

Care Quality Commission

Inspection Evidence Table

Boleyn Medical Centre (1-2379611272)

Inspection date: 22 July 2019

Date of data download: 19 July 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

The practice is rated inadequate for safety due to a range of fundamental safety concerns including safeguarding children, safety alerts, significant events identification and management, and arrangements in the event of a medical emergency.

Safety systems and processes

Several systems, practices and processes to keep people safe and safeguarded from abuse were not effective.

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.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Partial
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
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.	Partial
Explanation of any answers and additional evidence:	
The principal GP was the lead for safeguarding both adults and children and the long term salaried GP	

Safeguarding	Y/N/Partial
<p>was the deputy lead.</p> <p>There were safeguarding protocols for both adults and children that were not reviewed annually but were last reviewed in October 2017. The safeguarding children protocol stated children's missed appointments and failed immunisations must be considered, but we found a baby had missed its third set of immunisations and although there was evidence of recall attempts at no point was this brought to the attention of the clinical team.</p> <p>We found a letter relating to a child on the practice safeguarding register that attended hospital for a reason that should have been escalated to the practice safeguarding lead and acted on immediately due to potential neglect, including to alert allied health and social care professionals. However, no action had been taken, and the safeguarding lead GP was not aware until we brought it to their attention. The practice made an appointment for the child to come in and be seen immediately after our inspection.</p> <p>Safeguarding was not included in the induction pack for locum GPs.</p> <p>There was no evidence of level 3 safeguarding children training for a locum GP, other staff files indicated staff were appropriately trained according to their role including non-clinical chaperones. The practice had not appropriately considered where new DBS checks are needed such as carrying out related risk assessments. The most recent DBS check for a healthcare assistant dated back to April 2011 and there was no evidence of a DBS check for a practice nurse.</p> <p>There was an up to date list of safeguarded children, but this was not checked or reviewed by the clinical team. Safeguarding issues were discussed with allied health and social care professionals at multidisciplinary meetings and safeguarding meetings. There was no evidence of discussions or consideration of cases of any safeguarded children or adults in 2019 in any clinical, practice or reception meetings notes where discussions were limited to local systems considerations.</p> <p>Immediately after our inspection the practice sent us an action plan that included:</p> <ul style="list-style-type: none"> • One day every three months starting from August to hold a "Vulnerable Patient Day" during which a GP and senior administrator will review safeguarded adults and children on the child protection register, for any cases requiring review or referral actions that will be documented. • New DBS checks for the lead GP, all employed staff who have a major change in roles and all staff with DBS checks that are more than 3 years old to be completed by the end of August 2019. • Updating the locum pack to contain more information about safeguarding children and adults. Signposting staff to a safeguarding drawer in every clinical room and administrative room that contains relevant safeguarding numbers. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

Explanation of any answers and additional evidence:

Some recruitment checks were undertaken for staff such photographic ID checks and registration of clinical staff. However, arrangements for undertaking DBS checks were ineffective. There were no references, locum agreement, or job description for a locum GP.

Immunisations checks were generally appropriate for clinical staff, but MMR status had not been considered for at least one clinician. We also found Public Health England (PHE) guidance that is applicable to both clinical and non-clinical staff from May 2018 in response to an increase in measles circulation within the UK (<https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/06/staff-vaccination-briefing-may-2018.docx>) was not implemented.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: January 2019	Y
There was a record of equipment calibration. Date of last calibration: January 2019	Y
There were risk assessments for any storage of hazardous substances for example, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: April 2019	Partial
There was a log of fire drills. Date of last drill: 30 April 2019	Y
There was a record of fire alarm checks. Date of last check: 25 July 2019	Y
There was a record of fire training for staff. Date of last training: Annual, ongoing	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 12 October 2017 by premises landlord and 15 June 2019 by practice staff.	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Fire safety systems and records were generally effective, but leadership and management staff were not aware of the contents of premises risk assessments undertaken by the landlord and did not know whether or how identified risks had been managed. We checked the fire risk assessment with management staff and found some risks were addressed and some were not. For example, staff had been trained in fire safety, but it was unclear whether premises emergency lighting works had been completed. We also found some fire extinguishers were not included in routine checks and labelled</p>	

indicating a check was due April 2019, but there was no indication this check had been made. The practice conducted its own in house fire risk assessment, but it did not refer to risks identified in the landlord's premises risk assessment or follow them up.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 10 April 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10 April 2019	Y
Explanation of any answers and additional evidence: The practice was able to access the legionella risk assessment and show related actions were taken to ensure safety such as regular water testing and flushing of taps. Staff escalated tidying of a cleaning storage cupboard and overdue rubbish collections for action that had both been addressed.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met but infection prevention and control audit outcomes were unknown and not sufficiently followed up.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 20 February 2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
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: The infection prevention and control audit dated 20 February 2018 identified an immediate action to implement and maintain a strict protocol for checking sterile instruments and equipment for their use by date. The practice had not implemented any formalised protocol, but a member of staff explained how they made these checks on a regular basis. We made some random checks in clinical rooms and did not find any out of date sterile instruments or equipment. There was a delegated practice nurse lead for infection control that started at the practice during autumn 2018, but they were not aware of the contents of the audit including improvement works needed for sinks and taps in clinical rooms. A clinical waste pre-acceptance audit was in place. The practice was clean, well-organised and tidy.	

