Care Quality Commission

Inspection Evidence Table

Vicarage Lane Health Centre (1-1777010012)

Inspection date: 14 August 2019

Date of data download: 01 August 2019

Overall rating: Inadequate

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

Safe Rating: Inadequate

- The safe key question is rated inadequate because the provider had ineffective systems in place for the management of infection control, medicines management, risk management, recruitment, referral management and record management and this put patients at risk.

Safety systems and processes

The practice had systems practices and processes that did not always operate effective.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
The practice had a vulnerable adults and a children's and young people's safeguarding policy. The vulnerable adults' policy did not contain external contact details, but these were displayed in all the clinical rooms. The nurse practitioner had completed level two child safeguarding training and not level three as required in the Royal College of Nursing intercollegiate guidance. We were told that there were two staff members (one male and one female) who acted as a chaperone, we saw that they had completed chaperone training and had a DBS check. However, the option for patients to have a chaperone was not clearly advertised in the waiting area. We viewed a random sample of patients on the palliative care register, the learning disabilities register and the mental health register and found that not all these patients had alerts on the patient record clinical system to highlight that they were priority patients. We saw examples of multi-disciplinary meeting minutes where vulnerable patients, including children with autism, homeless patients and patients suffering from mental health illnesses, were discussed and actions agreed.	

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.	No
Explanation of any answers and additional evidence: We viewed a sample of five staff records and found there was information missing, such as references and proof of identification. We saw evidence some staff members were appropriately vaccinated, but there was no evidence that some staff members were vaccinated in line with PHE guidance. The practice told us all staff were vaccinated and they would submit the evidence after the inspection, however this information was not received. There was no system to ensure clinical staff were still registered with the appropriate regulatory bodies and organisations such as the General Medical Council, the Nursing and Midwifery Council and NHS England Performers List team. We viewed a sample of staff files and found the registration records and indemnity cover for clinicians were not routinely monitored.	

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: 12 August 2019	Yes
There was a record of equipment calibration. Date of last calibration: 1 March 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: April 2019	Yes
There was a log of fire drills. Date of last drill: 11 April 2019	Yes
There was a record of fire alarm checks. Date of last check: Every Thursday	Yes
There was a record of fire training for staff. Date of last training: various	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 27 June 2019	Yes
Actions from fire risk assessment were identified and completed.	No

Explanation of any answers and additional evidence:

The practice had a COSHH policy in place but did not have a COSHH risk assessment and did not have oversight of the building risk assessment which was undertaken by the landlord.

The building management team completed a fire drill which consisted of 10 fire marshals and over 200 people in the building, which was evacuated in four minutes. There was no evidence of how many people from the practice were involved or any practice learning or discussions as a result of this exercise. There were two fire marshals, one had completed fire marshal had completed training in 2016 and the other attended in June 2019.

The building management team completed a fire risk assessment that resulted in a number of issues being identified and requiring action, including items requiring PAT testing, potential cladding issues, rooms being overloaded with combustible items, damaged portable heaters in use and missing fire signage. The practice did not monitor the issues identified to ensure they had been rectified. We spoke with a member of the building management team who confirmed that there was no action plan to monitor resolution of these issues and that a plan was in the process of being produced.

The health care assistant carried out spirometry tests, but the machine was not clinically calibrated before its use to ensure it was in good working order.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Partial
Explanation of any answers and additional evidence: The practice management team told us that these risk assessments were carried out by the building management team. However, they did not have oversight of this and did not complete their own risk assessments for the areas that practice staff and patients used.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection 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:	No N/A
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	No
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: We saw the isolation room and found that it was cluttered and was unable to be deep cleaned. However, the consulting rooms were clean and tidy. The practice was unable to demonstrate that the practices infection control lead, who was the practice nurse, had completed sufficient training for this role. There was no overview of infection control, the practice had not completed their own audit and did not monitor that the actions from the building management's audit had been completed, this included a lack of oversight in relation to legionella actions (legionella is a bacterium which can contaminate water systems in buildings).	

Staff members did not follow the practice policy when disposing of urine samples and being bare below the elbow to assist with the prevention of infection.

