

# Care Quality Commission

## Inspection Evidence Table

### Westwood Clinic (1-537739816)

Inspection date: 9 July 2019

Date of data download: 27 June 2019

## Overall rating: Inadequate

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

### Safe

### Rating: Inadequate

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

- We found the practice's system for managing patient and drug safety alerts was ineffective. We found the practice had not actioned two alerts, one of which affected two patients. There was no evidence to show the practice had taken action to protect those patients from avoidable harm.
- The practice's system for ensuring patients had a structured and comprehensive medicine review was not effective. We found 63% of eligible patients had not had a review within the previous 12 months and 58% of patients had not had a review within the previous 18 months.
- The practice did not have a system for ensuring prescribing by non-medical prescribers was appropriate or safe.
- We found a non-prescribing member of staff had made changes to patients' prescribed medicines. However, there was no documented evidence of discussions with or approvals from a GP.
- We reviewed consultation records and found the documentation was brief and lacking detail. Observations had been manually typed into the clinical systems so alerts such as sepsis would not automatically be triggered.
- The practice's safeguarding processes and systems were ineffective. We found that patients with safeguarding concerns did not have appropriate indicators or alerts on their records. This meant that other providers, such as out of hours services reviewing the patient records, would not be alerted to the concerns.
- We found the practice did not have oversight of the progress of actions arising from a fire risk assessment.
- The process for recording, investigating and learning from significant events was not effective. This was raised as a concern at our December 2018 inspection visit.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N <sup>1</sup>
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial <sup>2</sup>
There was active and appropriate engagement in local safeguarding processes.	N <sup>3</sup>
The Out of Hours service was informed of relevant safeguarding information.	N <sup>1</sup>
There were systems to identify vulnerable patients on record.	N <sup>1</sup>
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found there was an inconsistent approach to safeguarding from members of staff within the practice. For example, not all staff recorded patient safeguarding concerns on the consultation records. We reviewed four consultation records for patients the practice had made safeguarding referrals for. We found there were no indicators on the patients' records to identify there was potential safeguarding concerns and it was only possible to be alerted to the concerns by reviewing the specific consultation record where the concerns were noted. We also found these patients were not on a safeguarding register.</p> <p>2 – We found that members of staff had completed safeguarding training appropriate to their role. However, when we reviewed training records we found members of staff had completed all of their training on one day. For example, one member of staff had completed 20 modules of training in one day and according to the certificates, this amounted to over 24 hours of training. This training included Safeguarding Level 3.</p> <p>3 – The provider told us that multi-disciplinary team meetings were held. When we reviewed these meetings, we found that the only attendees were practice staff and no other healthcare professionals attended. Following the inspection, the practice told us multi-disciplinary team meetings were attended by an external co-ordinator who would liaise with other services. The practice told us they were in communication with the district nursing teams about attending future meetings.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial <sup>1</sup>
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – At our previous inspection, we found the practice had not completed recruitment checks for all staff prior to commencing employment. At this inspection, we found the practice had made changes to their recruitment processes and newly employed members of staff had more checks completed.</p> <p>However, two non-clinical members of staff had commenced employment since our previous inspection and the practice did not have any evidence to show the identity of one of these employees had been verified. In addition to this, the practice did not provide any evidence they had sought references for the other newly employed member of staff. Therefore, it was not possible to evidence these improvements had been fully embedded, monitored and sustained.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: July 2019	Y
There was a record of equipment calibration. Date of last calibration: August 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: July 2018	Y
There was a log of fire drills. Date of last drill: July 2019	Y
There was a record of fire alarm checks. Date of last check: July 2019	Y
There was a record of fire training for staff. Date of last training: See <sup>1</sup> below	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2019	Y
Actions from fire risk assessment were identified and completed.	Partial <sup>1</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – At our previous inspection we found the practice had not completed a fire risk assessment. At this inspection we found a risk assessment had been completed, however, the accompanying action plan did not evidence the practice had complete oversight of the actions requiring completion and the progress of those actions.</p>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises risk assessment had been carried out. Date of last assessment: June 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2019	Y

