

Care Quality Commission

Inspection Evidence Table

Warrior Square Surgery (1-5281741688)

Inspection date: 29 July 2019

Date of data download: 23 July 2019

Overall rating: Inadequate

At the previous inspection in December 2018 the practice was rated as inadequate. Concerns were identified in relation to providing care and treatment in a safe way, ineffective governance systems, support, training and appraisal of staff and poor recruitment practices. At this inspection the practice is rated as inadequate. This is due to shortfalls in the oversight of non-medical prescribing, monitoring and improving patient outcomes, actions to ensure quality improvement, access to treatment and care, and overall governance and management of risks, issues and performance.

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

Safe

Rating: Requires Improvement

At the previous inspection in December 2018 the practice was rated as inadequate for providing safe services. Concerns were identified related to significant events, poor risk management practices, medicines management, monitoring of emergency equipment and lack of actions to address safety alerts. At this inspection the rating for safe remained inadequate. We found there were still shortfalls in environmental safety checks, oversight of prescribing processes and reporting of significant events.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse, with the exception of environmental risk assessments.

| 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. | Yes |
| 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. | Yes |

| Safeguarding | Y/N/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: At the December 2018 inspection we found that safeguarding policies had not been regularly updated and that not all staff had received regular safeguarding training updates. At this inspection we saw that the safeguarding policy had been reviewed and staff reported that safeguarding policies were accessible, and all had a good understanding of how to raise concerns. Clinical staff were trained to child safeguarding level three. All other staff were trained to safeguarding level two. | |

| 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. | Yes |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Explanation of any answers and additional evidence: At the December 2019 inspection we found that there were gaps in recent staff recruitment records and that the registration of clinical staff was not monitored. At this inspection we found improvements in these processes and saw that recruitment processes such as obtaining evidence of satisfactory conduct in previous employment were in place. The registration of clinical staff was effectively 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: 24 June 2019 | Yes |
| There was a record of equipment calibration. Date of last calibration: 10 January 2019 | Yes |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks. Date of last check: 28 November 2018 | Yes |
| There was a log of fire drills. | Yes |

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|--|-----|
| Date of last drill: 27 June 2019 | |
| There was a record of fire alarm checks. Date of last check: 8 February 2019 | Yes |
| There was a record of fire training for staff. Date of last training: March 2019 | Yes |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed. Date of completion: 3 October 2018 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: At the December 2018 inspection we found that a fire safety risk assessment had been undertaken by an external contractor, however action by the practice to mitigate the risk had not been carried out. This included a failure to undertake regular fire alarm checks and fire drills. At this inspection there was evidence that actions from the risk assessment had been carried out including routine alarm and extinguisher checks, updates to the fire safety procedure, evacuation plans and regular fire drills with learning recorded. | |

| Health and safety | Y/N/Partial |
|--|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: n/a | No |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: n/a | No |
| Explanation of any answers and additional evidence: At the December 2018 inspection we found that a health and safety risk assessment had been carried out but that actions relating to mitigating risks had not been undertaken. At this inspection we found there was no evidence of environmental health and safety checks or risk assessments being carried out as staff were unable to locate them. A health and safety policy dated 14 March 2019 stated that regular inspections of the workplace were carried out, however these were not recorded and there was no evidence of these being carried out. A fire risk and safety assessment dated 4 March 2019 stated that a health and safety assessment was carried out on a regular basis, however the practice were unable to evidence this. A legionella risk assessment was in place and action had been taken in line with the risk assessment to mitigate the risk. This included regular water temperature checks and flushing of water outlets. | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | |
|--|-------------|
| | Y/N/Partial |
|--|-------------|

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|--|-----|
| There was an infection risk assessment and policy. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2019 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| 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 |
| Explanation of any answers and additional evidence: At the December 2018 inspection we found that staff had not received regular infection control training. At this inspection we saw evidence of infection control training having been undertaken by both clinical and non-clinical staff. | |

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. | Yes |
| 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. | Yes |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Yes |
| Explanation of any answers and additional evidence: There were posters in reception and clinical rooms reminding staff to be aware of sepsis. There was evidence of clinical staff having received sepsis training and receptionists had an awareness of this although had not yet received training. However, a training session was planned for August 2019 with the paramedic practitioner for all reception and administrative staff. | |