Risks to patients

There were adequate 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No

Explanation of any answers and additional evidence:

Non clinical staff had not received specific training for identifying and managing suspected sepsis.

There was no evidence of risk assessments being carried out when there were changes to staffing, which led to tasks such as paper record management not being completed in a timely manner.

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	No

to deliver safe care and treatment.	
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	No
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.	Yes

Explanation of any answers and additional evidence:

The practice had an up to date 'Processing documents' policy which was last reviewed in November 2018. However, there was a cupboard in the practice management office that contained over 100 Lloyd George files dating back to 2017 that had a mixture of active patients whose records had not been summarised and patients that had been deducted but their records were not sent back to the health authority, even though the practice had submitted on the clinical system that they had been. There were also records that stated they had been summarised but had not.

We looked at one patient file that was filed away correctly and found that this patient had been deducted, with the clinical record stating that their file had been sent back to the health authority. The practice management team told us that they were aware of these issues that date back two years and they had a dedicated member of staff dealing with this. However, this staff member was completing records stating they were summarised when they were not, and we were told this staff member had not had any summarising training.

In response to these findings, we sampled ten patients notes summaries and found all had been completed. However, information was missing which could have been detrimental to the patient if the not included in two patient records.

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)	0.61	0.73	0.88	Variation (positive)
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).	8.2%	9.7%	8.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
(01/04/2018 to 31/03/2019) (NHSBSA)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	6.30	5.58	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.13	1.49	2.07	Tending towards variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	No
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	Yes
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes

Medicines management	Y/N/Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	No
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.	No

Explanation of any answers and additional evidence:

The system for managing high risk medicines was not effective. For example:-
The practice submitted a high-risk medication audit carried out in June 2019, this reviewed the medicines warfarin, methotrexate and lithium only where patient need regular blood tests to ensure the medicine was safe to continue. The audit demonstrated that the high risk medications were not always carried out following The National Institute for Health and Care Guidance. (NICE)

At the inspection we reviewed the high-risk medicines and found that patients on Lithium and Methotrexate had recent blood tests. For warfarin the practice had commenced recording patients INR prior to prescribing the medicine, however a review of the five patient notes demonstrated that the practice had commenced recording INR on patient records but failed to have a consistent approach prior to this.

The practice did not provide an audit for azathioprine, during the inspection we found some patients had not been monitored correctly

This clearly demonstrated the practice did not operate an effective system for the monitoring of high-risk medicines and this put patients at risk.

Whilst prescriptions were securely stored in a locked cabinet, the practice did not monitor their use.

The practice nurse administered medicines in accordance with signed Patient Group Directions. The health care assistant administered vaccines such as B12 and flu, however when we spoke to the healthcare assistant they were not aware of any Patient Specific Directions associated with administration of these vaccines and they had not completed flu update training since 2017.

Vaccines were appropriately stored and maintained, however the cold chain monitoring arrangements were not effective. We found the vaccine fridge temperatures were only monitored on a Tuesday, Wednesday and Thursday, when the health care assistant was working. This was not monitored on a Monday and Friday when the practice nurse worked and there was no risk assessment carried out to mitigate against any risks that this could potentially cause. The practice did however have a data logger which recorded the fridge temperature electronically.

The practice did not have at least two named individuals who were responsible for ordering vaccines and therefore there was no contingency arrangement should the responsible person be absent from work.

Medicines management	Y/N/Partial
The practice had an oxygen cylinder, however there was no high flow oxygen masks that would be required in the event of a cardiac arrest. The practice was unable to provide evidence of emergency equipment monitoring to ensure the equipment was in good working order. The oxygen and defibrillator were kept in separate parts of the practice and therefore were not immediately and easily accessible in case of an emergency. Emergency medicines were not kept in an organised manner to ensure they could be found in a timely manner in the case of an emergency. The emergency medicines were last checked on 18 July 2019, however, we found chlorphenamine injection and rectal diazepam were listed as being in the emergency medicines but were missing from the supply. The practice manager told us they had checked the day before the inspection and that chlorphenamine was in stock. We also found atropine and adrenaline was due to expire in less than a month, but this was not highlighted on the log sheets. This demonstrated he practice did not have a process to ensure these would be restocked prior to expiring. The practice had did not have process in place to ensure that clinicians had the correct information in place when prescribing medication, because they did not record when prescriptions were not picked up from the patients.	

