

Care Quality Commission

Inspection Evidence Table

Dr Masud Prodhan (1-509077812)

Inspection date: 23 July 2019

Date of data download: 22 July 2019

Overall rating: Inadequate

The overall rating for Dr Masud Prodhan was Inadequate because there was no effective leadership in place to safely manage the requirements of the Health and Social Care Act Regulations. The concerns we found related to an overall lack of safe care and treatment and an absence of effective governance and oversight. This created an environment where there were risks to both patients and staff.

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

Safe

Rating: Inadequate

The overall rating for the safe domain was inadequate because patients were at risk of harm because of poorly managed systems and processes that were not well implemented. Concerns were found around incident reporting, safeguarding, clinical record keeping, patient safety alerts, prescription protocols, emergency equipment, and information sharing.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	No
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	NA
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	No
The Out of Hours service was informed of relevant safeguarding information.	No
There were systems to identify vulnerable patients on record.	No
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	No
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.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The salaried GP was the safeguarding lead at the practice in the absence of the provider. However, the salaried GP was only in attendance at the practice on one day a week. • We found incidences of safeguarding that had not been dealt with in an appropriate or expected manner. • Since January 2019 there was no documented meetings between practice staff, the safeguarding team and/or health visitors about vulnerable patients or looked after children or children on the safeguarding register. • The safeguarding and looked after children registers were not consistently monitored and updated. When we reviewed the registers, we found a patient who was 38 years old on the list of looked after children. • We found evidence of children that were clearly vulnerable and due to no clear clinical oversight had not been placed on the safeguarding register. • We found evidence (from a paediatric letter dated 2015) that a child patient at the practice and their siblings were on the child protection register. There was no code for the adults in the household (patients at the practice) and it was not clear who had parental responsibility for those children. There was no mention in the records since 2015 about safeguarding or vulnerability of those children or consent around parental responsibility when they were brought for their immunisations. • There was no system to identify vulnerable patients and they were only dealt with as and when they were found rather than because of an auditable process. • Due to a recent incident at the practice, policies, procedures and the pathway for escalation was reviewed at both sites. Learning from that identified that staff competencies and understanding required review and that a deputy was required in the absence of the provider. This was escalated to the Clinical Commissioning Group and deputy cover was being provided by a neighbouring practice in the event of any emergencies. • Not all staff who chaperoned had been appropriately trained for the role. • On the day of the inspection an email was sent to all staff reminding them to update their DBS status. • We were told that discussions took place by the relevant professionals if and when required but there was no documented evidence of this. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> On 15 January 2019 a CCG infection control report highlighted that only 50% of staff had received seasonal flu vaccinations. (The expected standard is at least 70%). There was no written evidence to show that staff had been offered and declined. On the day of the inspection an email was sent to all staff asking them to update management on their immunisation status, so the practice could assess the level of need. There was no evidence that staff, specifically those with direct patient access, had any other immunisations or that boosters were up to date, in line with Public Health England (PHE) guidance. 	

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: This was completed annually by NHS Property Services. The practice did not carry out their own assessment.	Partial
There was a record of equipment calibration. Date of last calibration: This was completed annually by NHS Property Services. The practice did not carry out their own assessment.	Partial
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: This was completed annually by NHS Property Services. The practice did not carry out their own assessment.	Partial
There was a log of fire drills. Date of last drill: Not asked	Partial
There was a record of fire alarm checks. Date of last check: NHS Property Services – meeting 3 months ago to check that checks performed	Partial
There was a record of fire training for staff. Date of last training: Staff were requested to complete basic fire training on line.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: Not asked	Partial
Actions from fire risk assessment were identified and completed.	N/A
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The property was managed by NHS Property Services and the community team within the building kept checks that all the above were carried out. We did not review this on the day 	