Information to deliver safe care and treatment

Staff had 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. | Yes |
| 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. | Yes |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>At the December 2018 inspection staff reported there were issues with providing adequate clinical appointments due to staffing issues and that there were concerns with adequate administrative cover. At this inspection staff reported there had been improvements in the provision of clinical appointments. Action relating to this included GP partners not taking time off work at the same time and the use of regular locum staff and clinical staff in advanced roles to provide cover.</p> <p>At the December 2018 inspection we found evidence of incidents relating to delays in referrals that had not been adequately addressed. At this inspection we found that referrals had been appropriately followed up and that referral letters contained appropriate information.</p> | |

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, there was insufficient review and oversight of non-medical prescribing.

| 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) | 0.92 | 0.99 | 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) | 7.9% | 9.0% | 8.7% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA) | 6.74 | 6.04 | 5.61 | Tending towards variation (negative) |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA) | 3.26 | 3.05 | 2.07 | No statistical variation |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | Yes |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | 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. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| 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 |
| 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. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At the December 2018 inspection we found that medicines were stored in clinical rooms that were not locked, the practice had not carried out a risk assessment as to the appropriate emergency medicines held in the practice and records of emergency medicine checks were not maintained. At this inspection we found that all medicines were stored securely, that an emergency medicine risk assessment had been carried out and that records or emergency medicine checks were maintained.</p> <p>At the December 2018 inspection we found issues with patients on high risk medicines not having a date recorded for review or where medicines had been stopped but still appeared on their repeat medicine list. At this inspection we found that prescriptions were appropriately reviewed and up to date and that patients on high risk medicines were reviewed.</p> <p>At the December 2018 inspection we found that non-medical prescribers did not have their prescribing competence monitored through a process of clinical supervision. At this inspection we found that there continued to be no clear process for clinical supervision, including for those staff operating in advanced roles where prescribing was part of their role. We were provided with a print out of a February 2019 mentoring record for one member of the nursing staff where they had reviewed and discussed patients with one of the GPs. However, there was not a formal ongoing process, and regular meetings or reviews were not in place. Managers and GPs acknowledged during inspection that there was not a process for supervision in place and immediately prior to inspection the GP partners had approached one of the salaried GPs to provide this, however this had not been formally agreed at the time of inspection. There was no specific plan or timeline in place for this at the time of inspection.</p> | |

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|-----------------------------|--------------------|
| Medicines management | Y/N/Partial |
|-----------------------------|--------------------|

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, however not all incidents were reported or recorded.

| Significant events | Y/N/Partial |
|---|--------------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| 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. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 8 |
| Number of events that required action: | 8 |

Explanation of any answers and additional evidence:
 At the December 2018 inspection we found evidence that not all significant events were reported or recorded and that there was limited evidence of learning being identified, shared or discussed. Records relating to significant events were not comprehensively maintained and staff were unable to identify individual patients from the significant event log as a result. At this inspection we found that not all incidents were reported or recorded. For example, only eight incidents had been recorded in the previous eight months and we were told of an incident where a clinical sample had gone missing that had not been reported or recorded, meaning that the root cause of the incident and learning could not be identified and shared. For those incidents that had been recorded we saw improvements in the way information was maintained and there was evidence of review, shared learning and discussion at staff meetings.

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|---|---|
| A patient was aggressive with reception staff. | The incident was reviewed and discussed at a staff meeting. Discussions included suggestions for ways in which staff could de-escalate situations and developing an understanding of why patients may become angry or frustrated. |
| Results from electrocardiograms had not been saved onto the appropriate electronic record system. | Each incident was reviewed by a GP and patients reviewed as appropriate. Administrative staff received instruction on the appropriate methods for storing results and a system was implemented where the healthcare assistant undertook a monthly check to ensure that results were stored appropriately. |

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

Explanation of any answers and additional evidence:

At the December 2018 inspection we found that there was no log or record of action taken in response to safety alerts. At this inspection there was a system for acting on safety alerts. We saw examples of actions taken on recent alerts for example, an alert relating to the potential needle failure of an adrenaline pre-filled syringe. The practice had written to relevant patients informing them of the risks and the actions to take to mitigate the risk.