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.	No
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
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:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: The practice had a record of all significant events which included the action taken, how the learning was implemented and the outcome. However, this did not state how the learning was shared with staff members. We asked the three members of the practice management team for evidence the learning and outcomes from the two significant events were shared with all relevant staff members and they were unable to find any minutes where these were discussed.	

Examples of significant events recorded and actions by the practice:

Event	Specific action taken
Flu vaccinations were not ordered for the 2018/19 flu season.	Referrals were made to pharmacists and local practices supplied the practice with a supply of vaccines.
Wrong dose of aspirin was prescribed to the wrong patient and queried by the pharmacist.	The correct dose was issued for the correct patient and the significant event form stated that clinicians should ensure the correct dose is selected.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	No

Explanation of any answers and additional evidence:

The practice did not have a system to record receipt of safety alerts and any action taken as a result. We found evidence Medicines and Healthcare Products Regulatory Agency (MHRA) advice regarding the medication's sodium valproate, hydrochlorothiazide and carbimazole had not been effectively actioned and this put patients at risk.

A clinical pharmacist left the practice in December 2018 their handover to the provider stated that the safety alerts for hydrochlorothiazide in November 2018 had not been action and asked for patients to be reviewed. It also asked for the practice to follow up an alert regarding suction catheters, and an alert on the systemic and inhaled fluoroquinolones which had a risk of aortic aneurysm. It also confirmed that the practice had not told some patients about the risks of sodium valproate.

From the audit carried out in June 2019 by the recently recruited pharmacist. submitted by the provider prior to the inspection, it was demonstrated that the handover actions had not been completed as patients on sodium valproate had not been commenced on a recommended programme.

Effective Rating: Inadequate

- The effective key question is rated inadequate because the practice did not have an effective system to monitor QOF performance, there was limited quality improvement activity, staff training was not routinely monitored and staff performance was not managed effectively.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
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.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A

Explanation of any answers and additional evidence:

The provider submitted a undated audit of patients how required a medical review due to a long-term condition. Where they had put in place an action plan to ensure that patients were reviewed appropriately. We reviewed a sample of patients and found:-

For asthma one patient had not had a review in the last year, one was carried out over the telephone and five had not had a peak flow recorded. (Peak flow is a measurement of how quickly the patient can blow air out of your lungs. It's used to help diagnose and monitor asthma.)

For diabetes we reviewed four records and found three had not had a diabetic review.

This and the results of the quality and outcome framework clearly demonstrated the practice does not have an effective system in place to ensure patients treatments were regularly reviewed and updated.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics	0.35	0.33	0.77	Tending towards

Prescribing	Practice performance	CCG average	England average	England comparison
prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)				variation (positive)

Older people

Population group rating: Inadequate

The effective key question is rated inadequate overall and therefore all population groups are also rated inadequate.

Findings

- Our review of the patient records evidenced an inconsistent management of patients' records, medicine and health reviews, and ineffective systems for the management of patient referrals, safety alerts, demonstrated that patients' care and treatment was not regularly reviewed and updated, and this put patients at risk.
- The practice did not carry out structured annual medication reviews for older patients. Medication reviews were not synchronised and therefore reviews did not consider all medicines at one time.
- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had a GP lead for older people who met fortnightly with the multidisciplinary team

People with long-term conditions

Population group rating: Inadequate

The effective key question is rated inadequate overall and therefore all population groups are also rated inadequate.