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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Partial
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The rota was well planned and managed except there was insufficient contingency planning for in the absence of the lead GP that was single handed GP with a list size of 10,455 patients. There was no formalised cover arrangement in the absence of the lead GP to ensure appropriate oversight and maintenance of important considerations such as clinical leadership and governance.</p> <p>Induction had been carried out for a practice nurse but there was no evidence of induction for a locum GP.</p> <p>There was a book for recording accidents and incidents, but it did not contain any framework to ensure near misses were captured, action to identify causes or prevent recurrence, or report where necessary for example under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). There was a reporting form for significant events that all staff were aware of.</p> <p>The practice had “co-ordinate my care” plans in place for five patients.</p> <p>Risk management plans for patients were variable and we found several examples of long-term conditions reviews, such as for asthma, diabetes, and chronic obstructive pulmonary disease (COPD) undertaken by nursing and healthcare assistant staff with risk factors or considerations that should have been escalated to a GP but were not.</p> <p>Non-clinical staff were aware of signs and symptoms requiring urgent or emergency treatment, except for sepsis. There were no sepsis awareness notices, such as posters, available for staff to use as quick reference guides.</p> <p>The defibrillator, emergency use oxygen, and emergency medicines were securely stored but kept in different rooms which meant arrangements were impractical in the event of a medical emergency, because medicines and equipment needed would not be immediately accessible. Care and treatment was delivered on the ground and second floors and the proximity/ accessibility of all items that may be needed concurrently had not been considered.</p>	

There was insufficient management of changes in staffing such as services mostly being delivered by locum GP, nursing and healthcare assistant staff with no effective systems of clinical oversight. Non clinical changes had been managed such as a handover from the practice manager going on long term leave to an acting manager. However, there were gaps we identified in management functions such as awareness and response to health and safety risk assessments.

Immediately after our inspection the practice:

- Sent us evidence it was reviewing these arrangements as a priority and had stored all items for the event of a medical emergency together near the reception area.
- Sent us evidence of a formalised agreement between leadership, salaried GP staff and the practice manager, outlining responsibilities in the event the lead GP is overseas or temporarily incapacitated; but this did not consider medium to longer term absence of the lead GP.

Information to deliver safe care and treatment

Staff generally had the information they needed to deliver safe care and treatment except some necessary test results had not been sought.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
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.	N
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.	Partial
Explanation of any answers and additional evidence:	
Summariser staff received and dealt with patient's documents after receiving training from the lead GP. The document management system was audited by the lead GP in Jan 2019, when over 200 documents were audited and only one was found with an issue. There was no backlog of test results, or tasks generated by summarisers on the clinical system.	
There was no protocol in place for the tracking of urgent referrals such as potential cancer referrals under the urgent two weeks wait process, but staff responsible for monitoring and ensuring these were seen through were consistently doing so and documenting appropriately.	
Only five palliative care patients had a "coordinate my care" plan arrangement in place.	
We considered the practice had a relatively young population but concluded that only five patients with	

a care plan may indicate insufficient identification of patients to assure information sharing with staff and other agencies. Staff acknowledged was a low number for the practice list size of 10,455 patients.

We reviewed clinical, practice and reception meeting minutes for the year to date 2019 and there was no evidence of discussion of significant events or safety alerts. Discussions regarding safeguarding were limited to one discussion regarding local processes. Meeting minutes did not contain any framework to ensure actions were agreed or followed up.

Immediately after our inspection the practice sent us an action plan including:

- A new 2 week wait protocol.
- An updated the document management protocol to capture child protection matters and cancer diagnoses.
- Criteria for patients that did not attend (“DNAs”) or “were not brought” (such as children) was established for summarisers to refer the patient for urgent review.

Appropriate and safe use of medicines

The practice did not have adequate systems for the appropriate and safe use of medicine.

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	0.73	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)	11.3%	9.7%	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)	6.23	5.58	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	3.71	1.49	2.07	Tending towards variation (negative)

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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
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/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
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.	Partial
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
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>Blank prescriptions were kept securely but monitoring was limited to boxes delivered and did not include monitoring of prescriptions distribution / usage.</p> <p>Uncollected prescriptions were checked on a regular basis and there were no prescriptions older than a month in the collection box</p> <p>Appropriate Patient Group Directions were in place, but Patient Specific Directions were missing for the healthcare assistants when administering B12 and flu vaccines.</p> <p>There were no non-medical prescribers employed by the practice.</p> <p>There were no controlled drugs on the premises.</p>	

Processes for the safe handling of requests for repeat medicines and structured medicines reviews for patients on repeat medicines were not sufficiently formalised and outcomes variable and, in some cases, entailed risk.

There was no policy for monitoring patient's health in relation to the repeat prescribing of medicines including high risk medicines. The lead GP told us all GPs were given a card with guidance which we saw on the day of our inspection; however, a salaried GP was not aware of the card when asked about a specific medicine hydroxychloroquine. (Hydroxychloroquine is a disease-modifying anti-rheumatic drug (DMARD). It regulates the activity of the immune system, which may be overactive in some conditions).

- Of six patients whose files we checked prescribed a high risk medicine Azathioprine, there was no record of blood tests being up to date and appropriate at the time this medicine was prescribed, but all relevant blood tests were up to date by the final day of our inspection.
- Of three patients prescribed a high risk medicine Lithium, two were slightly overdue a blood test.
- The practice had undertaken an audit in March 2018 for patients prescribed a high risk medicine Methotrexate which indicated a few patients were not sufficiently monitored, which was a collective responsibility between the practice and a hospital provider; however, it remains the responsibility of the prescriber to assure themselves that appropriate monitoring has been undertaken. A conclusion of the audit was Methotrexate was not always being prescribed safely due to lack of timely blood test monitoring, clarity regarding who is responsible for monitoring and there was prescribing when blood tests were overdue. The audit included recommendations and a re-audit in six months to one year but there was no evidence the recommendations had been implemented and no second cycle audit had been undertaken. We reviewed six patients prescribed Methotrexate and found relevant test results were not consistently recorded on the practice system. We checked further into hospital records and could see relevant blood tests had been undertaken prior to prescriptions being issued.
- We reviewed 11 clinical records for patients prescribed a high risk medicine Warfarin and found concerns, including four international normalized ratio (INR) blood tests being overdue at the time of prescribing, and Warfarin being stopped without the patient being informed. Warfarin is a blood thinner medicine used to prevent heart attacks, strokes and blood clots in the veins and arteries. Warfarin needs to be adjusted based on the most recent international normalized ratio (INR) blood test result. Both an under dose and an overdose of Warfarin can prove fatal and therefore careful monitoring of patients prescribed Warfarin is essential.