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y <sup>1</sup>
Staff had received effective training on infection prevention and control.	Partial <sup>2</sup>
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2019	Y <sup>3</sup>
The practice had acted on any issues identified in infection prevention and control audits.	Y
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.	Y
Explanation of any answers and additional evidence: 1 – Since our previous inspection visit, the practice had implemented a new infection prevent and control policy in June 2019. 2 – We found that members of staff had completed infection prevention and control training. However, when we reviewed training records we found members of staff had completed all of their training on one day. For example, one member of staff had completed 20 modules of training in one day and according to the certificates, this amounted to over 24 hours of training. This training included infection prevention and control training. 3 – The practice had commenced monthly infection control audits since January 2019, we saw evidence to show these audits were completed and where actions were required, the practice had evidenced these were followed up and completed.	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N <sup>1</sup>
Risk management plans for patients were developed in line with national guidance.	N <sup>1</sup>
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Partial <sup>2</sup>
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We reviewed care records and found patients did not always have risk management plans in place. In addition to this, we found patients did not always receive adequate support or reviews.</p> <p>2 – We reviewed some consultation records and found the documentation was brief and lacking detail. We also found an example of a patient who had their observations manually typed into the clinical systems so alerts such as sepsis were not automatically triggered, however, we did not find this patient was at risk of sepsis.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N <sup>1</sup>
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N <sup>2</sup>
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – We reviewed some clinical records as part of our inspection and found records were not always written in line with current guidance. For example, some consultation records we reviewed were brief and lacked detail meaning we were unable to assess if the consultations were always appropriate, as it was not possible to get a full understanding of the patient’s concern and history.</p> <p>In addition to this, we found the practice’s system of coding clinical records was not always effective. We found one example of a six-year-old child who had been incorrectly coded as having a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). We found a member of the practice team had excepted this patient from COPD annual monitoring, rather than highlighting the incorrect coding.</p> <p>2 – We found patient records did not always contain the appropriate alerts or indicators, such as patients with safeguarding concerns. In addition to this, we found the only attendees at multi-disciplinary meetings were practice staff and no other healthcare professionals attended to share information. Following the inspection, the practice told us multi-disciplinary team meetings were attended by an external co-ordinator who would liaise with other services. The practice told us they were in communication with the district nursing teams about attending future meetings.</p>	

## 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)	1.15	0.94	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	8.6%	11.3%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	6.52	5.86	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.80	2.08	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N <sup>1</sup>
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N <sup>2</sup>
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 <sup>3</sup>

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice told us they did not complete any audits or monitoring of the prescribing of non-medical prescribers. The practice told us there was no formal method of clinical supervision or peer review of non-medical prescribers. However, GPs were available during the day to discuss any concerns they had.</p> <p>2 – We found the coding of medical records did not ensure there was a process of completing structured medicine reviews; of 3,246 patients who were prescribed a medicine:</p> <ul style="list-style-type: none"> <li>• 2,068 were coded as not having a review in the previous 12 months (63%).</li> <li>• 1,871 were coded as not having a review in the previous 18 months (58%).</li> </ul> <p>We reviewed six of these records and confirmed that no review had taken place. We also reviewed six records where it had been coded that a medicine review had been completed. We found two of these only evidenced a medicine review code being added to the record and there was no accompanying information to suggest a structured review had taken place to ensure the prescribing was safe and appropriate.</p> <p>3 – We reviewed some patient consultation records and found a non-prescribing member of the clinical team was undertaking diabetic, COPD and asthma reviews. When reviewing consultation records of these reviews we found changes to prescribed medicines were made. There was no evidence in the consultation records of a clinical discussion with a GP to authorise the changes made. When we spoke with the member of staff, they told us GPs would authorise the changes but there was an inconsistent approach in the practice. For example, GPs would sometimes sign the prescription without reviewing the medical record or documenting any discussion of the consultation.</p>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N <sup>1</sup>
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	N <sup>1</sup>
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <p>1 – At the previous inspection, we found the practice had identified that not all significant events were recorded as there was confusion around what a significant event was. The practice had taken action and implemented a new policy and guidance to staff which evidenced an improvement to the number of significant events reported. However, at this inspection we found only three significant events were recorded, which was less than during our previous inspection visit and previous events which occurred prior to our last inspection, but within the last 12 months, were no longer recorded on the significant event log.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Uncollected prescriptions in reception box for over three months.	Reception staff were made aware of this event and a new protocol was set up for all staff. Weekly checks of uncollected prescriptions were implemented, and staff were told to report uncollected prescriptions to GPs to decide on actions needed.
The practice door was left unlocked.	A new protocol was established and a record of locking the practice doors was set up.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N <sup>1</sup>
Staff understood how to deal with alerts.	N <sup>1</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found the practice had an inconsistent approach to acting upon patient and medicine safety alerts. We found some alerts, but not all, had been actioned. We reviewed three patient safety alerts:</p> <ul style="list-style-type: none"> <li>• <u>Sodium valproate:</u> The practice had completed appropriate searches of medical records and followed up with patients potentially affected by the medicine safety alert.</li> <li>• <u>Tapentadol:</u> The practice had not completed appropriate searches of medical records and had no assurance that patients were not affected, although when we ran a search we found no patients at risk.</li> <li>• <u>Carbimazole:</u> The practice had not completed appropriate searches of medical records and had no assurance that patients were not affected. We ran a search on the day of the inspection and found seven patients prescribed carbimazole, two of whom were of potentially child bearing age. Clinical records failed to provide evidence of appropriate clinical discussions and reviews having been held with these patients.</li> </ul>	

