Care Quality Commission

Inspection Evidence Table

Gloucester House Medical Centre (1-507073740)

Inspection date: 7 August 2019

Date of data download: 13 August 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, lack of safety within the building 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

Safety systems and processes.

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.

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Partial
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.	No
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	No
The Out of Hours service was informed of relevant safeguarding information.	No

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	No
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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

- The salaried GP who worked at the provider's second practice had been nominated safeguarding lead at this practice in the absence of the provider. The salaried GP was only in attendance one day per week at the other practice and did not work at Gloucester House at all. We were told by the practice manager that a GP from a neighbouring practice had also agreed to be the safeguarding deputy in the event of any emergencies.
- On 7 August 2019 the inspection team was made aware of 25 letters that had been identified as possible safeguarding concerns at Gloucester House. They had been allocated to the safeguarding lead, but that safeguarding lead was unaware of their existence.
- The salaried GP was also the safeguarding link for Trafford Clinical Commissioning Group (CCG) and had access to information about safeguarding incidents in Trafford. However, safeguarding meetings did not take place within the practice to discuss patients on the safeguarding register.
- Not all practice staff were able to demonstrate that they fully understood when to escalate concerns. One member of staff described a time when a patient presented oddly during their consultation and described this to the inspector as something that might alert them to have concerns. Despite that concern they did not escalate this to anyone.
- The practice was unable to demonstrate any documented meetings between practice staff, the safeguarding team and/or health visitors about vulnerable patients, looked after children or children on the safeguarding register.
- 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.
- Not all staff who chaperoned had been appropriately trained for the role. We saw evidence that a patient was not offered a chaperone when they should have been.

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.	Partial

- There was no written evidence to show that staff had been offered and either accepted or declined a flu vaccination.
- Not all staff, specifically those with direct patient access, were up to date with immunisations or boosters were up to date, in line with Public Health England (PHE) guidance.
- There was no risk assessment in place to demonstrate where staff had refused an immunisation

booster.

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 had been done within the last twelve months.	Yes
There was a record of equipment calibration. Date of last calibration: This had been done within the last twelve months.	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	No
There was a fire procedure.	Partial
There was a record of fire extinguisher checks. Date of last check: These had been done in the last twelve months.	Yes
There was a log of fire drills. Date of last drill: Not known	No
There was a record of fire alarm checks. Date of last check: 7 August 2019 which was arranged on the day of the inspection.	Partial
There was a record of fire training for staff. Date of last training: Not known	No
There were fire marshals.	Partial
A fire risk assessment had been completed. Date of completion:	No
Actions from fire risk assessment were identified and completed.	N/A

- On the day of the inspection we requested the practice undertake an urgent fire and electrical assessment. The practice contacted the Greater Manchester Fire department who sent an inspector to assess the building immediately.
- The fire inspector requested the practice seek an urgent electrical assessment of the basement. They also identified health and safety issues for staff and patients and fire safety issues within the building. The practice was given two weeks to comply with actions directed by the fire department's assessor.
- There was a documented fire procedure. Staff who worked on the top floor of the building were unable to demonstrate how they would evacuate themselves and/or patients safely from the practice.
- Staff we spoke to did not know who the fire marshals were or what their role was. One of the fire marshals we spoke with was unable to demonstrate how they would evacuate themselves and/or patients safely from the practice.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	No
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	No

The practice was in a very old large house with wooden features throughout, we observed:

- No risk assessments had taken place for the building or individual rooms. For example, we observed in one of the treatment room, the desk faced forward which meant patients (particularly young and/or vulnerable patients) were exposed to the wires for the electrical and IT system and could easily trip over them or pull them out.
- There was no adjustable examination couch in the practice making it difficult for patients who were not able bodied to access the couches.

The practice had a large basement area where multiple fire and electrical hazards were identified, and no risk assessments had been completed. There was a strong pungent smell of mould and damp identified on the first floor of the practice, at the basement access door. This smell was also observed by the Greater Manchester fire inspector who had been called in to undertake a safety assessment during our inspection. We were told that only staff had access to the basement and it had been closed to patients since 2016. However, it was not locked and was accessible to patients if they sought to enter. We advised the practice manager immediately following the inspection that this should be rectified.