Findings

- Our review of the patient records evidenced an inconsistent management of patients' records, medicine reviews, and ineffective systems for the management of patient referrals, safety alerts and the quality outcomes framework results demonstrated that patients' care and treatment was not regularly reviewed and updated, and this put patients at risk.
- Patients with long-term conditions were not appropriately coded on the clinical system and therefore it was unclear if reviews were undertaken in a timely manner.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

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)	50.1%	71.3%	78.8%	Significant Variation (negative)
Exception rate (number of exceptions).	3.2% (14)	6.9%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	46.6%	79.8%	77.7%	Significant Variation (negative)
Exception rate (number of exceptions).	6.2% (27)	5.0%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	52.4%	79.7%	80.1%	Significant Variation (negative)
Exception rate (number of exceptions).	5.7% (25)	7.5%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	72.8%	78.5%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.2% (8)	3.0%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	72.4%	92.0%	89.7%	Variation (negative)
Exception rate (number of exceptions).	4.9% (3)	6.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading	52.7%	81.7%	82.6%	Significant Variation (negative)

measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	3.7% (26)	3.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	78.9%	88.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	24.0% (6)	5.7%	6.7%	N/A

Any additional evidence or comments

The practice had identified a lead for the management of QOF. However, at the time of the inspection the practice did not have a process for monitoring QOF performance and therefore no actions had been taken to improve the areas with low scores.

The practice was not consistently using read codes for inviting patients for reviews and therefore the inspection team were unable to establish if the searches for recalling patients were effective.

Families, children and young people

Population group rating: Inadequate

The effective key question is rated inadequate overall and therefore all population groups are also rated inadequate.

Findings

- Our review of the patient records evidenced an inconsistent management of patients' records, medicine reviews, and ineffective systems for the management of patient referrals, safety alerts, demonstrated that care and treatment was not regularly reviewed and updated, and this put patients at risk.
- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.
- The practice had not taken action to address the low uptake of immunisations.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus,	76	90	84.4%	Below 90% minimum

Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)				
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)	77	94	81.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	79	94	84.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	78	94	83.0%	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

Any additional evidence or comments

The practice had not taken action to review and improve the number of patients attending for vaccines.

Working age people (including those recently retired and students)

Population group rating: Inadequate

The effective key question is rated inadequate overall and therefore all population groups are also rated inadequate.

Findings

- Our review of the patient records evidenced an inconsistent management of patients' records, medicine reviews, and ineffective systems for the management of patient referrals, safety alerts, and the quality outcomes framework demonstrated that patients' care and treatment was not regularly reviewed and updated, and this put patients at risk.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat 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)	52.7%	62.9%	71.7%	Significant Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	46.0%	55.0%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	39.4%	45.1%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	76.5%	80.4%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	70.0%	44.3%	51.9%	No statistical variation

Any additional evidence or comments
The practice had not taken action to review and improve below average screening of patients attending for cervical screening.

People whose circumstances make them vulnerable

Population group rating: Inadequate

The effective key question is rated inadequate overall and therefore all population groups are also rated inadequate.

Findings

- Our review of the patient records evidenced an inconsistent management of patients' records, medicine reviews, and ineffective systems for the management of patient referrals, safety alerts, and the quality outcomes framework demonstrated that patients' care and treatment was not regularly reviewed and updated, and this put patients at risk.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- The practice did not have a system to identify and manage patients receiving palliative care, therefore the inspection team could not find evidence these patients were being appropriately managed.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

The effective key question is rated inadequate overall and therefore all population groups are also rated inadequate.

Findings

- Our review of the patient records evidenced an inconsistent management of patients' records, medicine reviews, and ineffective systems for the management of patient referrals, safety alerts, and the quality outcomes framework demonstrated that patients' care and treatment was not regularly reviewed and updated, and this put patients at risk.
- Same day and longer appointments were offered when required.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	89.9%	90.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	2.3% (3)	8.4%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	66.7%	91.6%	90.0%	Variation (negative)
Exception rate (number of exceptions).	2.3% (3)	4.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	81.1%	84.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.1% (2)	4.3%	6.6%	N/A

Any additional evidence or comments

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity and did not routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	442.4	510.1	537.5
Overall QOF score (as a percentage of maximum)	79.1%	91.2%	96.2%
Overall QOF exception reporting (all domains)	4.5%	5.1%	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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice did not have a programme of quality improvement activities. Three single cycle audits had been completed regarding high risk medicines in June 2019. However, although the audits demonstrated that when warfarin medication was prescribed the blood results (INR scores) had not been checked within the appropriate timeframe, the practice had not implemented an action plan.