## Effective

## Rating: Inadequate

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

- We found patients were not receiving full assessments of their clinical needs and patient care was not regularly reviewed and updated. We reviewed consultation records and found the documentation was brief and lacking detail.
- The practice's Quality Outcomes Framework (QOF) performance evidenced a higher than average exception reporting rate. We raised this as a concern during the previous inspection visit in December 2018, however the practice had taken no actions to improve this and data submitted but unverified for 2018/2019 evidenced the high exception reporting rate had been sustained.
- The practice's uptake of cervical, breast and bowel cancer screening was lower than the CCG and England averages. We raised this as a concern during the previous inspection visit in December 2018, however the practice had taken no actions to improve this.
- The practice's recall system was not effective. We found a large number of patients were overdue a medicine review. In addition to Quality Outcomes Framework data which evidences that not all patients received a review of their condition(s), due to higher than average exception reporting rates and some indicators evidencing lower than average performance.
- The practice did not have a system in place for monitoring the competence of clinical staff employed. We found examples where a clinician's consultations were not completed or recorded in line with NICE guidelines and this had not been identified by the practice.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N <sup>1</sup>
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N <sup>2</sup>
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N <sup>3</sup>
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N <sup>4</sup>
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
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Explanation of any answers and additional evidence:

1 – The practice did not have systems in place to ensure clinicians were up-to-date with current evidence-based practice. We identified a number of consultations which were not recorded in line with NICE guidelines, however, the practice were not aware of these consultations or the performance of clinicians.

2 – We reviewed consultation records and found the documentation was brief and lacking detail. We found a patient presented with chest pain but there was no evidence that their blood pressure or pulse was taken or recorded.

3 – We found that a patient had their observations manually typed into the clinical systems so alerts such as sepsis would not automatically be triggered.

4 – The practice’s recall system was not effective. We found a large number of patients were overdue a medicine review and Quality Outcomes Framework data showed that not all patients received a review of their conditions, demonstrated through higher than average exception reporting rates and lower than average performance for some clinical indicators.

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>	1.11	0.82	0.77	No statistical variation

## Older people

## Population group rating: Inadequate

### Findings

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

- 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.
- All patients aged 75 and over were listed on a register in order for the practice to monitor them more efficiently and closely on an ongoing basis.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- All older patients had a named GP.
- Older patients whom were deemed high risk or were on end of life care were discussed during a monthly practice meeting.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

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

- The practice had shared care agreements and consent procedures in place to enable the sharing of data and information with relevant organisations for co-ordination of care.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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>	94.8%	80.5%	78.8%	Significant Variation (positive)
Exception rate (number of exceptions).	29.7% (97)	15.7%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	91.1%	74.4%	77.7%	Variation (positive)
Exception rate (number of exceptions).	24.5% (80)	11.9%	9.8%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	87.6%	79.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	33.6% (110)	15.5%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	76.8%	76.2%	76.0%	No statistical variation
Exception rate (number of exceptions).	7.2% (16)	7.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.9%	90.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	12.4% (12)	13.2%	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) <small>(QOF)</small>	85.2%	82.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.7% (32)	4.7%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>	78.6%	90.8%	90.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.3% (1)	7.6%	6.7%	N/A

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice had a higher exception reporting rate for diabetes indicators. The practice were aware of this; however, the practice had no plans to try to reduce the number of exceptions made. We reviewed submitted but unverified exception reporting data for 2018/2019 and found this high level of exception reporting had been sustained.</li> <li>In those patients with atrial fibrillation, the percentage of patients who are currently treated with anti-coagulation drug therapy was lower than both the CCG and England averages. The practice were aware but had no actions in place to attempt to address this, although, we note the practice had a lower than average exception reporting rate for this indicator.</li> </ul>

**Findings**

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

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets with a range of 91% to 92%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception. Contraceptive devices were fitted at the practice.
- A weekly midwife clinic was held at the practice.