In the basement we observed:

- The basement toilet was the cleaner's storage room. We saw exposed electrical lighting wires hanging from the ceiling, a visible leak on the floor leaving the floor in a pool of water, dirty mops and mop heads, dirty sponges and old stale water in various buckets. The practice hired an external cleaner who attended daily and would access this room alone in the evening.
- The large meeting room, where staff regularly sat for meetings had a very strong odour of damp and visible surface areas of rising damp. The meeting table had patches of old and new green mould growing, and the chairs had to be wiped dry before staff could sit on them. The floor was visibly wet all over. There was a large book shelf with a number of old books covered in dust and mould. There were no windows that could be opened to ventilate the room and the inspection team felt the effects within a very short time.
- There were several piles of patients notes in boxes on top of filing cabinets in a room storing patient records and papers in boxes on the floor. Various bags of paper were also in bags on the floor which posed a visible fire risk.
- Large black areas of mould patches were visible from the raising damp in the same room as the gas mains and the electrical fuse box. An urgent electrical assessment was sought.

There was limited understanding of the necessity to assess and mitigate risk to staff and patients.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
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: Within the last twelve months	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

- There was a policy for infection control and an infection control audit had been undertaken by Trafford CCG on 6 Feb 2019 with an overall score of 90%. There were four suggested actions from that audit, which had not identified multiple issues.
- The practice infection control lead had not undertaken any in-house infection control audits.
- The minimal problems the audit had identified were presented to the practice in an action plan format, seen and dated 6 Feb 2019 with a request that they were completed by 15.2.2019. The actions had not been completed.
- The inspection team identified significant additional hygiene concerns throughout. For example, the walls throughout the practice were artexed and had cobwebs in areas and a build-up of dust and grime. Clinical treatment rooms and waiting rooms were dirty and dusty. Carpeted areas throughout the practice were visibly dirty with no schedule for deep cleaning.
- There were hygiene concerns in several of the clinical treatment rooms. For example, a dirty square patch of carpet in the middle of the clinical room floor, dirty and dusty treatment lamps in more than one of the treatment rooms, areas of clutter, multiple dirty wooden and canvas pictures on the walls, wooden sink areas which were worn in parts, dirty equipment in the anaphylaxis treatment kit and dirty windowsills and radiators in each room.
- Every room (clinical and non-clinical) had dirty blinds with old metal pull cords hanging loose. Most had missing slats or were broken. We were told that the blinds were over 18 years old and had never been washed.

Risks to patients

There were no 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.	No

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.	No
There was a process in the practice for urgent clinical review of such patients.	No
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No

- The provider was currently absent, and the practice 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.
- There was no evidence of appropriate risk management plans documented in patient records that we reviewed. There was evidence of patients on end of life care with no management plans in place. There was also evidence that patients had not been advised on what to do should their condition deteriorate.
- In addition, there was serious risks to patients because of faults within the building. For example:
    - The front entrance carpet was not fixed down correctly and had a large piece of tape holding it down.
    - A glass panel on the front entrance door had been smashed and was boarded up from the inside, but not from the outside.
    - The downstairs toilet had a wooden baby changing frame and plastic mat which was dusty. There was a rusty metal toilet roll holder and no clinical waste bin for the disposal of nappies.
    - The second-floor toilet had no sanitary bin, no grab rail and no alarm cord with the door being locked from the inside by a key. This was not accessible for patients with a disability. There were different opinions from staff as to whether this was a staff toilet, patient toilet, or both.
    - The practice had a lift for patients, but this had been out of service for two years. We were told that this had a huge impact on the predominantly elderly patients in the practice. Patients with disabilities or parents with prams could not be seen upstairs. This also had a direct impact on clinicians who had to come downstairs to see patients on the ground floor and use clinical rooms that were already in use by other clinicians. We were told this could happen two or three times each day.