The practice provided unpublished data to demonstrate that the practice had achieved 490 points out of an overall target of 559 points for the quality and outcomes framework for 2018 to 2019. With a high clinical exception rate of 7.67%. Which demonstrated no improvement on the 2017 to 2018 results.

Effective staffing

The practice was unable to demonstrate 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.	Yes
Staff had protected time for learning and development.	Partial

There was an induction programme for new staff.	Yes
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.	No
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
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:

There was no process for monitoring that staff training was completed and up to date. We identified gaps in staff training for infection control, basic life support, sepsis, mental capacity and safeguarding at the role-appropriate level.

There was no system for supervising the nurse practitioner and routinely auditing their prescribing.

There was no evidence that all staff had received an annual appraisal. We only received appraisal documentation for one member of the clinical team.

The practice nurse was being supported to complete their master's degree in 'Advanced Nursing Practice' and attends regular prescribing conferences and obtains local updates from the GP. However, other staff told us there were limited development opportunities.

The health care assistant carried out spirometry tests, but was unaware that the machine must be clinically calibrated before its use to ensure it was in good working order and had not completed their annual training for the vaccination of flu.

The practice used a management consultant to help them deal with issues and training the new practice manager. We saw a documented training plan for the practice manager.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Partial
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.	Yes

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence: We saw minutes of multi-disciplinary team meetings from May and July 2019 which discussed and made the necessary arrangements to coordinate patient's health and social needs.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	No
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
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.	Yes
Explanation of any answers and additional evidence: The practice did not have a system to identify and manage patients receiving palliative care, therefore the inspection team could not find evidence these patients were being appropriately managed.	

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)	85.7%	96.5%	95.1%	Significant Variation (negative)
Exception rate (number of exceptions).	0.9% (12)	0.7%	0.8%	N/A

Any additional evidence or comments
The practice had identified a lead for the management of QOF. However, at the time of the inspection the practice did not have a process for monitoring QOF performance and therefore no actions had been taken to improve the areas with low scores.

Consent to care and treatment

The practice 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Not inspected
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence:	

Caring Rating: Requires Improvement

The caring key question has been rated requires improvement due to limited action to review and improve the patient experience.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	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.	Yes
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	16
Number of CQC comments received which were positive about the service.	14
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Two comment cards noted difficulty in getting an appointment and the rest of the cards were complimentary about the practice and the staff members.
NHS Choices	The practice was rated 2.5 out of 5 stars from approximately 50 responses on the NHS Choices website. Most of the one-star responses related to difficulties accessing the practice and rude behaviour of reception staff. The five-star ratings refer to the care and compassion of the full team. The practice had not responded to any comments since April 2018.

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
9579	469	91	19.40%	0.95%

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)	67.3%	83.7%	88.9%	Significant 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)	74.7%	81.0%	87.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	84.6%	91.3%	95.5%	Variation (negative)
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)	61.6%	75.6%	82.9%	Variation (negative)

Any additional evidence or comments
The practice reviewed the findings of the 2018 GP patient survey and identified actions to address the areas where the practice was performing below local and national averages. The actions included the recruitment of two additional partner GP, additional staff being tasked with answering the phones during peak periods, changes were made to the voicemail system, and appointments and prescription requests were made available online. However, none of the actions had been implemented. In addition, the 2019 GP patient survey had not been reviewed therefore we could not determine if improvements have been made based on the actions taken from the 2018 data. To improve access to patients' preferred GP the practice had planned to recruit two additional GPs to meet patient demand and an alert was added to vulnerable patients to state who their preferred GP was. However, the two additional GPs had not been recruited by the time of this inspection.

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

Any additional evidence
The practice had not undertaken an in-house survey in 2018 and 2019.