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)	60	65	92.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	72	79	91.1%	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)	72	79	91.1%	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)	73	79	92.4%	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)

Population group rating: Inadequate

### Findings

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

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. 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 prescriptions 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)	65.3%	70.9%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	68.3%	73.4%	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)	41.5%	56.9%	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)	20.0%	63.0%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	76.9%	60.6%	51.9%	No statistical variation

#### Any additional evidence or comments

- The number of patients screened for cervical cancer was lower than both the CCG and England averages. The practice were aware of this as we raised this as a concern on our previous inspection visit but the practice had no action plan in place to attempt to address this.
- The number of patients attending for bowel cancer screening was lower than both the CCG and England averages. The practice were aware of this as we raised this as a concern on our previous inspection visit but the practice had no action plan in place to attempt to address this.
- The practice's percentage of patients newly diagnosed with cancer, who had a patient review recorded within six months of the date of diagnosis was significantly lower than the CCG and England averages. The practice had no action plan in place to attempt to address this.

## People whose circumstances make them vulnerable

Population group rating: Inadequate

### Findings

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- 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 and support people who misused substances.
- Nurses conducted home visits to patients who required blood tests and chronic disease reviews if the patients were unable to leave their home.

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

Population group rating: Inadequate

### Findings

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients attending A&E or who have had contact with out of hours services were followed up by the practice to see if any additional support was required.
- A local mental health team provided weekly specialist clinics at the practice.

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>	94.4%	91.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	33.3% (9)	13.2%	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%	89.7%	90.0%	Variation (positive)
Exception rate (number of exceptions).	18.5% (5)	11.8%	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>	73.3%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	31.8% (7)	6.6%	6.6%	N/A

#### Any additional evidence or comments

- The practice had a significantly higher than average exception reporting rate for mental health indicators. The practice were aware of this and believed the higher exception rate was due to a lower prevalence of mental health conditions in the practice population, meaning that each exception reported will lead to a higher average.

#### 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)	556.2	543.0	537.5
Overall QOF score (as a percentage of maximum)	99.5%	97.1%	96.2%
Overall QOF exception reporting (all domains)	12.7%	6.5%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N <sup>1</sup>
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N <sup>2</sup>
Quality improvement activity was targeted at the areas where there were concerns.	N <sup>3</sup>
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

#### Any additional evidence or comments

1 – The practice did not provide any evidence of national or local quality improvement initiatives which they had been involved in.

2 – We found the programme of quality improvement in place was ineffective and the practice could not demonstrate sustained improvements to the quality of care provided to patients.

2 – Whilst we found the practice had a system for completing clinical audits, we found the practice had taken no action in relation to areas where concerns had been identified. For example, at our previous inspection visit we highlighted concerns with the significant exception reporting rates for Quality Outcomes Framework indicators. At this inspection we found the practice had taken no action in relation to this and submitted but unverified data for 2018/2019 evidenced the high exception reporting rates had been sustained.

## 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.	Y
The learning and development needs of staff were assessed.	N <sup>1</sup>
The practice had a programme of learning and development.	Y <sup>1</sup>
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
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.	N <sup>2</sup>
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 <sup>3</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – The quality of the training provided to staff was not clear. We found a number of staff had completed all of their training on one day, including the practice manager and lead GP. We found that a clinical staff member had completed 20 modules of training in one day and according to the certificates, this amounted to over 24 hours of training.</p> <p>2 – The staff appraisal and supervision system was unclear. We were unable to ascertain how the practice reviewed the competency of clinical staff. However, since the previous inspection we were informed non-clinical staff had received an appraisal with the lead GP.</p> <p>3 – We reviewed clinical consultation records and found consultations were lacking in detail and were not of sufficient quality and therefore did not meet national guidelines. These records could not demonstrate patients seen by this member of staff received safe and effective care and treatment. The lead GP reviewed these consultations on the day of the inspection and agreed with the inspection team that these did not meet standards for record keeping. We asked for evidence of how the practice could demonstrate the competence of staff employed, and the practice were unable to do this.</p>	