- There was no 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.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
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 use 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 that 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 had no record of 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 this was becoming more difficult to accommodate due to the lack of medical capacity.
- Distribution lists were in place for regular locums to keep them informed of information changes.
- There was evidence that referral letters did not always contain the correct information. In one record we saw that a referral to the memory clinic was delayed for at least six months and had still not been completed.
- 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. On 7 August 2019 there were still 367 tasks to do. The oldest one was dated 01/08/2018 from a nurse to another member of staff requesting a patient to come in for blood samples. There was no patient identification documented and no way of checking whether that patient had the necessary tests completed.
- There was insufficient and inconsistent 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 still being missed and/or misfiled. We saw that tasks were being looked at and turned into "more tasks".
- 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 with instructions to change medicines and those had not been actioned.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	1.07	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)	17.4%	13.8%	8.7%	Significant 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)	5.89	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)	5.81	2.33	2.07	Variation (negative)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	No
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No
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	Partial

Medicines management	Y/N/Partial
or peer review.	
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.	No
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	No
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	No
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

- There was no adequate clinical oversight of changes to patients' medicine being undertaken by locum pharmacists and/or reception staff.
- The system to protect staff from over-issuing prescriptions had been over ridden, and staff had been told to continue issuing prescriptions even when the required number had been reached and patients were due a review. This is not a safe way to issue repeat prescriptions, particularly to patients who are not well known to the person reviewing them.
- A member of locum staff told the inspection team that authorising and signing prescriptions was just a paper exercise because they did not know the patients and did not know what contra-indications or risks could be in place.
- Blank prescriptions were kept in the printers and were not monitored. The back door to the premises was unlocked and access could have been gained by any person from the street. On 7 August 2019 we saw that clinical rooms were not secure when empty and were left unlocked.
- There was no written process for the checking of uncollected prescriptions.
- 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.
- Changes to patient's medicines were not always done safely or in a timely manner. We identified 1,000 patients who required a medicine review. We also identified hospital letters that had not

Medicines management	Y/N/Partial
been actioned. • We saw that normal blood results were being filed by a non-clinical member of staff. We were told they were doing this according to a protocol but when we asked for the protocol it could not be found. We saw that normal blood results for Lithium (a medicine that requires monitoring) had been filed without first being reviewed by a clinician. There could be occasions when a normal blood result may indicate something abnormal and this task should be closely monitored and reviewed to ensure that no errors are made. • Antibiotic prescribing was being monitored by the pharmacists at the practice because significantly higher than average levels had been identified. • A significant number of out of date medicines and equipment were found in various rooms and various drawers throughout the premises. In the emergency medicines in reception area, we found three expired emergency medicines dated June 2018. They were awaiting disposal but remained in the emergency medicines bag and had not been replaced. . • In a drawer in one of the consulting rooms we found several out of date medicines belonging to patients (Indomethacin capsules BP 25mg dated 17/5/2016, Water for injections dated 2018, Atenolol 25mg tablets dated July 2019, Powder for meningitis 1 dose and calcium tablets dated 2017). • Also, in that drawer we found more than 100 token prescriptions of various medicines for various patients as well as hundreds of patient summaries and extracts from patient records with patient identifiable information that was not being kept securely. The door to that room was not locked and the drawer in the room was not locked. • The health care assistant (HCA) and assistant practitioner (AP) worked at Gloucester House and at another practice registered to the provider which was inspected on 23 July 2019. Up to 23 July 2019 the HCA and AP were initiating and performing injections without clinical consent. On 7 August 2019 we reviewed the patients that had been seen at Gloucester House by those staff. We were shown that PSDs were in place for the records we reviewed. An emergency oxygen cylinder required replacement but this had not yet been done.	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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 from 15/4/2018 to 7/8/2019 (there was nothing previous)	6
Number of events that required action:	6

Explanation of any answers and additional evidence:

- The spreadsheet that we were provided showed six significant incidents that had been recorded since April 2019. There had been a good system in place previously to report and record significant incidents but recently this had deteriorated because, we were told, staff were afraid of reprisal if documented or reported.
- During discussions with several different members of staff they told us about incidents 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. Major examples related to concerns with the premises such as a broken lift and a damp basement. Clinical concerns included prescriptions that had been lost, reports that were not written by a clinician, tasks that had not been actioned, blood results that had been filed incorrectly and appointments that had not been attended.
- 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.