Effective

Rating: Inadequate

At the December 2018 inspection the practice was rated as inadequate in effective. This was due to the clinical audits not demonstrating improvements, action to improve patient outcomes not being sufficient and childhood immunisation targets not always being achieved, and gaps in staff training, induction and appraisal. At this inspection the practice is rated as inadequate for effective services. This is due to continued poor performance in specific population groups in relation to mental health performance, cancer screening and childhood immunisations.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was 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. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| 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. | Yes |
| Explanation of any answers and additional evidence: Clinical meetings were held on a regular basis. We viewed minutes of these meetings and saw that evidence-based practice was discussed, including discussions around the use of The National Institute for Health and Care Excellence (NICE) guidance. Hypnotic prescribing was higher than average, however there was evidence of a marginal reduction since our previous inspection when practice performance was 1.93. | |

| Prescribing | Practice performance | CCG average | England average | England comparison |
|---|----------------------|-------------|-----------------|----------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small> | 1.81 | 1.17 | 0.77 | Variation (negative) |

Older people

Population group rating: **Good**

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Diabetes performance was higher than average, for example, in relation to blood pressure control.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan. The nursing team opportunistically reviewed patients with asthma and there was information in the waiting area encouraging patients to attend for a review. Performance remained below average.

| Diabetes Indicators | Practice | CCG average | England average | England comparison |
|---------------------|----------|-------------|-----------------|--------------------|
|---------------------|----------|-------------|-----------------|--------------------|

| | | | | |
|---|-----------|-------|-------|--------------------------|
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 76.2% | 78.6% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 4.9% (20) | 11.8% | 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) <small>(QOF)</small> | 90.1% | 76.5% | 77.7% | Variation (positive) |
| Exception rate (number of exceptions). | 4.6% (19) | 10.7% | 9.8% | N/A |

| | Practice | CCG average | England average | England comparison |
|--|------------|-------------|-----------------|--------------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 82.4% | 82.0% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 14.4% (59) | 14.8% | 13.5% | N/A |

| Other long-term conditions | Practice | CCG average | England average | England comparison |
|---|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 63.3% | 70.4% | 76.0% | Variation (negative) |
| Exception rate (number of exceptions). | 31.1% (119) | 11.4% | 7.7% | N/A |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 91.4% | 83.4% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 13.8% (30) | 13.2% | 11.5% | N/A |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 77.4% | 81.1% | 82.6% | No statistical variation |

| | | | | |
|---|------------|-------|-------|--------------------------|
| Exception rate (number of exceptions). | 2.9% (31) | 5.3% | 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) | 90.4% | 86.9% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 14.5% (16) | 5.2% | 6.7% | N/A |

Any additional evidence or comments

During the December 2018 inspection we found that asthma performance was below average and there was higher than average exception reporting in some areas. At this inspection we found there continued to be a negative variation (7%) in relation to the proportion of patients with asthma who had received an asthma review in the last 12 months when compared with local and national averages. Exception reporting had marginally improved from 31% to 26% although this was still more than double the rate of local practices and more than three times the rate of national practices. We were told during inspection that the nursing team were working to improve asthma reviews and we saw patient information in the waiting area reminding patients of the importance of regular reviews.

Families, children and young people

Population group rating: Inadequate

Findings

We rated this population group as **inadequate**.

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets, however there was evidence of improved performance from unverified data provided by the practice on inspection.

However, there were areas of good practice:

- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- 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.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|---|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)(i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England) | 79 | 86 | 91.9% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England) | 76 | 93 | 81.7% | 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) | 72 | 93 | 77.4% | Below 80% uptake |
| 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) | 72 | 93 | 77.4% | Below 80% uptake |

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

At the December 2018 inspection we found that the practice were performing below the 90% minimum in three out of four childhood immunisations. At this inspection we found that the practice had taken action to increase the immunisation uptake, including working with the local immunisation outreach team to promote and increase uptake. Unverified data provided by the practice showed some improvement. For example, the percentage of children aged 2 show had received their booster immunisation for pneumococcal infection had increase from 81.7% to 91%. The uptake for influenza, meningitis and MMR vaccines had also increased, from 77.4% to 86%.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

We rated this population group as **inadequate**.

- Cervical screening was below the 70% uptake and other aspects of cancer screening were below average.