of the inspection. The practice manager told us that she had regular meetings with the community team about fire safety and was assured that the appropriate undertakings had been met. However, the practice manager did not keep copies of this information at the practice's disposal.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Annual	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Annual	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff were encouraged to complete basic on line training for health and safety. • The property was managed by NHS Property Services and the community team within the building kept checks that all the above were carried out. We did not review this on the day of the inspection. The practice manager told us that she had regular meetings with the community team about health and safety and was assured that the appropriate undertakings had been met. However, the practice manager did not keep copies of this information at the practice's disposal. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection control risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 15 January 2019	Partial
The practice had acted on any issues identified in infection prevention and control audits.	No
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The infection control audit was undertaken by Trafford CCG on 15 January 2019 with an overall score of 87%. There was three suggested actions from that audit. However, the practice had not had the resources to ensure those actions were completed. • The practice infection control lead had not undertaken any in-house infection control audits. • Practice staff were encouraged to complete infection control training on line. Not all training was up to date. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
Comprehensive risk assessments were carried out for patients.	No
Risk management plans for patients were developed in line with national guidance.	No
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There was a process in the practice for urgent clinical review of such patients.	Partial
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial

Explanation of any answers and additional evidence:

- The provider was currently absent from the practice and staff were under pressure to recruit locum medical staff on a daily basis. There was a systematic approach to this, but it was not always effective because the practice manager was having to deal with situations reactively due to the uncertainty of the provider's leave of absence.
- We saw that long-standing staff had changes in their job roles, but they did not have appropriate job descriptions or tailored inductions for those roles. We members of clinical and non-clinical staff who were working outside their competencies.
- There was no evidence of appropriate risk management plans documented in patient records that we reviewed. We saw a record where the patient presented with a risk of sepsis because of their condition. There was no documented clinical assessment and no documented information that the patient had been advised of what to do should their condition deteriorate.
- A member of reception staff we spoke with did not know what they would do in an emergency situation such as sepsis.
- A member of reception staff we spoke with was not aware of a business continuity plan.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	No
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.	Partial
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	No
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	No

- The records we reviewed of patients seen by the provider demonstrated inadequately documented consultations and were not written in line with guidance and legislation. This was particularly unsafe because of the number of patients being reviewed by locum staff who did not know patients' histories.
- Trafford CCG had recently created a new patient template with a new patient pack. All staff had been trained how to add registrations on computer. Up until recently patients were encouraged to have new patient checks but recently this had not been possible due to the lack of medical capacity.
- Distribution lists were in place for regular locums to keep them informed of information changes.
- The responsibility for managing referral letters had been held by the secretary and not by a clinician. Until very recently there had been no monitoring process for two week waits. However, this had recently been identified and a process was now in place which was being managed by a non-clinical member of staff.
- Up until June 2019 there was no process or audit trail of how fast actions were being attended to. There was a significant number of tasks identified that had not been dealt with. We observed over 200 test results that had not been actioned.
- There was insufficient GP capacity to deal with any tasks in a timely manner.
- The practice management staff had attempted to put a system in place to deal with the backlog of tasks, but the inspection team identified that this was not a safe process because important information about patient conditions and treatment was being missed and/or misfiled.
- There was no clinical oversight in any of the processes.
- The records we reviewed did not demonstrate that appropriate information was shared when patients attended multiple services. We saw letters from outpatient appointments on patient records that had not been reviewed.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.95	0.94	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	12.5%	13.8%	8.7%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	5.25	5.39	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)	6.05	2.33	2.07	Significant Variation (negative)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
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.	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Not asked
If the practice had controlled drugs on the premises there were appropriate	Not applicable

Medicines management	Y/N/Partial
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.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No
For remote or online prescribing there were effective protocols for verifying patient identity.	Not applicable
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.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Non-clinical staff were not working within Patient Specific Directions for flu or vitamin B12. We saw that a non-clinical person had initiated a vitamin B12 for a patient without medical request or oversight. This meant there was a risk of patient harm as clinical input had not been sought. • There was no adequate clinical oversight of changes to patients' medicine being undertaken by locum pharmacists and/or reception staff. • There was high antibiotic prescribing which was not being monitored until recently. On review of patient records the inspection team identified inappropriate and/or incorrect antibiotic prescribing. • There was high opioid prescribing (medicines that can become addictive). On review of patient records the inspection team identified inappropriate and/or incorrect opioid prescribing. • No incidents were raised or appropriately escalated to the NHS England Area Team Controlled Drugs Accountable Officer which would have been expected when high and incorrect opioid prescribing was identified. • We observed blank prescriptions in the printers were within reach of anyone leaning in through the open window. Therefore, they were not appropriately secured. • Clinical rooms were not secure and left unlocked. In two of the clinical rooms we found the window leading out to the carpark open wide enough for anyone to enter. Confidential waste was also within reach. • There was no written process for the checking of uncollected prescriptions. • There was no list of expiry dates on checks of emergency medicines. • In one of the rooms there was an unchecked oxygen cylinder with no explanation as to why it was there or whether it was in use. 	

