variation)

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>

Working age people (including those recently retired and students)

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.
- 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)	79.0%	70.5%	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)	74.5%	68.7%	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)	54.0%	52.9%	54.4%	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)	80.0%	64.2%	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)	66.7%	52.5%	51.9%	No statistical variation

Any additional evidence or comments

People whose circumstances make them vulnerable

Findings

- 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 demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Findings

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients 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) <small>(QOF)</small>	87.5%	87.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	42.9% (6)	14.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	88.2%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.1% (1)	13.5%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	96.0%	85.9%	83.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	16.7% (5)	6.9%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	547.4	528.3	537.5
Overall QOF score (as a percentage of maximum)	97.9%	94.5%	96.2%
Overall QOF exception reporting (all domains)	5.9%	5.6%	5.8%

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N ¹
The learning and development needs of staff were assessed.	N ²
There was an induction programme for new staff.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N ²
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N ²
Explanation of any answers and additional evidence: 1. We found evidence of nurses delivering care which was not within her competencies. 2. There was no supervision or oversight of clinical performance within the practice. There was evidence of staff who had raised concerns about clinical competency of other staff however there was no evidence this had been acted on.	

Helping patients to live healthier lives

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

	Y/N/Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N ¹
Explanation of any answers and additional evidence: 1. There was no consistent approach for patients who had test results indicating they were at risk of developing diabetes. We saw one patient had been referred to the diabetes prevention programme however there was not a consistent approach to referral or coding these patients.	

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,	99.0%	95.0%	95.1%	Variation (positive)

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>				
Exception rate (number of exceptions).	1.6% (8)	0.9%	0.8%	N/A

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing well-led services because:

- Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N ¹
They had identified the actions necessary to address these challenges.	N ²
Staff reported that leaders were visible and approachable.	N ³
There was a leadership development programme, including a succession plan.	P ⁴
Explanation of any answers and additional evidence: 1. Leaders were unaware of the quality of healthcare being provided at the practice. 2. Leaders had not implemented the same changes at the surgery that they had implemented elsewhere such as increasing clinical capacity and appointments. There were long periods of time where there was not a doctor available at the practice and also times where there was no doctor or nurse present. 3. Staff reported they had raised concerns previously however there was no evidence this had been followed up appropriately. 4. The practice had a plan in place for the ongoing change in management. Systems were not embedded at the time of our inspection.	

Vision and strategy

The practice had a vision but had not got an embedded strategy 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.	Partial
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.	N
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection the practice was going through changes in management. The practice did not have a clear vision in place as they were restructuring the organisation. The practice had an aspirational strategy to achieve their priorities, however this had not been put in place and we did not see evidence of the plan during the inspection.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N ¹
Staff reported that they felt able to raise concerns without fear of retribution.	N ²
There was a strong emphasis on the safety and well-being of staff.	N ³
The practice encouraged candour, openness and honesty.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. There was a lack of clinical oversight to ensure that treatment was being provided in line with the vision and values. 2. We were told staff had raised concerns about clinicians' competencies however there was no evidence this had been followed up. 3. Staff wellbeing was not considered. The staff toilets did not lock and did not contain a sink to wash hands. 	

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
<p>Explanation of any answers and additional evidence:</p> <p>At the time of our inspection the practice was transitioning through governance and management changes, and therefore governance systems were not in place. Practice staff knew who to report immediate concerns to.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were processes to manage performance.	N ¹
There were effective arrangements for identifying, managing and mitigating risks.	N ²
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 ³
Explanation of any answers and additional evidence: 1. Performance of staff was not always reviewed, such as prescribing or consultation reviews. 2. We identified risks to patients which the practice was not aware of. 3. There was no evidence that lack of clinical cover at the practice had been risk assessed.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	N ¹
Performance information was used to hold staff and management to account.	N ²
Our inspection indicated that information was accurate, valid, reliable and timely.	N ³
There were effective arrangements for identifying, managing and mitigating risks.	N ⁴
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: 1. Practice management were not always aware of the performance of staff. We saw no evidence of supervision or consultation reviews. 2. There was no evidence of who was accountable for failings in systems. For example, it was not clear who took control of prescribing or infection control at the practice. It was therefore unclear who was responsible for poor performance in these areas. 3. We found evidence of patients not receiving appropriate treatment in a timely manner. Consultation documentation lacked comprehensive details. 4. The provider had implemented changes at other surgeries to increase clinical cover following a recent CQC inspection at a practice which had been part of the Beechdale Medical Group, however these changes had not been implemented at the Boulevard Medical Centre. We saw several areas of risks to patients which the practice were unaware of,	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence: Nottingham City CCG reported that the practice was not always engaged with the practice during times where the CCG could have offered support.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: There was no evidence that the practice had taken any learning from previous CQC inspections at the other locations to ensure patients were safe.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.