However, there were areas of good practice:

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat 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) | 66.1% | N/A | N/A | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 55.7% | 66.8% | 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) | 46.7% | 57.7% | 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) | 54.5% | 67.4% | 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) | 42.5% | 62.9% | 51.9% | No statistical variation |

Any additional evidence or comments

Cervical screening was below the 70% uptake. There was no alert on the electronic patient record system to trigger opportunistic discussions about screening and nurses did not have access to patient data held on the National Health Application and Infrastructure Services (NHAS) system. The practice were below average on all cancer screening.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

We rated this population group as **inadequate**.

- There was significant negative variation in mental health performance in some areas relating to patient outcomes. This was in the context of mental health prevalence within the practice being significantly higher than average at three times the national average.

However, there were areas of good practice:

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- 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) <small>(QoF)</small> | 82.1% | 81.3% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 19.7% (37) | 13.6% | 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 | 53.4% | 79.8% | 90.0% | Significant Variation (negative) |

| | | | | |
|--|------------|-------|-------|--------------------------|
| months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | | | | |
| Exception rate (number of exceptions). | 13.3% (25) | 11.3% | 10.5% | N/A |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 78.6% | 79.9% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 7.4% (9) | 7.4% | 6.6% | N/A |

Any additional evidence or comments

Mental health exception reporting for patients having a comprehensive care plan had improved from 19.7% to 13.6% and was in line with the local (CCG) average as shown by unverified data (March 2019) provided by the practice. However, the percentage of patients on the mental health register with a record of alcohol consumption was more than 25% below average at 52% compared with the local (CCG) average and was 38% below the national average. This showed significant negative variation. The percentage of patients on the mental health register with a record of smoking status was 5% below the local (CCG) average.

Monitoring care and treatment

The practice had undertaken some quality improvement activity to review the effectiveness and appropriateness of the care provided. However, actions to ensure improvements were inconsistent and not always clear.

| Indicator | Practice | CCG average | England average |
|--|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 496.3 | 533.4 | 537.5 |
| Overall QOF score (as a percentage of maximum) | 88.8% | 95.4% | 96.2% |
| Overall QOF exception reporting (all domains) | 5.8% | 6.1% | 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. | No |
| 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

At the December 2018 inspection we found that the practice were unable to fully demonstrate that quality improvement activities and information was used to make improvements. At this inspection we found some evidence of audits and quality improvement activities, however, some areas of audit activity did not consistently show improvements or how improvements would be achieved.

A July 2019 blood pressure audit of patients with a cardiovascular risk assessment recorded showed poor results and the action to be taken to improve this and monitor or repeat the audit was unclear. The audit showed that only 13% of patients audited had a blood pressure check and only 9% had a cholesterol check recorded. Only 50% had a QRISK (an algorithm to predict cardiovascular risk) recorded but the QRISK template had not been used. The action plan was incomplete. An undated sore throat audit had been carried out with the need for improvements identified in relation to the use of approved algorithms and compliance with National Institute for Health and Care Excellence and Public Health England guidance on self-care advice given to patients. A re-audit date of six months was recorded but there was no record if this had been carried out or when it was due to be carried out. Minutes of clinical meetings did not include evidence that either the hypertension or sore throat audit had been discussed. Therefore, there was no evidence of action being taken or of a clear plan of quality improvement as a result of these audits.

However, a vaccination audit of patients with an absent or dysfunctional spleen who were at increased risk of severe infection showed that patients who had not received vaccines were being offered appointments for review in line with national guidance. An audit of patients taking a diuretic (used to treat heart failure) where there was an increased risk of skin cancer was carried out and all patients were written to warning of the risk of skin malignancy. All received medication reviews and all bar one had changes to medication, a repeat audit in July showed two patients on the medicine, both of whom had been identified as being treated appropriately.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles, however, there was insufficient supervision and oversight of non-medical prescribing.

| | 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. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Partial |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Partial |
| There was a clear and appropriate approach for supporting and managing staff when | Yes |

| | |
|--|--|
| their performance was poor or variable. | |
| Explanation of any answers and additional evidence: | |
| At the December 2018 inspection we found there were gaps in staff training, clinical supervision and appraisal. | |
| At this inspection we found that staff received regular appraisals and there was evidence of clinical supervision and training as part of a regular clinical meetings. | |

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) | Yes |
| 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. | Yes |