Track record on safety and lessons learned and improvements made

The practice did not learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial

There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	1
Number of events that required action:	1
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Although there was a process in place to escalate concerns we spoke to a number of staff who did not feel able to do so because they were afraid of reprimand by their employer. • The spreadsheet that we were provided showed only one significant incident that had been recorded and we saw that it had been dealt with appropriately. • We were made aware of several concerns that would constitute a significant event that had not been reported. They ranged in severity from minor to major and included clinical and non-clinical concerns. One example was an occasion where two home visits were not undertaken because a locum GP left for the day, when their shift was finished and there was no one to complete the home visits. On another occasion six patients had been booked in for telephone consultations, none of which took place. We would have expected these to be raised as significant incidents to ensure that any risk to those patients was identified and dealt with and that learning was achieved to ensure the incident did not occur again. Similar incidents continued to occur. • We saw evidence in one instance of patient information being misfiled and a task from one member of staff to another highlighting this. This was a significant incident as there was potential that important action was not taken on one patient or the other. We would have expected this to be raised as a significant incident so that the error could be rectified, and learning could be applied. We saw that the incident was never escalated, and the task was never completed and therefore the risks to the patient remain unknown. Similar incidents continued to occur. • There was evidence that learning did not take place. Several issues had been highlighted to the practice by the CCG as much as twelve months previously and no action had been taken to rectify those issues. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We saw a system in place that was being managed by a non-clinical manager with assistance from the Medicine Management pharmacy team. • We saw an example where action had been taken on a recent alert, for example sodium valproate, a medicine that has contra-indications of females who may become pregnant. • There was no medical oversight or input to the process and it was not managed by the provider. We saw that although attempts were being made to ensure alerts were raised and communicated there was no review to ensure that action had been taken. 	

Effective

Rating: Inadequate

The overall rating for the effective domain was inadequate because none of the systems or processes in place were being carried out in a way that ensured positive outcomes for patients. Local and national guidelines were not always adopted and there was no pro-active monitoring or quality control. Internal tasks, patient consultations and call and recall processes did not provide effective patient care. These issues impacted across all population groups which as a result were all rated inadequate.

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
There was no evidence of discrimination when staff made care and treatment decisions.	Yes
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.	No
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Evidence demonstrated that not all patients’ treatment was reviewed and updated appropriately including those with long term conditions. • There was a referral pathway in place and locum GPs had been informed of this. However, the inspection team identified a number of letters relating to outpatient appointments that had not been attended by patients, in amongst the outstanding tasks dating as far back as February 2019 and these had not been followed up. • There was information on the shared drive such as NICE guidelines for clinical staff to refer. However, we saw a number of clinical records that demonstrated that guidelines were not always followed. This was dependent upon which clinician the patient was seen by. We reviewed a number of patient records that demonstrated that treatment was not in line with evidence-based practice and in some cases was unprofessional. • In records we reviewed there was evidence that patients immediate and ongoing needs were not fully assessed. A record we reviewed demonstrated very clearly a patient presenting with symptoms which could indicate serious illness, and this was not followed up in a timely or appropriate way. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	1.12	0.85	0.77	No statistical variation

Older people

Population group rating: Inadequate

Findings
<p>The concerns identified at this inspection impacted on all the population groups. We also found:</p> <ul style="list-style-type: none"> • On review of patients' clinical records, the inspection team identified a case where a home visit had been requested for a patient presenting with confusion. The home visit was not undertaken on the day it was requested and thereafter there was no clinical entry that the patient's presentation of confusion had been followed up. Subsequently the patient was admitted to hospital. • There was evidence that older patients were being seen by health care staff for reviews of their health with limited medical oversight. • Where older patients may have required further medical input there was limited medical cover to deal with that in a timely manner. • The inspection team identified several unactioned tasks that could present a high risk to patient's condition.