We also found repeat medicines where specific considerations were not monitored effectively, such as:

- Non-steroidal anti-inflammatory drugs (NSAIDs) insufficient kidney function tests and consideration of medicines to alleviate side-effects of these group of medicines. (NSAIDs are medicines that are widely used in a variety of conditions. NSAIDs are commonly used but are not suitable for everyone and can sometimes cause troublesome side effects).
- There were 29 women prescribed a specific medicine ACE Inhibitor medicine (ACEI) known as Ramipril where kidney function tests should be regularly checked, and contraception considered. (ACE inhibitors are medicines that are used to treat high blood pressure). We checked seven of the 29 records and found concerns such as no attempts to remeasure the patients' blood pressure and none recorded within the last five years, no relevant "U&E" blood tests and last results show evidence of Chronic kidney Disease (CKD), lack of consideration of ACEI prescribed and related discussion with patient, no checking of renal function on increasing ACEI, no discussion of contraception when starting ACEI.

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • There was no creatinine clearance level test as needed for seven patients prescribed a (DOAC) medicine known as Rivaroxaban. (DOACs are anticoagulant medications that require dose adjustments according to creatinine clearance, the amount of blood cleaned of creatinine by your kidneys is called the creatinine clearance. <p>There was no statistical variation in levels of antibiotics prescribing but all indicators were consistently higher than local and national averages, and the 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) was tending towards higher than average which is a negative indicator.</p> <p>There were additional examples of insufficient consideration of relevant factors for patients prescribed several other medicines including:</p> <ul style="list-style-type: none"> • Proton pump inhibitors (PPI) with no record of side effects discussions, or whether patients were taking or needed to continue taking this medicine. • A patient prescribed aspirin with no clinical indication. • A patient prescribed a controlled drug and additional pain relief without any discussion documented of this during the patients' medicine review. • Repeat prescribing of an anti-inflammatory painkiller and PPI medicine review with no record of discussion with the patient. <p>There was a lack of clinical oversight to monitor and ensure appropriate prescribing of controlled drugs and antimicrobial medicines.</p> <p>There was an audit trail for most of the required changes to a patient's medicines such as those made by hospital clinicians. However, there were gaps for certain medicines that are prescribed less frequently such as antiretroviral medicines (used, for example, to treat HIV) and sulphasalazine (a medication used to treat rheumatoid arthritis, ulcerative colitis, and Crohn's disease) that were not entered onto the practice system.</p> <p>Emergency medicines were held loose in a secured cupboard in a different room to emergency equipment. A system was in place to monitor emergency medicines stock levels and expiry dates but there was no risk assessment to determine what emergency medicines were needed.</p> <p>Immediately after our inspection the practice sent us an action plan that included:</p> <ul style="list-style-type: none"> • A three monthly "Patient Safety Day" to go through patient safety issues including teratogenic drugs (that can disturb the development of the embryo or foetus) and medicines prescribing. • A Methotrexate audit conducted and updated DMARD (disease-modifying antirheumatic drugs) protocol. • Holding emergency medicines together in a grab bag in the reception area next to emergency equipment. Staff told us emergency adrenaline will be put in every clinical room with a practice protocol on how to use it in case of an emergency. 	

Track record on safety and lessons learned and improvements made

There was limited learning and improvement when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	6
Number of events that required action:	6
<p>Explanation of any answers and additional evidence:</p> <p>The practice systems for the monitoring and reviewing of internal significant events were not effective. An internal significant event reporting form was used by staff that included actions taken to resolve individual significant events and learning points to improve. However, individual significant events follow up was variable, and there was no trigger to identify root causes or changes needed to systems to improve safety.</p> <p>There was no evidence of discussion of significant events at clinical, practice or reception meeting minutes for over six months prior to the inspection.</p> <p>Immediately after our inspection the practice sent us an action plan including:</p> <ul style="list-style-type: none"> • Monthly clinical meetings with significant events as a fixed agenda item. • Quarterly whole practice meetings with significant events as a fixed agenda item. 	

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

Event	Specific action taken
A contractor identified the defibrillator battery had expired and told staff.	A new battery was obtained and the staff member responsible for checking the defibrillator was asked to check all emergency equipment together monthly, and the expiry date was written on the new battery to order in advance of expiry.
The wrong patient was telephoned, and a message left for them in response to a hospital letter relating to another patient.	Staff left a second message to apologise for the error. The learning point was for staff to check details of patients properly before telephoning. There was no evidence the correct patient was telephoned or received an explanation.

Safety alerts	Y/N/Partial
---------------	-------------

There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	N
<p>Explanation of any answers and additional evidence:</p> <p>Safety alerts were reviewed and cascaded but there was no evidence of related searches for patients potentially affected or actions to follow up for two medicine alerts that we checked where action needed to be taken.</p> <p>Immediately after our inspection the practice sent us an action plan that included:</p> <ul style="list-style-type: none"> • Action to follow up the safety alerts. • A new protocol for safety alerts. • Three monthly “Patient Safety Day” to go through patient safety issues safety alerts. • Monthly clinical meetings with regular fixed agenda items including new safety alerts. 	

Effective

Rating: Inadequate

The practice is rated inadequate for effectiveness due to concerns including patient’s needs assessment, care and treatment across population groups. There were gaps in arrangements to ensure effective staffing and a lack of oversight, monitoring and improving care and treatment that affected all population groups ratings.

Effective needs assessment, care and treatment

Patients’ needs assessment and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance or 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
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients’ treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients’ needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Clinical meetings took place sporadically. We reviewed the four sets of meeting notes available for meetings during 2019 in January, February, June and July 2019 where various topics were discussed. Notes of these meetings made no reference to NICE or other best practice guidelines, had</p>	

no educational sessions, and no framework for or actions agreed or follow up. All clinicians were emailed the notes after the meetings, but nursing staff were not routinely in attendance.

The two weeks wait process was not included in the induction pack for locum GPs or formalised for staff to follow but was working effectively.

We reviewed a sample of patient records where the majority were satisfactory but some identified concerns with care and treatment. There were examples of a lack of escalation of patients to see a GP, insufficient review and updating of care and treatment for patients with long term conditions seen by healthcare assistant staff, no consideration of stepping down treatment and a lack of discussion about whether patients were taking inhalers.

There were coded medication reviews with no documentation of asking about side effects, compliance or tolerance, or checking if the reason a medication had been prescribed was still relevant. We found examples of patients not getting a PPI to protect their stomach as a side effect from NSAID medications, examples where a patient had been on a PPI for some time and there was no discussion documented on considering reducing the dose from the maximum to a maintenance dose to reduce a risk of osteoporosis or getting Clostridium Difficile.