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

Event	Specific action taken
Missed Kidney diseases diagnosis. The patient not on register. Missed diagnosis. Staff member recalled patient and further renal function done which confirmed kidney disease. Checked with provider who stated that he did not post the results, despite the audit trail stating this.	There was no specific action recorded or learning identified from this.
A medicine named Enstilar Foam had been issued since 25/11/17 when dermatology stated in a letter to be issued for only for four weeks, then change to Exorex for eight weeks then review. A prescription was issued as a repeat with no documented end date added to entry.	This was highlighted by a member of the external medicines management team who removed the prescription from repeat screen. The action was to check all other patients on this cream and review patients for over use. In addition, the GPs need to read request issues carefully.
Patient changed from Furosemide 40mg One Daily to Furosemide liquid 50mg/5ml take 10ml once daily (NO LIQUID USED)	This patient had kidney disease and the wrong dose. Dose should have been checked by GP. The pharmacy contacted the practice to clarify when medication was dispensed. The Nursing Home contacted to find out what medication was being administered to the patient. Action – doses to be double checked.
Patient with heart disease was started on aspirin EC 300mg daily and had been taking it ever since. A letter from Cardiology department dated 01/03/2014 stated this should be Aspirin 75mg daily. Discharge reconciliation on 01/03/2014 dose should have been changed.	Patient was identified after a review, where the high dose aspirin was identified. Patient was checked but the GP could not find relevant p paper work. Their records were reviewed again, once the hospital letter had been found. Actions – Hospital discharge letters need to be checked clinically. Discharge reconciliation need to be

	done.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

- 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.	No
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	No
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	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:

We reviewed patient records that demonstrated treatment was not in not in line with evidence-based practice and professional guidance.

- There was evidence from the records we looked at that patients immediate and ongoing needs were not fully assessed. One 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.
- 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 several letters relating to outpatient appointments that had not been attended by patients, in amongst the outstanding. The earliest task that had not been action was dated 01/08/2018.

- There was evidence that referral letters did not always contain the correct information. In one record we saw a referral to the memory clinic was delayed for at least six months and had still not been completed.
- There was information stored on the shared drive such as NICE guidelines for clinical staff to refer. However, we saw several clinical records that demonstrated that guidelines were not always followed. This was dependent upon which clinician was working.
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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) (NHSBSA)	1.27	0.85	0.77	No statistical variation

Older people — Population group rating: Inadequate

Findings

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

- On review of patients' clinical records, the inspection team identified older patients on multi-medicines who had not receive the appropriate follow up.
- 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 or effective manner.
- The inspection team identified several unactioned tasks that could present a high risk to an older patient's condition.

People with long-term conditions — Population group rating: Inadequate

Findings

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

- 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 rheumatoid arthritis 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 were positive for the years 2017/2018.

Diabetes Indicators	Practice	CCG average	England average	England comparison

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	88.1%	83.8%	78.8%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.6% (25)	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)	83.4%	77.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.9% (26)	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)	88.8%	81.7%	80.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	15.2% (50)	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)	88.1%	77.0%	76.0%	Variation (positive)
Exception rate (number of exceptions).	6.5% (28)	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)	95.6%	92.7%	89.7%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.6% (19)	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)	87.9%	84.1%	82.6%	Tending towards variation (positive)

Exception rate (number of exceptions).	3.1% (28)	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)	92.2%	89.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.8% (10)	6.0%	6.7%	N/A

Families, children and young people — Population group rating: Inadequate

Findings

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

- We reviewed the record of a minor who had attended a consultation. There was nothing in the consultation notes to say whether they attended with a parent or guardian and no record to state if they were offered a chaperone whilst undergoing an intimate examination.
- There was no system to monitor and contact young patients who did not attend appointments in secondary care or for immunisations.
- Child immunisations are significantly lower than the target of 95%.