People with long-term conditions

Population group rating: Inadequate

Findings
<p>The concerns identified at this inspection impacted on all the population groups. We also found:</p> <ul style="list-style-type: none"> • The inspection team could not be assured that all patients with long-term conditions received a structured annual review with the appropriate clinician to check their health and medicines needs were being met. • On review of patient records the inspection team identified a patient with diabetes who was not receiving appropriate treatment or care. • The practice did not demonstrate that clear and accurate information was shared with relevant professionals when deciding care delivery for patients with long term conditions. • Data indicators for patients with long term conditions are positive, however some exception rates are very high. • In January 2019 the provider sent an email to the practice staff highlighting that data indicators were low for COPD, asthma and hypertension. In March 2019 (the end of the QoF year) the figures were significantly positive.

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	82.7%	83.8%	78.8%	No statistical variation

64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	13.1% (47)	10.8%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	86.6%	77.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	11.1% (40)	8.6%	9.8%	N/A
	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	89.8%	81.7%	80.1%	Variation (positive)
Exception rate (number of exceptions).	18.3% (66)	13.1%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	92.2%	77.0%	76.0%	Significant Variation (positive)
Exception rate (number of exceptions).	13.1% (46)	5.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	92.7%	89.7%	Significant Variation (positive)
Exception rate (number of exceptions).	6.3% (4)	11.7%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	95.4%	84.1%	82.6%	Significant Variation (positive)
Exception rate (number of exceptions).	8.1% (44)	3.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	94.1%	89.2%	90.0%	No statistical variation

Exception rate (number of exceptions).	2.9% (1)	6.0%	6.7%	N/A
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Population group rating: Inadequate

Families, children and young people

Findings

The concerns identified at this inspection impacted on all the population groups.

- Records we reviewed did not demonstrate that appropriate consent was received from the parents or guardians of children having childhood immunisations.
- There were no arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. For example, the inspection team identified two young patients in particular where this would have identified a safeguarding incident that should have been flagged.

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)	64	65	98.5%	Met 95% WHO based target
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)	60	65	92.3%	Met 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)	59	65	90.8%	Met 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)	60	65	92.3%	Met 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 concerns that we identified at this inspection impacted on all the population groups. We also found:

- There was very limited medical cover to ensure that patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- There was evidence that appropriate and timely follow-up was not undertaken where abnormalities or risk factors were identified.
- Patients were not encouraged to 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)	76.0%	76.6%	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)	59.2%	69.9%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	45.0%	56.5%	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)	83.3%	77.3%	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)	38.5%	47.0%	51.9%	No statistical variation

Population group rating: Inadequate

People whose circumstances make them vulnerable

Findings
<p>The issues found at this inspection impacted on all the population groups. We also found:</p> <ul style="list-style-type: none"> • There was evidence that same day appointments and longer appointments were not always offered when required. We were told one of the reasons for this was the uncertainty of GP cover. • End of life care was not delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • There was no system for vaccinating patients with an underlying medical condition according to the recommended schedule. • Patients who misused substances were being offered complimentary therapy that was not approved by NICE and was not within professional guidance.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

The issues found at this inspection impacted on all the population groups. We also found:

- There was no evidence of a system to follow up patients who failed to attend for administration of long-term medication.
- Repeat prescriptions of addictive medicines were issued without appropriate follow up.
- Not all staff had received dementia training in the last 12 months.
- Patients with poor mental health were being offered complimentary therapy that was not approved by NICE and was not within professional guidance.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	96.0%	91.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	8.8%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	96.0%	91.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	8.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	81.6%	83.0%	Variation (positive)
Exception rate (number of exceptions).	16.7% (3)	6.0%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.8	551.1	537.5
Overall QOF score (as a percentage of maximum)	100.0%	98.6%	96.2%
Overall QOF exception reporting (all domains)	8.1%	5.0%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No
Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	No

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

<ul style="list-style-type: none"> • There was evidence that some clinical audit had been undertaken by an outside company around diabetes. • In 2017 and 2018 the practice undertook regular data quality meetings to identify where patient outcomes required review. However, since the end of 2018 the practice had been in a period of turbulence and regular meetings no longer took place. • There was no evidence of quality improvement activity overall.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Although there were systems in place around staff management they were not effective. • Staff had received appraisals and learning needs had been identified but they had not been actioned. 	