There were several examples of patients having review dates a year in advance where key disease views had not taken place, with missed opportunities, therefore, to encourage patient recall and review.

There were examples of failure to review medicines in a timely manner such as for a patient prescribed a medicine for their thyroid with evidence of overprescribing, which put the patient at risk of arrhythmia. This patients' record also demonstrated a lack of rationale for commencing thyroid medicines treatment.

Immediately after our inspection the practice sent us an action plan that included:

- Three monthly "Patient Safety Day" including to review clinical policies, guidelines and protocols.
- Monthly clinical meetings to with regular fixed agenda items including best practice guidelines.

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>	0.21	0.33	0.77	Significant Variation (positive)
Any additional evidence or comments				
Data showed the practice prescribing of hypnotics was relatively low which is a positive performance indicator.				

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • The practice did not use a clinical tool to identify older patients who were living with moderate or severe frailty to identify those needing a full assessment of their physical, mental and social needs. • We saw evidence of patients booked in for a review, safeguarding considerations noted and prescriptions were updated to reflect changed needs. • Staff had appropriate knowledge of treating older people including their psychological, mental

and communication needs.

- Health checks were offered to patients over 75 years of age.

Immediately after our inspection the practice sent us an action plan that included one day every three months starting from August they planned to hold a “Vulnerable Patient Day”, during which a GP and senior administrator will review all patients with severe frailty for any cases requiring review or referral actions that will be documented.

People with long-term conditions

Population group rating: Inadequate

Findings

- Patients with long-term conditions had an annual review and care plans were developed by nursing (such as for diabetes), and healthcare assistant staff (such as for asthma and COPD) that had been trained. However, we were not assured by existing arrangements for care and treatment of people with long term conditions across the clinical team as patients were not consistently escalated or recalled for further checks where needed. For example:
 - There was insufficient consideration for a patient with both asthma and COPD noted as experiencing shortness of breath that was not reviewed by a GP. The lead GP had logged and coded a medicine review afterwards for this patient but there was no evidence medicines prescribed to the patient had been considered.
 - Problems were identified for a further two patients with COPD. The first patient was coded as having COPD but not seen about this for several years, still got QOF alerts and regular medicines for other conditions, smoked 20 cigarettes per day and had a flu vaccines injection with no consideration or discussion of COPD. The second patient had a chest x-ray as their cough was not improving after antibiotics and appropriate treatments were not offered such as referral to pulmonary rehabilitation.
 - There were patients with concerns reviewed by healthcare assistant staff and a child with no consideration of stepping down treatment. For example, patients lacking a review and appropriate recall, reasons why/ discussion with a GP, and no documentation of care and treatment plan agreed.
 - A patient with diabetes with high blood sugar levels and no evidence of recall to follow up. A further patient with diabetes with a blood sugar level of 72 taking three or four tablets of a specific medicine with stomach issues that should have been considered for a change of medicines.
 - A patient prescribed medicines for hypertension (high blood pressure) whose last check was grossly abnormal and was continuing with repeat medicines prescribed. The “regime review” date was 18 October 2018.
- A further patient with high blood pressure that was prescribed a specific medicine and no appropriate follow up or consideration of 24hour monitoring. We also noted other patients were referred to a local provider for ambulatory blood pressure monitoring.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- On the days of our inspection we were unable to find evidence to verify whether GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

- Patients with atrial fibrillation were assessed for stroke risk but monitoring of some of their medicines commonly referred to as DOACs (anticoagulant medications) were not sufficiently well undertaken.

Immediately after our inspection the practice sent us an action plan that included:

- A three monthly "Patient Safety Day" including to review non-attendees for diabetes, hypertension, COPD, asthma and all chronic diseases, including a risk assessment on individual patients and creating an action plan. On this day a GP will sit in on healthcare assistants and nurses' consultations for training and feedback.
- A new protocol for non-attendees.

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>	70.0%	71.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	2.1% (16)	6.9%	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>	66.0%	79.8%	77.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.3% (33)	5.0%	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>	78.5%	79.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	5.2% (40)	7.5%	13.5%	N/A
Any additional evidence or comments				
Data showed the practice was tending towards a negative clinical performance data variation for 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). The latest unverified data held on the practice system indicated performance was improving and currently projected to be 76% for the full 2019/2020 reporting year.				

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	70.8%	78.5%	76.0%	No statistical variation

assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	1.9% (8)	3.0%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	90.4%	92.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	7.1% (4)	6.8%	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>	72.5%	81.7%	82.6%	Variation (negative)
Exception rate (number of exceptions).	2.4% (22)	3.2%	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>	94.1%	88.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (1)	5.7%	6.7%	N/A

Any additional evidence or comments

Data showed the practice had a negative performance data variation for 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). The practice had recruited more healthcare assistant staff to take patient's blood pressures, but this would not improve clinical management for this group of patients. The latest unverified data held on the practice system indicated performance was declining and currently projected to be 64% for the full 2019/2020 reporting year.

Families, children and young people

Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were slightly below the World Health Organisation (WHO) targets. Staff were aware of this and told us the practice had a transient population (which is a challenge across the locality), in addition some patients tended to refuse vaccinations making reaching the target more challenging. There was no strategy to improve the uptake of vaccinations. We saw multiple recalls by administrative staff but occasions where this was not escalated for clinical consideration in line with the practice safeguarding children policy. After our inspection the practice sent us evidence of improvements and a child we had identified that was booked in for their immunisation.
- 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 insufficient arrangements for following up failed attendance of children's appointments following an appointment in secondary care and immunisation.
- Young people could access services for sexual health and contraception.

Immediately after our inspection the practice sent us an action plan that included a three monthly "Patient Safety Day" including to review immunisations.

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)	112	128	87.5%	Below 90% minimum
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)	120	141	85.1%	Below 90% minimum
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)	121	141	85.8%	Below 90% minimum
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)	122	141	86.5%	Below 90% minimum

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 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. We checked six patients records and found none where the any risks or abnormalities required follow up.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	67.9%	62.9%	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)	63.2%	55.0%	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)	40.3%	45.1%	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)	77.8%	80.4%	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)	20.0%	44.3%	51.9%	No statistical variation

Any additional evidence or comments

The percentage of persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage), 40.3% (01/04/2017 to 31/03/2018); and the number of new cancer cases treated (Detection rate 20% of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) were both lower than local and national averages. There was no evidence of action the practice had taken to further understand or address this such referral audits or evidence of team discussions.