Helping patients to live healthier lives

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

| | Y/N/Partial |
|---|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Yes |
| 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. | Partial |
| Explanation of any answers and additional evidence: | |
| Smoking cessation advice was offered to patients, however there was a negative variation in the smoking status of patients being recorded. | |

| Smoking Indicator | Practice | CCG average | England average | England comparison |
|---|-----------|-------------|-----------------|----------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 87.8% | 93.4% | 95.1% | Variation (negative) |
| Exception rate (number of exceptions). | 0.5% (10) | 0.7% | 0.8% | N/A |

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | 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. | Yes |
| Policies for any online services offered were in line with national guidance. | Yes |
| Explanation of any answers and additional evidence: Consent was recorded in patient's medical records, including written consent for joint injections. Clinical staff received training in relation to the Mental Capacity Act (2005) and how this impacted on considering consent and decision making. | |

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people during inspection, although internal survey data showed some dissatisfaction in this area.

| | 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: Staff were seen to interact with patients with kindness and courtesy. | |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 11 |
| Number of CQC comments received which were positive about the service. | 10 |
| Number of comments cards received which were mixed about the service. | 1 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|---------------|--|
| Comment cards | One comment card was mixed about their experience with GPs, stating that a previous experience at the practice had not been helpful, although the more recent experience was good. Other cards were positive about the way staff treated patients. Comments included that patients received consistently positive care, that staff listen and have a good understanding of people's needs and that staff are kind, caring and helpful. |

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 |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 7780 | 372 | 137 | 36.8% | 1.76% |

| 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) | 83.0% | 87.8% | 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) | 80.3% | 87.5% | 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) | 91.6% | 95.9% | 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) | 67.1% | 81.7% | 82.9% | Tending towards variation (negative) |

Any additional evidence or comments

Results from the GP patient survey show that satisfaction with their overall experience was below average.

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

Any additional evidence

We viewed results of a survey that had been carried out between March and June 2019. Results of the survey were mixed. For example, while 33% of those surveyed responded that the service they received was excellent, a further 33% reported that it was poor, 57% of patients reported being satisfied with the care received from the clinician, 30% were dissatisfied. There were similar mixed results in relation to patient's experience of being listened to and how well treatment options were discussed with them. Other areas where satisfaction was mixed was in relation to access to appointments.

The practice were aware of areas that needed improvement and had implemented a 'you said, we did' board where details of action taken by the practice as a result of feedback was recorded for patients to see.

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. | Yes |
| Explanation of any answers and additional evidence: Easy read materials were available. | |

| Source | Feedback |
|---------------------------|--|
| Interviews with patients. | Patients reported that staff were kind and caring and gave them support as they needed it. |

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 | 91.3% | 92.1% | 93.4% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------|
| much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019) | | | | |

Any additional evidence or comments

Patients we spoke to reported feeling satisfied with the way GPs and other clinical staff involved them in their care and treatment.

| | Y/N/Partial |
|--|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Yes |
| Information about support groups was available on the practice website. | Yes |
| Explanation of any answers and additional evidence: Patient information in the waiting area included a range of topics such as those relating to immunisations, support groups, mental health and long-term conditions. Staff reported that these could be made available in different languages and formats as needed, however the need for this had been low. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified 114 carers which was 1.45% of the practice population. |
| How the practice supported carers (including young carers). | The practice supported carers by signposting them to a local carers group and supporting them to access carer breaks as necessary. |
| How the practice supported recently bereaved patients. | The practice offered appointments to recently bereaved patients as needed and provided information and referral to support services available in the local community. |

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: Patients were asked to step back from the reception desk to allow for confidentiality. Staff were able to speak with patients in a more private area as needed. | |

If the practice offered online services:

| | Y/N/Partia I |
|--|-----------------|
| 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. | n/a |
| Online consultations took place in appropriate environments to ensure confidentiality. | n/a |
| The practice advised patients on how to protect their online information. | Yes |

Responsive

Rating: Inadequate

At the December 2018 inspection the practice was rated as requires improvement in responsive. This was due to complaints not always being responded to in timely way and limited learning in relation to this. In addition, patient satisfaction with how they were able to access appointments was poor. At this inspection we rated responsive as inadequate. We found that the practice had made improvements to the complaints process with evidence of learning. However, the system for managing complaints did not always take account of patient's needs. There continued to be poor satisfaction with how patients could access appointments and results from the national GP patient survey had deteriorated. In addition, an internal survey showed poor satisfaction in relation to patient access. The practice had plans to implement a triage system to improve access but this was not yet in place.