- The inspection team identified that staff were working outside their competencies. The practice manager had also identified this and practice staff themselves had identified this, but the provider had not addressed the concerns that had been raised.
- There was an e-learning system in place for staff but there was no capacity for staff to carry out necessary and mandatory training which was not up to date for some staff in a number of areas such as infection control, fire, health and safety, equality and diversity etc.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment but this was not always achieved.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) <small>(QoF)</small>	No
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.	No
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	No
Patients received consistent, coordinated, person-centred care when they moved between services.	No
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	NA
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The inspection team identified a number of tasks that were not actioned. • On 23 July 2019 clinical tasks outstanding for one member of staff amounted to some 170 that were not being actioned in a timely manner. • The inspection team identified 161 letters that had not been viewed by anyone. • One of those letters was a hospital letter about a child who had missed an appointment. This should have alerted a clinician to a possible safeguarding concern, but the letter remained unallocated to any clinician. • A post inspection audit by NHSE corroborated our findings and identified a greater level of unactioned tasks, some outstanding from 2018. 	

Helping patients to live healthier lives

Staff reactively assisted in helping patients to live healthier lives where a need was identified.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	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.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes

The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice could not demonstrate that patients were proactively receiving appropriate care and treatment to improve their overall health. However, data indicators for 2017/2018 were positive. There was limited medical cover, but the practice was able to demonstrate that a well-functioning nursing team continued to review patients' overall health and wellbeing. 	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	97.0%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.6% (14)	0.6%	0.8%	N/A

Consent to care and treatment

The practice did not demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	No
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
The practice monitored the process for seeking consent appropriately.	Partial
Policies for any online services offered were in line with national guidance.	NA
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The inspection team found examples in the care records of two minors where it was not clear who had parental consent when the minor was brought for immunisation. Not all staff had received awareness training around mental capacity. 	

Caring

Rating: Inadequate

The overall rating for the caring domain was inadequate because the issues identified at the inspection impacted on all domains. In addition there was evidence that a number of patients had been offered a service that was not in line with ethical practice.

Kindness, respect and compassion

Staff treated patients mostly with kindness, respect and compassion.

Feedback from patients mostly was mixed.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was mixed feedback from patients, dependant on who they were dealing with at the practice. • There were a number of examples identified by the inspection team where patients had not received appropriate or timely information. 	

CQC comments cards	
Total comments cards received.	16
Number of CQC comments received which were positive about the service.	11
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Comment Cards	The themes emerging from the comment's cards were that receptionist staff were kind, access to appointments and services was difficult but staff were helpful.
Comment Cards	One patient with a long-term condition was very negative about access and appointments and delays accessing other services.
NHS Choices	Patient feedback was mixed
Social Media	Patient feedback was mixed with some very unhappy comments.
GP Patient Survey	There was some negative and trending towards negative feedback about treatment received.

National GP Survey results

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4515	459	94	20.5%	2.08%

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)	73.5%	91.0%	88.9%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	72.9%	89.1%	87.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	94.0%	97.0%	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)	68.1%	87.3%	82.9%	No statistical variation

Involvement in decisions about care and treatment

Not all staff helped patients to be involved in decisions about care and treatment

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Patient records reviewed by the inspection team did not display documented evidence that patients had been involved in decisions about their care or were provided with enough advice and information to make informed decisions about their treatment. • Easy read and pictorial materials were available. • Non-medical staff that we spoke with said they assisted patients with advice and information on other services available to them within the community. 	

Source	Feedback
Interviews with patients.	Patients were not interviewed as part of this inspection.