The practice did not have a process to encourage patients to have the bowel cancer screening test. Bowel cancer screening was not coded, for example where patients had not responded to an invitation to take a bowel cancer screening test, or to indicate whether a patient had the test or not.

There was no system to ensure review of cancer diagnoses.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- Same day appointments and longer appointments were offered when required.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability, but it was not used proactively. Patients with a learning disability had care plans but these were not satisfactory; for example, care plans did not cover all diseases patients with learning disabilities might have but instead were more a tick box of coding plan that included

named carer and level of disability. There was no proactive checking of symptoms in each clinical domain.

- There were no separately named GPs for patients that may be vulnerable to assure co-ordinated care, for example for palliative care patients at the end of life.
- Only five patients had a “coordinate my care” plan arrangement in place and the practice list size was 10,455 patients, albeit with a relatively young population may indicate an under identification of patients that would need this type of plan to ensure appropriate sharing of information with staff and other agencies.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

Immediately after our inspection the practice sent us an action plan that included one day every three months starting from August they would hold a “Vulnerable Patient Day” during which a GP and senior administrator will review all patients with a learning disability, with a “coordinate my care” plan, or needing palliative care, for any patients requiring review or referral actions that will be documented.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- There were no separately named GPs for patients with severe mental illness to ensure continuity of care.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- Arrangements for patients assessed to be at risk of suicide or self-harm had weaknesses. Eleven patients had been coded for overdose but only one of these patients had an alert on their record or note on the prescribing screen. GP staff told us this was dealt with by restricting prescriptions for medicines supplied to these patients to monthly. However, this did not address our concerns because a lack of alert meant GPs would not be alerted to specific considerations such certain medicines prescribed to this group of patients, that can be toxic in overdose and some of these patients may need less than a month’s supply.
- Dementia case finding had been undertaken to inform referral to appropriate services.
- There was limited evidence of staff dementia training. The practice had appointed a member of the management team as a dementia care champion.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with	95.0%	90.4%	89.5%	No statistical

schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				variation
Exception rate (number of exceptions).	9.1% (2)	8.4%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.0%	91.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.1% (2)	4.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	84.8%	83.0%	Variation (positive)
Exception rate (number of exceptions).	8.3% (1)	4.3%	6.6%	N/A

Any additional evidence or comments

The practice 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) was above average, which is a positive performance indicator.

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)	531.6	510.1	537.5
Overall QOF score (as a percentage of maximum)	95.1%	91.2%	96.2%
Overall QOF exception reporting (all domains)	3.7%	5.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N

Any additional evidence

Quality improvement initiatives were limited to the lead GP taking part in a diabetes virtual clinic educational meeting where more complex patient cases were discussed.

Oversight of clinical care was limited to one consultation observed by the lead GP within a seven month period for each nurse and healthcare assistant. There was no peer review or audit, such as of referrals or deaths. There were no systems to monitor care and treatment being delivered by a long term salaried GP and four locum GPs.

There was an audit of methotrexate prescribing undertaken in March 2018 that indicated improvements were needed but there was no evidence of follow up.

The document management system was audited by the lead GP in Jan 2019, when of over 200 documents were audited and only one was found with an issue, and no further auditing of this system since then.

Immediately after our inspection the practice sent us an action plan that included:

- A three monthly "Patient Safety Day" including to ensure auditing and completing the cycle of previous audits.
- Monthly clinical meetings with regular fixed agenda items including deaths in the practice and recent audits.
- Twice yearly GP review of healthcare assistants and nurse's consultations increased to quarterly.

There were no examples of improvements resulting from clinical audits or other improvement activity in past two years.

Effective staffing

The practice was generally able to demonstrate staff had the skills, knowledge and experience to carry out their roles except some elements of healthcare training were unclear.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	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.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
Staff were generally well and appropriately trained in accordance with their role, except for non-	

clinical staff sepsis awareness and training and a locum clinician with no evidence of safeguarding children training.

Nursing and healthcare assistant staff were generally appropriately trained but we found occasions where patients care had not escalated to GPs such as long term conditions including COPD, asthma, and diabetes. The complexity of patients care considerations had not been properly understood and addressed. For example, for healthcare assistant staff that were undertaking reviews for patients with COPD, and where related training was limited to spirometry.

Patient Specific Directions were not in place as legally required such as for healthcare assistants administering injectable medicines. Healthcare assistants had received immunisations training but there was no assurance this covered intramuscular injections or of any related assessments of competence.

Immediately after our inspection the practice told us it had previously been assured on the injection update training that healthcare assistants can administer all intramuscular injections. However, as this was not specified on related training certificates the provider suspended all healthcare assistants from administering injections and told us they would investigate the matter further.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The provider 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) <small>(QOF)</small>	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There were no separately named GPs for patients because all were registered with the lead GP, which meant there was no method of for co-ordinated clinical consideration. There was no method of ensuring correspondence for vulnerable patients would be directed to a GP with sufficient knowledge to best inform and co-ordinate care. Staff told us they allowed patients to choose which GP they would wish to see and if urgent, patients would see any GP.</p> <p>We saw examples of patients that were signposted for example patients with CVD to a local health club.</p>	

Helping patients to live healthier lives

Staff were helped patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Health promotion information in the reception area was limited, there were no information leaflets such as for cancer screening, but posters were up for considerations such as vaccines.</p> <p>Care plans we reviewed for two older patients to help avoid their unplanned admission into hospital did not include evidence of appropriate encouragement or advice for self-care and management. The care plans were not individualised to the patient and goals and treatment plan were not specific to the patient. Additionally, when patients had asthma, for example, no mention was made of when not use the reliever inhaler and when to specifically call for help.</p> <p>Patient's feedback indicated staff educated and encouraged healthier living.</p> <p>Patients were referred to local pharmacists for stop smoking services.</p> <p>We saw evidence patients were referred to relevant clubs such as an exercise for patients with cardiovascular disease (CVD) and a local cancer support group.</p> <p>Immediately after our inspection the practice sent us an action plan that included:</p> <ul style="list-style-type: none"> • One day every three months starting from August they would hold a "Vulnerable Patient Day" during which a GP and senior administrator will review all patients on their avoiding unplanned admissions list for any patients requiring review or referral actions that will be documented. • A calendar for health promotion weeks and months to update the practice social media and website to promote these. 	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	95.2%	96.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.9% (30)	0.7%	0.8%	N/A

Consent to care and treatment

The practice generally 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.	Partial
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.	Partial
Explanation of any answers and additional evidence: We checked GPs and Nurses patient's consultation records and saw evidence patient consent was sought and recorded for immunisations, minor surgery and cervical screening but the minor surgery consent form did not inform patients of the procedure risks and benefits.	