Responding to and meeting people's needs

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

| | Y/N/Partial |
|---|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| 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. | Yes |
| 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. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |
| Explanation of any answers and additional evidence: | |
| The practice developed services in response to the needs of the local population. This included the use of staff in advanced roles. | |

| Practice Opening Times | |
|-------------------------|----------------------------|
| Day | Time |
| Opening times: | |
| Monday | 8.30am – 1pm and 2pm – 6pm |
| Tuesday | 8.30am – 1pm and 2pm – 6pm |
| Wednesday | 8.30am – 1pm and 2pm – 6pm |
| Thursday | 8.30am – 1pm and 2pm – 6pm |
| Friday | 8.30am – 1pm and 2pm – 6pm |
| Appointments available: | |
| Monday | 8.30am – 1pm and 2pm – 6pm |

| | |
|-----------|----------------------------|
| Tuesday | 8.30am – 1pm and 2pm – 6pm |
| Wednesday | 8.30am – 1pm and 2pm – 6pm |
| Thursday | 8.30am – 1pm and 2pm – 6pm |
| Friday | 8.30am – 1pm and 2pm – 6pm |

Extended access appointments were available as part of a collaboration with two neighbouring GP practices. Warrior Square Surgery was the main hub for the extended access appointments which were available to patients from all three practices up until 8.00pm Monday to Friday and on alternate weekends. Standard practice opening times was until 6.00pm with emergency access available from 6pm and between 8am and 8.30am through the out of hours provider. Telephone lines were open from 8.00am Monday to Friday.

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 7780 | 372 | 137 | 36.8% | 1.76% |

| 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) | 92.2% | 94.4% | 94.5% | No statistical variation |

Older people

Population group rating: Inadequate

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as **inadequate**. However, there were areas of good practice:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Inadequate

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as **inadequate**. However, there were areas of good practice:

- Patients with multiple conditions had their needs reviewed in one appointment and patients were able to book double appointments if they had additional issues to discuss.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.

- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Inadequate

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as **inadequate**. However, there were areas of good practice:

- Additional nurse appointments were available on Monday and Tuesday evenings and on a Saturday morning, so school age children did not need to miss school.
- 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

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as **inadequate**. However, there were areas of good practice:

- 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 on a Monday and Tuesday and on a Saturday morning providing pre-bookable appointments. Telephone appointments were also available on a Saturday and Sunday morning as part of this extended access service located at the practice.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as **inadequate**. However, there were areas of good practice:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable 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. An advanced nurse practitioner had undertaken additional training to meet the needs of this patient group and appointments were offered at times when the practice was less busy to ensure a calm environment where necessary.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as **inadequate**. However, there were areas of good practice:

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

Timely access to the service

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

National GP Survey results

| | 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: At the December 2018 inspection we found examples of where patient's with urgent needs had not been prioritised. At this inspection we found that patients did have their urgent needs prioritised. | |

| 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 | 24.8% | N/A | 68.3% | Significant Variation (negative) |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| to 31/03/2019) | | | | |
| 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) | 39.0% | 70.2% | 67.4% | 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) | 52.1% | 67.5% | 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) | 64.3% | 76.6% | 73.6% | No statistical variation |

| Any additional evidence or comments |
|---|
| <p>At the December 2018 inspection we found that some patients had experienced difficulties accessing appointments and getting through to the practice by phone. The practice had taken some action to address this by extending the telephone lines and the time that the telephones were open.</p> <p>At this inspection three of the six patients we spoke with during inspection commented on some difficulties getting through to the practice by phone, with online access or with appointments overrunning. Comment cards did not include comments on access to appointments. However, results from the GP patient survey and from the practice's own survey showed evidence of poor satisfaction in relation to getting through by phone and the overall experience of making an appointment. The practice told us they were planning on setting up a new triage system in the next few weeks, having trialled this at other local practices in recent months. They told us they had delayed starting it at this practice because they were aware that access to appointments was a particular concern and wanted to make sure that the system was effective elsewhere before commencing it at Warrior Square.</p> <p>The practice's own survey showed that 44% of patients described making an appointment as being difficult.</p> |

| Source | Feedback |
|--------------------------|---|
| For example, NHS Choices | Since April 2019 there had been 10 reviews on NHS Choices. Half of these were positive and half showed concerns. For example, one review made reference to having an immediate appointment when they needed it. Four of the negative comments included issues with access such as being unable to get through by phone, there not being enough GPs and no appointments available when needed. |