## 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)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

## Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	97.5%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.3% (13)	0.9%	0.8%	N/A

### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	N <sup>1</sup>
Policies for any online services offered were in line with national guidance.	N/A
Explanation of any answers and additional evidence: 1 – The practice had not completed an audit to evidence consent had been gained appropriately; however, in records we reviewed we found consent had been obtained.	

## Caring

## Rating: Requires Improvement

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

- The practice was aware of lower than average GP Patient Survey data however the practice had not taken or planned action to address this.
- Patients we spoke with and some CQC comment cards received on the day of the inspection contained negative feedback in relation to the attitude of some clinicians at the practice. This was reflected by some complaints received by the practice. The practice had not taken or planned action to address this.
- The practice had identified 37 carers and supported them, only 0.7% of the practice population.

### Kindness, respect and compassion

Feedback from patients was mixed about the way staff treated people.

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

### CQC comments cards

Total comments cards received.	29
Number of CQC comments received which were positive about the service.	21
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	3

Source	Feedback
Patient consultations	Patients we spoke with on the day of the inspection provided negative feedback in relation to the attitude of some clinicians at the practice. Patients were positive in relation to the non-clinical staff at the practice but informed us that some clinicians did not always display the same caring attitude.
CQC comment cards	21 of the 29 comment cards received were wholly positive about the service and how staff treat people. Five of the eight cards which contained negative comments were in relation to the negative attitude of some clinicians at the practice.
NHS Choices	Patient reviews on NHS Choices were predominantly positive about the caring attitude of staff.

## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5290	385	123	31.9%	2.33%

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)	77.4%	90.5%	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)	71.4%	89.1%	87.4%	Variation (negative)
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)	91.8%	96.3%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	76.1%	85.6%	83.8%	No statistical variation

### Any additional evidence or comments

- The practice was aware of lower than average GP National Survey data. However, at the time of the inspection the practice did not provide evidence of any actions they had taken to improve the satisfaction of patients in relation to the care provided.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N <sup>1</sup>

### Any additional evidence

1 – The practice told us they were in the process of completing a patient survey and we saw evidence of the survey which was to be distributed amongst patients. However, this survey had not yet been completed and no results were available at the time of the inspection.

### Involvement in decisions about care and treatment

**Patients were not always involved in decisions about care and treatment.**

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

Source	Feedback
Patient consultations	Patients we spoke with on the day of the inspection provided mixed feedback in relation to being involved in care and treatment decisions. Patients told us some clinicians were more approachable than others and at times, they did not feel involved in decisions about care and treatment.
CQC comment cards	21 of the 29 comment cards received were wholly positive about the service and how staff treat people. Five of the eight cards which contained negative comments were in relation to the negative attitude of some clinicians at the practice.
NHS Choices	The practice achieved four stars from four patient reviews on NHS Choices. Three of the four reviews were wholly positive and none of the reviews contained any negative feedback in relation to being involved in decisions about care and treatment.

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	83.7%	94.6%	93.5%	Tending towards variation (negative)

### Any additional evidence or comments

- The practice was aware of lower than average GP National Survey data. However, at the time of the inspection the practice did not provide evidence of any actions they had taken to improve the satisfaction of patients in relation to feeling that they were involved in decisions about their care and treatment.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y <sup>1</sup>
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: 1 – Since the previous inspection the practice had sourced a number of leaflets and posters in different languages, such as Lithuanian, to meet the needs of the practice population. The practice told us they intended to continue to identify further materials in different languages to support their diverse population.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 37 carers and supported them, which was approximately 0.7% of the practice population.
How the practice supported carers (including young carers).	The practice provided carers with a pack of information in relation to local support services or groups. Carers were also offered routine health checks and flu vaccinations.
How the practice supported recently bereaved patients.	The practice told us they would send a bereavement card and letter to the patient containing useful information, signposting to relevant services and the offer of support or a consultation.  We were provided with a copy of this letter on the day of the inspection.