Caring

Rating: Requires improvement

The practice is rated requires improvement for caring due to concerns including insufficient arrangements for patient's privacy in the reception area and to identify carers.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
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

Source	Feedback
1. GP Patient Survey results.	Clinical and non-clinical staff are kind, caring and respectful.
2. Seven patients we spoke to on the inspection day.	All seven patients said staff was caring and kind.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10424	466	100	21.5%	0.96%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	87.4%	83.7%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	84.0%	81.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	98.5%	91.3%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	80.6%	75.6%	82.9%	No statistical variation

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

Any additional evidence
The practice undertook its own a patient survey over a period of six weeks by handing out patient's survey questionnaires during November and December 2018. Fifty-nine patients responded. The practice analysed the results of the survey that focused on assessing patient's awareness of ways to book an appointment and satisfaction with access. No actions had been taken, four actions were identified but had no date for commencement or completion or delegated responsible staff.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment 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
Explanation of any answers and additional evidence: National and in-house survey results as well as feedback from the seven patients we spoke to indicated staff helped patients to be involved in decisions about care and treatment.	

Source	Feedback
1. GP Patient Survey results.	Patients are involved in their care though being listened to and options explained.
2. NHS Choices	The practice scored three of a possible five stars for patients feeling involved in their care.

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 (01/01/2019 to 31/03/2019)	91.9%	87.9%	93.4%	No statistical variation

	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.	Partial
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Any additional evidence

Information in the reception area was limited, there was no bereavement support information but there was a carers support group poster.
--

Carers	Narrative
Percentage and number of carers identified	The practice register of all people who are carers is 78 patients which is less than 1% of the practice list size.
How the practice supports carers	The practice had a dedicated carers champion in the practice for all patients who were carers, that was responsible for creating and updating an

	appropriate carers pack support resource. The practice offered annual flu vaccinations to carers.
How the practice supports recently bereaved patients	Staff sent them a sympathy card and where appropriate/ desired offered a patient consultation at a flexible time and location to meet the family's needs. By giving the patient advice on how to find a support service.

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff were aware of offering a private space if necessary and documents were promptly filed. We observed staff were quiet when speaking with patients, to minimise the chances of conversations being overheard. However, there was no queue management signage or system and patients were standing very close to each other whilst discussing issues at the reception desk and we told leaders and managers these arrangements should be reviewed.</p> <p>Immediately after our inspection the practice sent us an action plan including:</p> <ul style="list-style-type: none"> A poster placed in reception stating for waiting patients to give space to the patient speaking to reception staff and plans to submit a landlord's variation request to allow foot markers to be painted on the floor. 	

Responsive

Rating: Inadequate

The practice is rated Inadequate for responsive due to concerns including a lack of effective action to improve access, appointments not offered according to timings on the practice website and leaflet, and arrangements for receiving and acting on complaints were insufficient. These concerns affected all population groups and population groups ratings.

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the	Y

services provided.	
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Partial
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Partial
Explanation of any answers and additional evidence:	
The number of patients with a “coordinate my care” plan was limited to five.	

Practice Opening Times	
Day	Time
Monday	8am-6:30pm
Tuesday	8am-6:30pm
Wednesday	8am-6:30pm
Thursday	8am-6:30pm
Friday	8am-6:30pm
Appointments available	
	Staff told us appointments were available Monday to Friday 8am-6:30pm but the appointments calendar indicated there were no appointments after 5pm on Wednesdays and 4pm on Thursday for a period of six weeks prior to our inspection.
Off-site after hours surgeries- Through a local network hub of GP practices	
	8am to 8pm Monday to Sunday. The extended hours service offers weekday evening appointments from Wednesday to Friday between 6.30pm to 9.30pm, and Saturday morning appointments between 9.00am to 12.00pm.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10424	466	100	21.5%	0.96%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	95.9%	90.6%	94.5%	No statistical variation

Population group rating: Inadequate

Indicator	Practice	CCG average	England average	England comparison
-----------	----------	-------------	-----------------	--------------------

Older people

Findings
<p>The provider was rated as inadequate for responsive due to issues that affected all patients including this population group.</p> <ul style="list-style-type: none"> All 10,455 patients had the lead GP as a named GP who supported them in whatever setting they lived, but this did not underpin effective arrangements to ensure continuity and coordination of patients care. For example, for palliative care or health visitor teams to direct queries and correspondence to a named GP, or for the named GPs responsibility for follow up of a patient post hospital admission. The lead GP explained it was not viable for practice systems to have temporary GPs that were working on a long term basis as a named GP. The practice was responsive to the needs of older patients and offered home visits and walk in and urgent appointments for those with enhanced needs and complex medical issues. In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Inadequate

Findings
<p>The provider was rated as inadequate for responsive due to issues that affected all patients including this population group.</p> <ul style="list-style-type: none"> Patients with multiple conditions had either a single appointment or separate appointments to review their care. Staff told us patients would request separate appointments at times. Only five patients had a "coordinate my care" plan arrangement in place and the practice list size was 10,455 patients indicated insufficient identification of patients to assure information sharing with staff and other agencies. Aside from this the practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: Inadequate

Findings
<p>The provider was rated as inadequate for responsive due to issues that affected all patients including this population group.</p> <ul style="list-style-type: none"> There was no systemic approach 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 a patient was on the child protection register for neglect, had attended hospital for a reason that indicated possible further neglect, but this information had not been conveyed to social services. The practice took immediate action to call the child in for an appointment and make relevant

referrals.