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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	53	62	85.5%	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) (01/04/2018 to 31/03/2019) (NHS England)	37	44	84.1%	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) (01/04/2018 to 31/03/2019) (NHS England)	38	44	86.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	38	44	86.4%	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 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)	84.1%	N/A	N/A	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	68.8%	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)	55.7%	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)	65.4%	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)	64.5%	47.0%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings
The issues found at this inspection impacted on all the population groups. We also found: • End of life care was not delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. In one case a locum GP had to refuse to sign a

statement of intent for a dying patient because they would not have been available to complete a death certificate. This could mean a delay for the family in burying their relative if the death had to be recorded as unexpected.

- Patients who misused substances were being offered complimentary therapy that was not approved by NICE or in line with professional guidance. In the records where we found this was occurring there was no documented evidence that the patient had been appropriately informed of the pros and cons and what to do in the event of a crisis.
- 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.

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:

- Patients with poor mental health were being offered complimentary therapy that was not within professional guidance and was not approved by NICE. In one of the records we reviewed the complimentary medicine had been offered and taken by a person with suicidal ideation. There was no documented evidence that they had been informed of the any risks or what to do in the event of crisis
- 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 or monitoring checks in place.
- Not all staff had received dementia training in the last 12 months.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.3%	91.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	18.6% (8)	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) (QOF)	94.3%	91.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	18.6% (8)	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	89.7%	81.6%	83.0%	No statistical variation

preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	9.4% (6)	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)	559.0	551.1	537.5
Overall QOF score (as a percentage of maximum)	100.0%	98.6%	96.2%
Overall QOF exception reporting (all domains)	4.9%	5.0%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	No
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

Any additional evidence or comments
We did not review any clinical audits or other improvement activity at this inspection. There was no evidence of any quality improvement activity overall. • In 2017 and 2018 the practice had 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 with the provider and other GPs at the practice did not take place.

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.	N/A
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

- 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.
- Since 23 July 2018 action had been taken by the practice manager to limit the number of tasks being carried out by administration staff that should be carried out by a clinician. However, there was limited clinical capacity to deal with these tasks and this also was causing other issues.
- 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.

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) (QOF)	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

- 1000 patients out of 2500 with repeat prescriptions had overdue medication reviews.

- An audit by NHSE on 23 July 2019 identified 1116 outstanding letters at Gloucester House Medical Practice. 941 of those were described as “old” and 175 were described as “new”. There were 21 outstanding medication updates from those letters that needed completing. There were 66 appointments that needed to be sent.
- The inspection team identified several tasks that were not being actioned.
- On 7 August 2019 the inspection team identified 367 tasks that still required action.
- One of those tasks related to a discharge letter for an 87-year-old patient who needed a referral to the memory clinic. The letter was dated 19/3/19. The task was dated 29/3/19. On 7 August 2019 that referral had not been done.

Helping patients to live healthier lives

Staff were trying help patients to live healthier lives but this was not always achieved.

	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:

- Staff we spoke with told us how they supported patients with smoking and health problems.
- They were able to refer patients to other support organisations within the community. However they were unable to demonstrate that patients were proactively receiving the right care and treatment to improve their overall health.
- Data indicators for 2017/2018 were mostly positive because the 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	96.0%	95.3%	95.1%	No statistical variation

smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0.3% (4)	0.6%	0.8%	N/A

Consent to care and treatment

The practice was unable to 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.	Partial
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:

- Not all staff had received awareness training around mental capacity.
- The inspection team did not feel assured that non-clinical staff were always working within guidelines when administering injections and other areas of the service.
- There was no documented evidence in patients notes that they had given informed consent to take part in a clinical trial or that they understood what the product may or may not do for them.