## Privacy and dignity

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

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

# Responsive

# Rating: Good

## Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5290	385	123	31.9%	2.33%

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)	86.6%	95.5%	94.8%	Tending towards variation (negative)

### Any additional evidence or comments

- The practice was aware of lower than average GP National Survey data. However, at the time of the inspection the practice did not provide evidence of any actions they had taken to improve the satisfaction of patients in relation to feeling that their needs were met.

### Older people

### Population group rating: Good

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice signposted patients to a medicine delivery service for housebound patients.
- The practice was trialling a regular clinic at a local care home to reduce the number of telephone calls received from staff.
- Older patients would be offered a priority or longer appointment where appropriate.

### People with long-term conditions

### Population group rating: Good

#### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- Nurses conducted home visits to patients who required blood tests and chronic disease reviews if the patients were unable to leave their home.

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

**Population group rating: Good**

### **Findings**

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

**Population group rating: Good**

### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, online appointment booking and requests for repeat prescriptions.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.

## **People whose circumstances make them vulnerable**

**Population group rating: Good**

### **Findings**

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability; for example, longer appointments were available to book.

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

**Population group rating: Good**

### **Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff we spoke with had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Timely access to the service

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

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	72.3%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	77.4%	74.1%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	72.2%	69.3%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	80.3%	79.7%	74.4%	No statistical variation

Source	Feedback
Patient consultations	Patients we spoke with on the day of the inspection provided mainly positive feedback in relation to accessing care and treatment. Patients told us they were able to access appointments when required. The only concern raised by patients was on occasion, the waiting time for appointments once arriving at the practice was longer than they would like.
CQC comment cards	21 of the 29 comment cards received were wholly positive about the service and how staff treat people. Three of the comment cards received contained negative comments in relation to waiting times for appointments at the practice.
NHS Choices	The practice achieved four stars from four patient reviews on NHS Choices. Three of the four reviews were wholly positive and none of the reviews contained any negative feedback in relation to accessing care and treatment.

## Listening and learning from concerns and complaints

### Complaints were listened and responded to but not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Three
Number of complaints we examined.	One
Number of complaints we examined that were satisfactorily handled in a timely way.	One
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	None

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N <sup>1</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found the practice had only recorded three complaints and we were told by staff that verbal complaints were not recorded. This meant the practice missed the opportunity to identify trends and take action to improve patient experiences.</p> <p>The three complaints recorded by the practice related to patients' unhappiness with consultations and there was no evidence that these complaints had been used to drive improvement.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient was unhappy regarding the consultation received.	The practice contacted the patient to apologise for their poor experience and provided feedback to the clinician involved.

## Well-led

## Rating: Inadequate

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

- We found the practice had not made improvements to address all the concerns noted in our previous inspection report and during this inspection we identified a number of new concerns.
- We found a lack of leadership capacity and capability to successfully manage challenges and implement and sustain improvements.
- The practice could not evidence that risks, issues and performance were managed to ensure that services were safe or that the quality of those services was effectively managed.
- The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care. For example, the practice did not act on negative patient survey data and there was no active patient participation group.

### 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 <sup>1</sup>
They had identified the actions necessary to address these challenges.	N <sup>1</sup>
Staff reported that leaders were visible and approachable.	Y <sup>2</sup>
There was a leadership development programme, including a succession plan.	N <sup>3</sup>
Explanation of any answers and additional evidence: 1 – We found a lack of leadership capacity and capability to successfully manage challenges and implement and sustain improvements. The practice did not evidence concerns with quality identified during our previous inspection visits had been addressed. 2 – The practice’s leadership team consisted of three partners, however we found, and staff told us that only one partner was visible at the practice on a regular basis. The leadership team held registrations for other locations and attempted to manage their time across all of their locations. 3 – The practice did not have a succession plan in place and had not identified any future planning at the practice.	