Involvement in decisions about care and treatment

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
Explanation of any answers and additional evidence: The reception area provided limited information such as leaflets and posters about local services which could support patients. However, the practice website listed local services and organisations which patients could access for support.	

Source	Feedback
Interviews with patients.	No patients were interviewed during 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)	81.2%	87.9%	93.4%	Variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	No
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:	

There was no information in the waiting area advising patients what interpretation services were available for patients who first language was not English.

There was limited information for patients in the waiting area regarding local services and access to support groups. However, this information was available on the practice website.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 57 carers (less than 1% of the practice population).
How the practice supported carers (including young carers).	We were told that the practice identifies patents opportunistically and through the registration process. Carers are signposted to the local carers network and invited for an annual flu vaccination.
How the practice supported recently bereaved patients.	There was no advice leaflets or posters advising patients of local bereavement services.

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
Explanation of any answers and additional evidence:	

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.	No
Patients were made aware of the information sharing protocol before online services were delivered.	N/A
The practice had arrangements to make staff and patients aware of privacy settings on	N/A

video and voice call services.	
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	N/A
Explanation of any answers and additional evidence: The practice had not effectively managed a significant number of paper patient records going back as far as 2017. In some cases, the practice still had paper records despite the electronic record stating the paper records had been sent to a different service.	

Responsive Rating: Inadequate

The responsive key question is rated inadequate as the practice had not made sufficient improvements following the release of the GP patient survey and the complaints process was not easily available to patients and not followed by the practice in a timely manner.

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.	Yes
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Partial
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The practice was not able to provide information on how it reviews the needs of its local population and delivers services to reflect those needs. We were told an interpreter could be requested, however there were no signs advising patients that this service was available.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 8pm
Tuesday	8am – 8pm
Wednesday	8am – 8pm
Thursday	8am – 6.30pm
Friday	8am – 8pm
Saturday	9.30am – 12.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9579	469	91	19.40%	0.95%

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)	84.7%	90.6%	94.5%	Variation (negative)

Any additional evidence or comments

The practice had not undertaken an in-house survey, however an audit of the 2018 GP patient survey was used to identify areas for improvement. We were not provided evidence that the actions had been implemented and a second cycle of the audit had not been carried out to determine if the changes made had a positive impact on patient satisfaction. No audit or in-house survey had been completed following the release of the 2019 National GP Patient Survey results.

Older people

Population group rating: Inadequate

The responsive key question has been rated inadequate overall and therefore all populations groups have also been rated inadequate.

Findings

- The practice had failed to make sufficient improvement following the 2018 GP survey this would have impacted upon the patient experience when accessing the service for all of the population groups.
- The practice offered older patients home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice enabled older patients to access appropriate services.
- The practice supported a 80 bed nursing home and provided weekly visits by the GP.

People with long-term conditions

Population group rating: Inadequate

The responsive key question has been rated inadequate overall and therefore all populations groups have also been rated inadequate.

Findings

- The practice had failed to make sufficient improvement following the 2018 GP survey this would have impacted upon the patient experience when accessing the service for all of the population groups.
- Patients with multiple conditions did not have their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to

discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: Inadequate

The responsive key question has been rated inadequate overall and therefore all populations groups have also been rated inadequate.

Findings

- The practice had failed to make sufficient improvement following the 2018 GP survey this would have impacted upon the patient experience when accessing the service for all of the population groups.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Inadequate

The responsive key question has been rated inadequate overall and therefore all populations groups have also been rated inadequate..

Findings

- The practice had failed to make sufficient improvement following the 2018 GP survey this would have impacted upon the patient experience when accessing the service for all of the population groups.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm most weekdays. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday until 12.30pm.

People whose circumstances make them vulnerable

Population group rating: Inadequate

The responsive key question has been rated inadequate overall and therefore all populations groups have also been rated inadequate.

Findings

- The practice had failed to make sufficient improvement following the 2018 GP survey this would have impacted upon the patient experience when accessing the service for all of the population

groups.

- The practice had not put an alert on the medical records of vulnerable patients to help identify them when they attended the practice.
- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided enabled patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

The responsive key question has been rated inadequate overall and therefore all populations groups have also been rated inadequate.