Caring Rating: Requires Improvement

The overall rating for the caring domain was requires improvement because the significant issues identified throughout the inspection which had a direct impacted over all domains. In addition, there was evidence that a number of patients had been offered a service that was not not in line with evidence-based practice and professional guidance.

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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: • There was mixed feedback from patients, dependant on who they were dealing with at the practice. • There were many examples identified by the inspection team where patients had not received appropriate or timely information.	

Source	Feedback
Patients	We received feedback from patients, one who wrote in to CQC saying they were dissatisfied with the care and treatment offered to them.
GP Patient Survey	There was no significant variation in the data about patient satisfaction in this area.
NHS Choices	There were three reviews and all were positive. They were dated 2017. The site has not been updated since 2016.

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

5099	325	111	34.2%	2.18%

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)	84.7%	91.0%	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)	86.3%	89.1%	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)	95.7%	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)	84.0%	87.3%	82.9%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

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

- 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.
- Non-medical staff that we spoke with said they assisted patients with advice and information on other services available to them within the community.

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)	93.4%	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.	No
Information leaflets were available in other languages and in easy read format.	No
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: • In the main waiting area, the patient information boards were cramped on one wall behind the reception desk area. We asked to see the Chaperone poster and it took the receptionist time to identify the poster on the board. We were told more room for patient posters and practice information would be great. In the same room we observed on a large wall, an array of amateur photography pictures and frames taking up a full wall.	

Carers	Narrative
Percentage and number of carers identified.	Due to significant issues during the course of the inspection, carers numbers or discussions did not take place. As was the same around any bereavements.
How the practice supported carers (including young carers).	
How the practice supported recently bereaved patients.	

Privacy and dignity

The practice was not always able to respect 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.	No
There were arrangements to ensure confidentiality at the reception desk.	No
Explanation of any answers and additional evidence: • The reception desk was in very close proximity to the waiting area and all conversations could be overheard • Conversations between consulting rooms one and two could be clearly overheard. This was a due to the room being split to try and accommodate patients who could not reach consulting rooms upstairs due to the lift being out of order.	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	NA
Online consultations took place in appropriate environments to ensure confidentiality.	NA
The practice advised patients on how to protect their online information.	NA

Responsive Rating: Inadequate

The overall rating for the responsive domain was inadequate because there was not enough consistent medical input to provide the safe and effective 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.	No
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 day to day basis, rather than having long term services and clear access for patients.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 8.00pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	7.30am 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
5099	325	111	34.2%	2.18%

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)	95.3%	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:

- The practice was not responsive to the needs of older patients in relation to urgent appointments for those with enhanced needs and complex medical issues.
- 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 premises were not responsive to the needs of older patients and those with difficulties using stairs.
- 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 missed appointments. 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 able 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.

- 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 appropriately assessed or appropriately 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.
- Several patients experiencing poor mental health had been offered and accepted complimentary therapy that the practice was not registered to provide. There was no documented consent on those records or any information to show that the patient had been given appropriate advice.

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:

- 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 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)	73.2%	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)	67.8%	73.2%	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)	63.9%	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)	74.6%	77.3%	73.6%	No statistical variation

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

Explanation of any answers and additional evidence:

- 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 were made aware of several complaints from patients about difficulty accessing appointments.
- CQC had been contacted by several patients who were unhappy with the responses from the practice when they had asked for help.
- The inspection team spoke with reception and non-clinical nursing staff who reported that verbal comments or complaints from patients were not escalated. Those were dealt with by the person receiving them and not discussed within the wider team.

Well-led Rating: Inadequate

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:

- 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 where 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: • 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: • 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	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. There was no consistency because the service was being carried out by locum GPs and the provider was absent. Several members of staff were concerned for their own wellbeing and felt anxious and unhappy about the future of the practice. 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.

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:

- 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:

- 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.	Partial
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:

- 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

Explanation of any answers and additional evidence:

- 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 and there was no evidence of a system of quality improvement activity overall.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices. Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Glossary of terms used in the data.

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