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Off-site after hours surgeries were available through a local network hub of GP practices for school age children, so that they did not need to miss school.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The provider was rated as inadequate for responsive due to issues that affected all patients including this population group.

- 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.
- Off-site after hours surgeries were available through a local network hub of GP practices.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The provider was rated as inadequate for responsive due to issues that affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability, but it was not used proactively.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided care coordination to enable patients living in vulnerable circumstances to access appropriate services.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

The provider was rated as inadequate for responsive due to issues that affected all patients including this population group.

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

Timely access to the service

People were not able to access care and treatment in a sufficiently 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 (01/01/2019 to 31/03/2019)	40.6%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	55.0%	62.3%	67.4%	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 (01/01/2019 to 31/03/2019)	55.2%	63.0%	64.7%	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 (01/01/2019 to 31/03/2019)	62.3%	66.9%	73.6%	No statistical variation

Source	Feedback
1. GP Patient Survey results.	The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019) was significantly below average, and all GP patient survey data relating to access was lower than average.
2. Patients NHS choices ratings	Patients NHS choices ratings for telephone access were 3 out of 5 stars (12 ratings), and for appointments 2 out of 5 stars (14 ratings).
3. CQC interviews with patients.	Four of the seven patients we interviewed expressed satisfaction with access arrangements, but three expressed dissatisfaction with getting an appointment including getting through on the phone.

Any additional evidence or comments

There was no strategy or effective action plan to improve patient access. Arrangements for appointments were not effective as evidenced and expressed through patient's feedback.

The practice ran a walk in clinic from 8.30am where patients queued outside the practice and on entry were allocated appointments on a first come first served basis for an hour and a half until slots were full. The practice told us this arrangement was implemented in response to general patient feedback and the intention was these appointments would be for urgent problems only. We noted the existing walk in system could result in some patients turning up for an appointment and being turned away, in less mobile patients not being able to stand in a queue which posed a risk of some groups of patients being less likely to get a walk in appointment or secure shorter waiting time, and the risk of putting off patients that were too unwell to stand especially in inclement weather, or not being able to do so. It also meant that patients might have to wait 90 minutes to be seen from being given an appointment and could not go home and come back as they might be called sooner than their indicative appointment time. The practice could not guarantee walk in patients would be seen at any time the same day. There was no method of triage to establish which patients may require an urgent or same day appointment, or for whom an advance GP appointment, GP telephone appointment, or practice nurse appointment may have been appropriate.

The practice undertook a survey during November and December 2018 when 59 patients responded and 59.3% said they wanted some of the allocated walk in appointments to be bookable in advance online the night before, but the practice had not acted on this information.

The practice website advised patients with long term or multiple conditions to book a routine appointment. Staff told us the practice encouraged patients on its list to sign up to access appointments booking online and were promoting this service via posters in the reception area. However, numbers were limited to 2065 patients (20%) of the practice population that had a live account to access online services.

Advance appointments were limited; for example, there were no appointments four weeks in advance across several days that some groups of patients (e.g. long term conditions for reviews) could book, and advance appointments were blocked to two weeks in advance.

The practice website was unclear about appointment availability because it stated, "Appointment times vary on a daily basis; they are available between 8.30am – 6.30pm". We checked the appointments calendar that showed there were no appointments after 5pm on Wednesdays and 4pm on Thursday for a period of six weeks prior to our inspection.

There was no evidence of a plan to improve telephone access to make it easier for patients to get through to someone on the phone, which patients were significantly less satisfied with compared to the national average as indicated in the GP patient Survey.

The practice told us it had extended its walk-in clinic times to run from 8.30am instead of 9am in response to patient's feedback. The practice action plan in response to its in-house survey had four main action points but none had been implemented or included a date for implementation.

Immediately after our inspection the practice sent us an action plan including:

- An in house patient survey for a period of one month starting on the 30 August 2019 to ascertain patient satisfaction with the current appointment system.
- Immediately doubling of the number of four week advanced appointments and an audit after one month including to assess "did not attend" rates.

Listening and learning from concerns and complaints

Individual complaints were addressed for individual patients, but complaints were not used for learning or to improve the overall quality of care.

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
Information about how to complain was readily available.	N
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <p>Information about how to complain was not readily available because the only visible information in the reception area invited feedback or comments, but not complaints information. Staff told us they would try to deal with patients' dissatisfaction informally wherever possible, and if not possible would provide a complaints leaflet. Not all Patient Participation Group (PPG) members were aware of the complaints system</p> <p>Staff were not aware of NHS England Policy and guidance for complaints and we found examples of patients' feedback/ suggestions that were clear expressions of dissatisfaction and matched the definition of a complaint but had not been treated as such. The practice response letter to complaints did not include the Parliamentary and Health Services Ombudsman details in case a patient remained dissatisfied with the outcome.</p> <p>Individual complaints were responded to promptly and appropriately to address individual patients concerns. However, evidence of discussions and learning from complaints in practice, reception and clinical meetings for several months leading up to the inspection date were limited to one practice meeting that noted a complaint was discussed. The practice had collated an annual record of all complaints but there was no evidence complaints were used to make improvements to practice systems or processes and prevent future recurrence of patients concerns or dissatisfaction.</p> <p>Immediately after our inspection the practice sent us an action plan including:</p> <ul style="list-style-type: none"> • Monthly clinical meetings with complaints as a fixed agenda item. • Quarterly whole practice meetings increasing in frequency if/ as required where complaints will be discussed as an agenda item. • Staff had reviewed the NHS England Policy for complaints and a new poster had been put in the reception area to make the opportunity to complain easier for patients. Staff had also considered some feedback/ suggestions would fall into the definition of a complaint. • Added PHSO details to complaints responses. 	