## Vision and strategy

**The practice 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 vision and set of values that prioritised quality and sustainability.	Y <sup>1</sup>
There was a realistic strategy to achieve their priorities.	N <sup>2</sup>
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	N <sup>1</sup>
Progress against delivery of the strategy was monitored.	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice provided us with a vision which had been implemented since our previous inspection:</p> <ul style="list-style-type: none"> <li>• With new proactive management and GP presence with fresh outlook.</li> <li>• Continual feedback and receptive to make changes.</li> <li>• Opportunity to progress the practice.</li> <li>• Improved working environment.</li> </ul> <p>However, practice staff we spoke with were unaware of the practice's vision.</p> <p>2 – The practice did not have a strategy in place to achieve their vision or priorities. The practice had an action plan in place following our previous inspection, however we found this had not been followed through to completion and we found areas which had deteriorated since our previous 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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Partial <sup>1</sup>
There was an emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – Staff we spoke with advised they felt comfortable when raising concerns with the practice manager. However, not all staff we spoke with felt they could raise concerns with all of the GPs at the practice.</p>	

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

Source	Feedback
Staff consultations	Members of staff we spoke with during the inspection told us they felt improvements had been made since the previous inspection visit in December 2018. They told us they felt the lead GP was more engaged in the practice and felt supported by the new practice manager.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N <sup>1</sup>
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found the practice did not have clear governance structures and systems in place. For example, we found the practice did not have a system in place to ensure medicine reviews were completed. In addition to this, the practice did not have systems in place for recording prescribing decisions taken during consultations with a non-prescribing member of the clinical team.</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 comprehensive assurance systems which were regularly reviewed and improved.	N <sup>1</sup>
There were processes to manage performance.	Partial <sup>2</sup>
There was a systematic programme of clinical and internal audit.	Y <sup>3</sup>
There were effective arrangements for identifying, managing and mitigating risks.	N <sup>4</sup>
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.	Partial <sup>5</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice did not provide evidence to show comprehensive assurance systems were in place. For example, we found the practice had failed to identify risks to patient safety which we found on the day of the inspection.</p> <p>2 – We found consultations completed by clinical member of staff which were not in line with NICE guidelines. We brought this to the attention of the lead GP who agreed these were not in line with NICE guidelines. However, the practice had not identified this performance issue due to a lack of competency checks and supervision processes.</p> <p>3 – Whilst we saw a program of clinical and internal audit, this did not ensure actions were taken to ensure improvements were made where needed.</p> <p>4 – We found the practice did not have effective arrangements for identifying, managing and mitigating risks. For example, the practice did not have oversight of actions taken in response to fire safety assessments.</p> <p>5 – Where changes had been implemented by the practice, we saw limited evidence that these were reviewed and performance and impact on quality was assessed.</p>	

## 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 <sup>1</sup>
Performance information was used to hold staff and management to account.	N <sup>2</sup>
Our inspection indicated that information was accurate, valid, reliable and timely.	N <sup>3</sup>
Staff whose responsibilities included making statutory notifications understood what this entails.	N <sup>4</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – We did not see sufficient evidence to show the practice used data to improve performance; for example, Quality Outcomes Framework exception reporting data was not reviewed by the practice to ensure it was always appropriate.</p> <p>2 – We found the practice did not have systems in place to monitor the performance of clinical staff and ensure support was provided where required.</p> <p>3 – We found the practice’s system of coding clinical records was not always effective. We found one example of a six-year-old child who had been incorrectly coded as having a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). We found a member of the practice team had excepted this patient from COPD annual monitoring, rather than highlighting the incorrect coding.</p> <p>4 – We found the practice were registered incorrectly and the partners listed on the registration were not correct and the practice had failed to ensure the registration was updated.</p>	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	N <sup>1</sup>
The practice had an active Patient Participation Group.	N <sup>2</sup>
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found that despite being aware of negative patient feedback in relation to caring services provided at the practice, the practice had taken no actions to improve patient satisfaction.</p> <p>2 – The practice did not have an active Patient Participation Group (PPG), which was raised at the previous inspection. However, we saw that the practice had started to attempt to recruit a PPG and there was literature available in the practice for interested patients.</p>	

## 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 <sup>1</sup>
Learning was shared effectively and used to make improvements.	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice did not evidence systems for learning to monitor and improve the care provided. Despite the practice being aware of Quality Outcomes Framework high exception reporting rates and lower than average performance for some indicators, there was no evidence to suggest the practice had taken actions to improve.</p> <p>In addition to this, we noted that several members of staff had completed a high volume of training in one day. For example, one member of staff had completed 20 modules of training in one day and according to the certificates, this amounted to over 24 hours of training.</p> <p>2 –We found the staff meeting minutes did not always demonstrate learning or actions were shared and the practice did not hold a complete record of significant events and complaints, reducing the ability to learn from and make improvements.</p>	

### 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.