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care. However, it was not clear that adequate consideration of the best way to

support patients making a complaint had been made.

| Complaints | |
|--|----|
| Number of complaints received in the last year. | 19 |
| Number of complaints we examined. | 4 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|--|-------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>Information leaflets were available to patients informing them how to make a complaint. Staff were aware of the process and knew to refer patients to the deputy practice manager who took a lead in coordinating complaints.</p> <p>At the December 2018 inspection we found that there was little evidence of learning from complaints. At this inspection we found that learning from complaints had improved and that there was evidence of discussion at meetings. However, we viewed a number of complaints from a single patient. We were told by the practice that they believed the relationship between the patient and the practice had broken down so had taken the decision to remove the patient from their list. This was done without consideration of other ways in which the practice might support the patient.</p> | |

Examples of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| A patient was unhappy with a misdiagnosis. | The patient was offered a face to face meeting and an alternative clinical opinion was offered. The complaint was discussed in a clinical meeting and learning identified. An apology letter was sent to the patient about a delay in the complaints process. |
| A patient made a number of complaints about their care and treatment. | The practice provided support around the patient's diagnosis, however, they made the decision to remove the patient from the practice list as they believed the relationship between patient and GP had broken down. It was not clear that adequate consideration of other ways to support the patient had been made. |

Well-led

Rating: Inadequate

At the December 2018 inspection the practice was rated as inadequate for well-led due to shortfalls in systems to promote quality and minimise risk, leadership capability and ineffective governance systems. At this inspection we have rated the practice as inadequate for well led services due to shortfalls in governance systems in relation to quality improvement, managing risk and leadership capability.

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. | Partial |
| They had identified the actions necessary to address these challenges. | No |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Partial |
| Explanation of any answers and additional evidence: At the December 2018 inspection we found that some actions to address challenges to quality and sustainability had been undertaken, however some internal quality systems did not have sufficient leadership to guarantee they were operating in a way that ensured ongoing quality improvements. At this inspection we found some improvement to quality systems such as significant events and complaints management. However, there were ongoing issues with clinical audits, reporting of significant events, the supervision of staff in advanced roles, improvements to patient outcomes and patient access. The practice had plans in place to develop the management of the service, including recruitment plans that were to be put in place in the coming week. However, there was no clear succession plan for the nursing team where staff were close to retirement. | |

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. | Partial |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Partial |
| Explanation of any answers and additional evidence: | |

The practice had identified areas for improvement and had clear priorities for the development of the service. This included a future merging of the practice with other local practices as part of a group structure. However, there were areas of the service where there was insufficient focus in relation to the provision of high-quality sustainable care. For example, in relation to quality improvement activities.

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. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Partial |
| 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. | No |
| The practice had access to a Freedom to Speak Up Guardian. | No |
| Staff had undertaken equality and diversity training. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>At the December 2018 inspection we found that the practice Whistleblowing policy was not in line with the NHS Improvement Raising Concerns (Whistleblowing) guidance. For example, it did not detail all of the necessary external organisations to whom staff could speak up to such as NHS England and there was no impartial or independent source identified for staff to access. At this inspection we found that details of external organisations to who staff could speak up to had been added to the policy. However, the practice did not have a named individual identified in the policy as a 'Freedom to Speak Up Guardian'.</p> <p>There was not a strong emphasis on safety and well-being of staff as the practice had not completed environmental risk assessments. When things went wrong people affected by them were given an apology and informed of resulting action, however there was evidence that not all incidents were identified and reported.</p> | |

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

| Source | Feedback |
|--------|--|
| Staff | Staff reported that they enjoyed working at the practice. One member of administrative staff told us that relationships between staff and managers had improved and that there was better support and open discussion. |