Findings

- The practice had failed to make sufficient improvement following the 2018 GP survey this would have impacted upon the patient experience when accessing the service for all of the population groups.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly, however this information was not readily available in the waiting area.

Timely access to the service

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

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

National GP Survey results

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)	22.7%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	47.8%	62.3%	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)	45.1%	63.0%	64.7%	Tending towards variation (negative)
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)	65.1%	66.9%	73.6%	No statistical variation

Any additional evidence or comments
The practice showed us a document which looked at four areas from the 2018 GP national patient survey where they felt they were rated significantly below the local averages. The document stated that extra staff members were appointed to answer telephones at busy times, online appointments were offered and the telephone voicemail was changed in order to increase patient satisfaction with access to the practice by telephone. There was no documented discussion regarding the survey and the practice did not monitor the impact of any changes made. The 2019 survey results showed the practice was still had a negative response rate of 23% for being able to get through to the practice by telephone. The document which the practice showed us stated that, in order to increase patient satisfaction with seeing their preferred GP, two additional regular GPs were appointed, and alerts were put on the clinical system for elderly patients, patients with dementia and disabled patients, to ensure these patients could book with their GP of choice. We viewed a sample of these patients records and found that not all of these patients had alerts on their record. There was no improvement in patient satisfaction with appointment times from the 2018 to the 2019 GP patient survey. The practice stated that they had trained staff to understand clinical priority and triage but there was no evidence of this.

Source	Feedback
NHS Choices	The practice was rated 2.5 out of 5 stars from approximately 50 responses on the NHS Choices website. Most of the one-star responses related to accessing the practice and rude behaviour of reception staff. The five-star ratings refer to the care and compassion of the full team. The practice had not responded to any comment since April 2018.

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.	4
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	No
There was evidence that complaints were used to drive continuous improvement.	Partial

Explanation of any answers and additional evidence:

The practice had a complaints policy, but there was no information displayed in the practice informing patients of how to make a complaint. The reception staff told us they were not allowed to display practice specific information.

The complaints policy stated who the nominated individuals were to manage the complaints process. Not all staff members we spoke to were able to clearly explain the correct process to follow should a patient wish to make a complaint.

We reviewed a complaint that was received by the practice in the second week of March 2019, but was only acknowledged in the first week of May 2019 and a final response was provided to the patient in June 2019. We found that one of the actions given to the patient had not been completed, namely an alert being put on the system regarding mobility issues. We viewed minutes of the practice meeting where this complaint was discussed, but the meeting minutes did not detail the events of the complaint or any action that had been taken.

We reviewed a complaint where there was no documented acknowledgement letter, but the final response was sent within five weeks of receipt. We saw that, in an attempt to contact the patient who submitted the complaint, the practice telephoned a family member; however there was nothing on the clinical system to identify this person as a carer or to state that the practice had received consent to do this. Although the practice's response to the patient listed all the staff that had been spoken to in relation to the complaint, which included GPs, nurses and management and reception staff members, there was no record of these discussions, including no meetings minutes where action and learning was agreed.

Prior to the inspection the practice submitted a record of all complaints. However, the most recent complaint recorded was in February 2019.

Examples of learning from complaints:

Complaint	Specific action taken
A number of separate issues including (but not limited to) access, timely referral, cancellation of appointments and online appointment process.	The practice addressed each issue identified and provided a clear rationale for the reasons identified within the complaint, including advising the patient of alternative methods of booking appointments and recruiting two additional GPs to meet demand.
Patient unhappy with GP attitude and findings within medical records.	The practice explained the records were mostly written by the patient's previous practice and therefore they should make contact with them to discuss the content of the medical records.

Well-led Rating: Inadequate

The well-led key question has been rated inadequate because the leaders did not demonstrate they could work together to set direction for the practice, there was no realistic strategy to deliver the practice vision, risks management and governance systems were not effective and performance data was not used to drive improvements.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

The practice was aware of some of the challenges affecting the delivery of care, including an increase of 5000 patients in the past two years.