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)	89.0%	94.0%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	75 Carers had been identified. This was under 1 per cent of the practice population.
How the practice supported carers (including young carers).	Carers services were available within the community and practice staff were aware of those.
How the practice supported recently bereaved patients.	Bereavement services were available within the community and practice staff were aware of those.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Inadequate

The overall rating for the responsive domain was inadequate because there was not enough consistent medical input to provide the services that patients were entitled to.

Responding to and meeting people's needs Services did not meet patients needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	No
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	No
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	No
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	
Due to there being no consistent clinical GPs at the practice, patient accessibility, choices and continuity of services were delivered on a week to week basis, rather than having long term services and clear access for patients.?	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 8.00pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments were available at various times throughout each day with a locum GP, nurse and/or health care assistant. Extended hours were offered on Tuesday evenings for routine appointments, ideally for those patients who were working. The practice was sometimes closed for staff training.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4515	459	94	20.5%	2.08%

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)	89.9%	95.4%	94.5%	No statistical variation

Older people

Population group rating: Inadequate

Findings

The issues identified during this inspection impacted on all the population groups. We also found:

- Although all patients had a named GP they were not supported in whatever setting they lived and did not have access on a regular basis to their named GP
- The practice was not responsive to the needs of older patients in relation to home visits and urgent appointments for those with enhanced needs and complex medical issues. We were told of home visits had been missed or not responded to by a clinician appropriately.
- The practice did not provide effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Inadequate

Findings

The issues identified during this inspection impacted on all the population groups. We also found:

- The practice did not provide effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice did not liaise regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was not adequately coordinated with other services.

Families, children and young people

Population group rating: Inadequate

Findings

The issues identified during this inspection impacted on all the population groups. We also found:

- Children living in disadvantaged circumstances were at risk because there were no systems to identify them and follow them up.
- There were no systems to identify children who were at risk, such as those who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Not all parents or guardians calling with concerns about a child were offered a same day appointment when necessary. This was due to not having the clinical access to offer this service.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The issues identified during this inspection impacted on all the population groups. We also found:

- There was no consistent medical cover and patients did not receive continuity of care.
- The practice had not been in a position to adjust the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients reported that difficulty getting an appointment.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The issues identified during this inspection impacted on all the population groups. We also found:

- The register of patients living in vulnerable circumstances was not appropriately reviewed to ensure those patients received a cohesive service.
- Clinical records we reviewed identified vulnerable patients whose needs were not assessed or responded to.
- The practice did not provide effective 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 issues identified during this inspection impacted on all the population groups.

- Not all staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- A number of patients experiencing poor mental health had been offered and accepted complimentary therapy that the practice was not registered to provide.

Timely access to the service

People were not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	No
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	No
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The inspection team identified patients with urgent needs whose care had not been prioritised. For example, locum GPs would only fulfil their contractual requirements for the day. The inspection team identified patients where a home visit had been requested by housebound patients these had not been undertaken. One of those patients had to be admitted to hospital soon after. The inspection was informed of GP clinics that had to be cancelled at short notice without appropriate reason. 	

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)	52.1%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	45.0%	73.2%	67.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	55.5%	71.3%	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)	55.4%	77.3%	73.6%	Tending towards variation (negative)

Any additional evidence or comments

- We were told the provider had tried but been unable to recruit GPs.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Several complaints of different nature had been received into the practice and were being dealt with by the practice manager in conjunction with other agencies. The inspection team did not review those complaints. • The inspection team was aware of several complaints from patients about difficulty accessing appointments. • The inspection team and the practice were aware of a number of complaints on social media that were being addressed. • The inspection team spoke with reception and non-clinical nursing staff who reported that verbal comments or complaints from patients were escalated. Those were dealt with by the person receiving them and not discussed within the wider team. 	