Well-led

Rating: Inadequate

The practice is rated inadequate for Well-led due to concerns including a lack of strategy and planning, insufficient systems of accountability to support good governance and management, and a lack of effective action to manage risks and issues and improve performance.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels, but leaders did not demonstrate sufficient insight to underpin operational planning and actions that were required.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	N
Explanation of any answers and additional evidence: The practice had over 10,455 patients with a growing list size, but leaders had not sufficiently identified or managed quality and sustainability such as ensuring systems to underpin patients safe, effective and responsive care and treatment. There was no overarching risk or performance assessment. Staff told us all leaders and managers were supportive and friendly. There was no succession plan or contingency plan to cover the absence of the lead GP We noted the practice manager had recently started the role to cover a long term absence of the permanent practice manager. The practice took swift planning and actions to mitigate and address most of the concerns identified at this inspection. However, the variety and scope of concerns we identified were likely to have built up over the longer term, and we were unable to verify the sustainability or effectiveness of action plans to assure sufficient leadership capacity and capability within this inspection process which will be re-assessed at the follow up inspection.	

Vision and strategy

The practice had no clear vision or strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	N
There was a realistic strategy in place to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial

Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a mission statement on its website, but staff were not aware of it. There was no forward vision or strategy, but staff knew the values of the practice were to be caring and put patients first. However, our inspection findings demonstrated that this was not always reflected into actions.</p> <p>Immediately after our inspection the practice sent us an action plan including:</p> <ul style="list-style-type: none"> • A scheduled dedicated meeting outside of the practice on 11 August 2019 with senior staff and all the clinicians to discuss the outcomes and action plans following CQC inspections. • A subsequent scheduled dedicated meeting outside of the practice on 25 August 2019 with all other staff regarding the CQC inspection and how the action plans relate to them. 	

Culture

The practice felt supported by management but to support high quality sustainable care, but systems and processes were not sufficient to do so.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a staff handbook and relevant HR processes in place.</p> <p>Arrangements to support staff wellbeing included regular social outings and flexible working hours.</p> <p>Complaints and significant events documentation we reviewed generally demonstrated the practice was open and honest with patients and apologised, if/ where appropriate, when things had gone wrong that indicated ensure compliance with the requirements of the duty of candour.</p>	

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

Source	Feedback
A range of non-clinical and clinical staff.	Staff felt it was a friendly, professional and happy place to work. The receptionists informed us that the practice manager and GPs were very supportive.
Open door approach.	Encouraged openness and support for staff across all roles to approach and discuss any issues with leaders and managers.

Governance arrangements

Systems of accountability to support good governance and management needed development.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence:	
The provider was not aware it had not applied to CQC as required to register the regulated activities of surgical procedures it was undertaking (joint injections) or maternity and midwifery (antenatal and postnatal checks). We notified the provider of its duty to apply register correctly and without delay.	
The practice had recently joined with another six practices to form a Primary Care Network (PCN) and was looking to improve the quality of patient care through access to a social prescriber and clinical pharmacist.	
The practice had an organisational structure, but it did not include clear or delegated lines of responsibility, or line management or clinical supervision arrangements. There was no internal appraisal of locum GPs that made up the majority of GP staff.	
Safeguarding protocols were last reviewed in October 2017 and the safeguarding children protocol was not consistently implemented. The safeguarding lead was not able to show us where the child protection register was kept. This register had recently been updated by administrators, but it was only after our inspection further action was taken including to follow up on a protected child following their attendance in hospital.	
Several risk assessments had been undertaken by the practice and premise's landlord, but staff with delegated responsibility lacked awareness of the findings and actions were not followed up.	
The practice had collated an annual record of all significant events and complaints but there was no evidence it had been discussed or used to identify trends to make improvements in the practice.	

Managing risks, issues and performance

Processes for managing risks, issues and performance were not sufficiently effective.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N
There were processes in place to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	Partial

A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
<p>There were no systems to ensure processes were operating effectively including fundamental safety issues such as safeguarding. There was no effective action to improve patient's satisfaction with access and types of available appointments</p> <p>Regular staff appraisals had been undertaken and appropriate HR processes were in place to manage staff performance. However, there were no frameworks to manage the overall performance of the practice including clinical performance and responding to patient feedback. There was no programme of clinical or internal audit.</p> <p>The major incident plan was comprehensive except for arrangements in the absence of the lead GP.</p> <p>Staff were trained in areas such as basic life support but non-clinical staff we spoke to could not identify signs of sepsis. There were also concerns with emergency medicines and equipment that meant the practice readiness to respond effectively to a medical emergency was not assured.</p> <p>There was no framework in place for appropriate consideration of service developments or changes. The practice employed several locum clinicians, and nursing and health care assistants whose work was not sufficiently overseen. We identified problems with fundamental aspects of patient care including high risk medicines, long term conditions care and treatment, and call and recall of patients.</p>	

Appropriate and accurate information

There was limited use of data and information to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	N
Explanation of any answers and additional evidence:	
<p>Clinical data such as QOF and data from PHE was not used to trigger improvement actions or planning. Non-clinical performance information such as patient's satisfaction and intelligence on appointments usage was not used effectively to identify or action areas for improvement.</p> <p>There was no clear system to hold leaders and managers accountable for underperformance.</p> <p>Two of four non-clinical staff and nursing staff were not able to access meeting notes or policy and</p>	

procedures via the desktop drive. A member of nursing staff was not able to access meeting minutes notes but told us they had received these via email and had since deleted them.

A range of clinical and non-clinical risks were not managed effectively including high risk medicines, patients call and recall, patients access to appointments, PSDs, safety alerts, significant events and complaints.

The provider was not aware and had not applied to undertake regulated activities as required until we notified that it must do so.

Arrangements for confidentiality were appropriate.

Engagement with patients, the public, staff and external partners

The practice involved 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
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>Patients survey feedback was not used to identify improvement actions.</p> <p>Staff told us they were listened to and had made suggestions that were used to make improvements such as managing patient's prescriptions collections.</p> <p>The practice was part of a new primary care network and was working with them to build a shared view of challenges and of the needs of the population.</p>	

Feedback from Patient Participation Group.

Feedback
The Patient Participation Group (PPG) was complimentary about the practice and acknowledged staff were working within constraints and with limited resources. The PPG met quarterly, examples of improvements made by the practice as a result of engagement with its PPG included implementing text reminders for patient's appointments and extending the walk in clinic times to run from 8.30am instead of 9am.

Continuous improvement and innovation

There were no effective 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 of continuous learning and improvement, or effective sharing of learning to make improvements.

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.