To overcome these challenges the practice recruited a practice manager and they told us they were also looking to recruit another partner or GP in near future to replace a GP who is due to retire.

The staff were not clear on their roles and responsibilities and there was limited managerial oversight to rectify this. There had been a new practice manager recruited who was being supported by a consultant practice manager, however the practice had not made arrangements to ensure the core duties of the practice were sustained during this period.

The inspection team identified the partners were not working collaboratively to drive the strategy and make necessary changes to improve the practice's overall performance. The practice could not demonstrate the direction of travel for the practice and staff felt the partners were not working together to agree a suitable strategy.

Vision and strategy

The practice had a clear vision but it 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.	Yes
There was a realistic strategy to achieve their priorities.	No
Staff knew and understood the vision, values and strategy and their role in achieving	Yes

them.	
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: The practice objectives were to put patients at the heart of all decisions and treat them fairly and to facilitate personal development for staff. However, we did not see evidence of a strategy to deliver this vision. As there was no credible strategy we were unable to assess how the practice was monitoring the delivery of the practice vision.	

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.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
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.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: Staff felt there was a disruptive partnership and therefore there was a division of loyalties on the correct way to manage the practice. When patients raised complaints, the practice apologised but did not follow up on agreed actions to ensure the issues did not happen again. The practice manager had recently been employed and was undergoing a period of induction, the business manager worked full time but did not have oversight of the day to day running of the practice, and the management consultant was not regularly based at the practice. Staff were affected by unclear decision-making and the disruptive partnership meant they were unclear on roles and responsibilities within the practice. We did not see any evidence demonstrating how the practice planned to overcome these issues and ensure staff members are accountable for their actions.	

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

Source	Feedback
Staff	Staff felt development opportunities were limited.

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:

The leadership team were not working collaboratively and this had resulted in ineffective systems and processes to manage the transfer and summarisation of paper medical records which are sent to and from the practice. The inspection team found a significant number of paper records which had not been appropriately transferred to other services in a timely manner. We found evidence of paper records which were sent up to nine months after the records had been requested by the patient's new GP practice. Paper records were found which had not been summarised on the electronic medical record going back as far as 2017.

The leadership team had not had not worked collaboratively to ensure there were safe and effective systems for the safe management of medicines, referral of patients to other services, safe recruitment and to ensure staff undertook their roles safely and in accordance with the law and best practice.

The leadership team had not monitored staff training effectively to ensure mandatory training was completed within the required timeframes.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	No
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial

A major incident plan was in place.	Yes
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 leadership team did not carry out their own risk assessments and relied on the building management team to do this, but there was no oversight of any of the outcomes of these assessments to see whether any actions that were identified had been completed. This included the health and safety, fire and the prevention and control of infectious diseases.

The leadership team did not have a process to systematically monitor practice performance using the data available such as the Quality Outcomes Framework, in-house patient surveys or National GP patient survey.

There was no evidence staff had been trained to respond effectively to major incidents.

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.	Yes

Explanation of any answers and additional evidence:

The leadership team did not have a process to systematically monitor practice performance using the data available such as the Quality Outcomes Framework, in-house patient surveys or National GP patient survey.

The leadership team used the results from the GP Patient Survey to identify areas in need of improvement and agree appropriate actions. However, there was no evidence the actions were monitored to review if they were effective.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	N/A
Patient records were held in line with guidance and requirements.	N//A

Any unusual access was identified and followed up.	N/A
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
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

Explanation of any answers and additional evidence:

The practice website held information about joining the patient participation group. However, there was no information in the reception area advising patients on how to join the group or any improvements made due to engagement with the group.

The reception/waiting room area did not contain information on how to provide feedback about the service.

Information about the practice's performance was not displayed in the reception area where it would be visible to patients.

Feedback from Patient Participation Group:

Feedback
A member of the group explained the practice listened to the issues raised by them and responded. The group met regularly.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No

Explanation of any answers and additional evidence:

Staff told us they felt there were limited development opportunities. We asked to view staff appraisals and the management team were only able to find an appraisal for one member of staff (the reception manager).

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.