Well-led

Rating: Inadequate

The overall rating for the responsive domain was inadequate because there was not enough consistent medical input to provide the services that patients were entitled to. Overall leadership across the practice was ineffective. Arrangements for identifying, monitoring, recording and managing risks did not meet the standards to ensure safe and effective care. Overall governance arrangements were not satisfactory and practice leaders did not demonstrate awareness of potential issues within the service. In addition, previous improvements had not been sustained and there was a history of instability.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	No
There was a leadership development programme, including a succession plan.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The provider was fully aware of the regulatory requirements of the Health and Social Care Act 2014 but was unable to demonstrate that the practice was being managed in a safe way. There was no clear accountability and leadership to keep patients safe.• The provider could not demonstrate that appropriate systems were in place to manage and oversee the clinical or day to day performance of the practice to ensure safe and effective working.• The senior administration team were knowledgeable about some of the issues but were unable to prioritise actions relating to the quality and future of the service.• Staff at the practice worked in silo with very little oversight or medical supervision.• The provider was neither visible nor approachable. Staff told the inspection team that they were afraid of reprisal when they escalated concerns and knew areas of work tasked to them were out of their competencies but had to complete these tasks as told.	

Vision and strategy

The practice had no clear vision and was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	No
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Most of the staff at the practice were unaware of any strategy for the future of the practice. • Staff were not clear about values that prioritised quality and sustainability because there were none. • The Clinical Commissioning Group had given the provider a set of undertakings twelve months previously and no progress had been made towards their delivery. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	No
Staff reported that they felt able to raise concerns without fear of retribution.	No
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	No
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	No
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	No
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The culture at the practice was one of extreme stress, unsettlement and anxiety. • Staff were unaware they were working toward a clinician level. • Where staff had raised concerns, they had not been supported. • The duty of candour was not being followed and the provider was not open and honest. • When patients complained formally in writing their concerns were dealt with appropriately but there was no process of escalation for verbal complaints. • Not all staff were up to date with required training. 	

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

Source	Feedback
Staff at the practice	<p>Several members of staff reported there had been a long period of unsettlement and many of the administration and management staff had resigned the previous year.</p> <p>There was no consistency because the service was being carried out by locum GPs and the provider was absent.</p> <p>Several members of staff were concerned for their own wellbeing and felt anxious and unhappy about the future of the practice.</p> <p>Staff members we spoke with both clinical and non-clinical told the inspection team that they were doing their best to support patients and provide appropriate services despite difficult circumstances.</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There were governance structures in place but because of the uncertainty and continual fire-fighting at the practice all staff members, including management, were dealing with day to day things in a reactive manner. • Not all staff were clear about the roles of other members within the team. • The practice was receiving support from NHSE and the CCG. 	

Managing risks, issues and performance

There were limited clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	No
Staff were trained in preparation for major incidents.	No
When considering service developments or changes, the impact on quality and sustainability was assessed.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The processes to identify, understand, monitor and address current and future risks including risks to patient safety were not managed by the provider. Issues that had been identified were being dealt with to the best of the ability of members of staff who were not in a position of autonomy and could only take actions up to a certain point. • The premises were full of risks that were not being managed and could cause harm to 	

patients and staff.

- The provider had not been pro-active in identifying the risks that could occur and the inspection team identified many of those.
- There was no documented action plan or protocol in place for staff to follow in the event of a patient emergency and a member of staff we spoke with was not aware of a business continuity plan.
- Reception staff had not received appropriate training about major incidents.
- Most of the process that had previously been in place to audit and review patient care had fallen by the wayside and the practice was unable to demonstrate evidence that good outcomes for patients were being considered.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	No
Performance information was used to hold staff and management to account.	No
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The provider had not supplied the Care Quality Commission with the necessary statutory notification in relation to their absence from the practice for more than 28 days. • The provider had not furnished CQC with a contingency plan. • The inspection team identified that clinical consultations were not appropriately documented by the provider. • The inspection team identified that tasks were not dealt with in a reliable and timely manner which adversely affected the care and treatment provided to patients. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	No
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	No
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	No

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
<ul style="list-style-type: none"> • There was no evidence of quality improvement activity overall. • The culture at the practice made it impossible for staff to openly escalate and discuss any concerns they had about the way the practice was being run. • There was no evidence that incidents were discussed, and improvements were made because learning had been achieved. The practice demonstrated the opposite was the case and the inspection team identified many areas of concern that had not been escalated, and where incidents continued to happen because there had been no learning from them. 	

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.
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