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. | Partial |
| There were appropriate governance arrangements with third parties. | No |
| Explanation of any answers and additional evidence: | |
| There were governance structures in place, however systems and processes were not always followed through appropriately and there was a lack of clinical and leadership oversight in some areas. (see table below). | |

| Examples of structures, processes and systems in place. | |
|---|---|
| Practice specific policies | Staff were able to access practice specific policies and procedures on the practice intranet system. |
| Audits | The practice audit plan had been developed to ensure that clinicians were involved in audit activities. However, audits did not always have clear actions to improve quality or patient outcomes and actions were not always timely. This included areas of quality improvement where there was potential risk to patients. |
| Recruitment | The practice had systems in place to ensure that appropriate recruitment checks were carried out prior to employment of new staff. |
| Leadership | There was insufficient evidence of clinical and leadership oversight of some systems and processes within the practice, for example, in relation to actions relating to clinical audit and supervision of non-medical prescribing activities. |
| Significant events | The practice had made improvements to the system for sharing learning from significant events. However, the practice was unable to demonstrate that all incidents were reported. |
| Complaints | The practice had made improvements to the system for managing complaints and there was evidence of discussion and review. However, the system for managing complaints did not always take account of the needs of patients. |
| Patient surveys | The national GP patient survey showed a deterioration in some areas of patient satisfaction, particularly in relation to accessing appointments and getting through to the practice by phone. Action to address this had not been successful in improving satisfaction. |
| QOF | The practice monitored performance against the Quality Outcomes Framework (QOF) to improve outcomes for patients. However, there continued to be issues with performance in relation to asthma and mental health outcomes and there was insufficient evidence of improvement activity. |
| Staff meetings | Meetings were held within the practice and meeting minutes were maintained. This included formal meetings where significant events and |

| | |
|---------------------|---|
| | complaints were discussed. However, nurses reported having regular meetings but these were not minuted. We requested nurse meeting minutes from the practice from the last 12 months and only one set of minutes was provided, from a March 2019 meeting. |
| Staff training | The practice manager monitored staff training to ensure compliance. |
| Safety alerts | Records relating to action taken to address safety alerts were maintained. |
| Business continuity | A business continuity plan was in place. Action to address business continuity included arrangements with other local practices. |

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. | No |
| 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. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Partial |
| Explanation of any answers and additional evidence: | |
| <p>The practice had made improvements in relation to the management of risks relating to fire safety and legionella since the 2018 inspection. However, environmental risk assessments and safety checks were not carried out in line with practice policy.</p> <p>There were assurance systems in place, however these were not regularly reviewed and improved. For example, clinical audits did not always have comprehensive or timely action plans and there was not a comprehensive programme that included clear review or re-audit processes.</p> | |

Appropriate and accurate information

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

| | Y/N/Partial |
|---|-------------|
| Staff used data to adjust and improve performance. | No |
| Performance information was used to hold staff and management to account. | No |
| Our inspection indicated that information was accurate, valid, reliable and timely. | No |

| | |
|--|-----|
| There were effective arrangements for identifying, managing and mitigating risks. | No |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Yes |
| Explanation of any answers and additional evidence: Staff did not always use data to adjust and improve performance. For example, performance in relation to some areas of QOF remained below average and results from national and internal patient surveys showed poor satisfaction in some areas that had not been used to improve performance. Arrangements for identifying, managing and mitigating risks were not effective as not all areas of risk were routinely assessed in line with practice policy. | |

If the practice offered online services:

| | Y/N/Partial |
|--|-------------|
| The provider was registered as a data controller with the Information Commissioner's Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes |
| Any unusual access was identified and followed up. | Yes |

Engagement with patients, the public, staff and external partners

The practice did not 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. | No |
| The practice had an active Patient Participation Group. | Partial |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| Explanation of any answers and additional evidence: The practice did not always act on patient views to improve services and culture. For example, the national GP patient survey showed deteriorating satisfaction in relation to patients' ability to access appointments. The patient participation group had approximately six members. We were told that meetings had not been as regular as they used to be due to changes within the practice. | |

Feedback from Patient Participation Group.

Feedback

We spoke with one member of the group who told us they were hopeful that current changes were leading to improvements. At the most recent meeting in June 2019 discussions included issues with the telephones, GP updates and staffing.

Continuous improvement and innovation

There was evidence of some systems and processes for learning, continuous improvement and innovation, however there were a number of areas where improvements had not been sufficient.

| | 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: There was evidence of some improvements following the December 2018 inspection, however, these improvements were insufficient in relation to areas such as clinical audits, clinical supervision, patient outcomes, risk management and patient satisfaction with how their access appointments. | |

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.