

Care Quality Commission

Inspection Evidence Table

Maples Family Medical Practice (1-545243728)

Inspection date: 16 October 2019

Date of data download: 18 September 2019

Overall rating: Requires Improvement

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

Safe: Requires Improvement

At our previous inspection in February 2019, we rated safe as inadequate and issued a warning notice in relation to safe care and treatment. This was because:

- The practice did not always have clear systems and processes to keep patients safe.
- Systems to support appropriate standards of cleanliness and hygiene were not in place.
- The practice did not always have appropriate systems in place for the safe management of medicines.
- There were gaps in the systems to assess, monitor and manage risks to patient safety.
- The practice did not always learn and make improvements when things went wrong.

Although the service had improved since our last inspection, we found areas where the practice had not fully implemented systems and processes. We have rated the practice requires improvement because:

- We were not assured lessons were being learnt from significant events.
- Not all clinical staff were aware of where the emergency medicines and equipment were held.
- It was not clear that there was an effective system for all safety alerts to be received and reviewed in the practice.

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
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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found:</p> <ul style="list-style-type: none"> • The practice did not have effective systems and processes in respect of safeguarding and sharing information with other agencies or health professionals regarding children and adults who were the subject of a safeguarding concern. • There were no designated safeguarding meetings. • Although we saw that concerns were discussed at clinical meetings, no entry was made in the patient record which meant that other health professionals may not have been aware of an issue or any discussions. • Current and up to date safeguarding registers were not in place. • We found that not all staff were trained to the practice appropriate level of safeguarding and not all staff had received safeguarding training within the last three years. <p>At this inspection we saw improvements:</p> <ul style="list-style-type: none"> • There were monthly meetings held to discuss safeguarding of adults and children. These meetings were well attended by multi-disciplinary teams including early start health visitors and a school nurse. • The practice had comprehensive plans in place on the computer system to identify vulnerable patients. They used visual alerts on vulnerable patients records for identification. • Up to date safeguarding adults and child registers were in place. • All staff were safeguarding trained to the practices appropriate level. Staff knew how to act on safeguarding concerns. 	

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

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
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection we reviewed six staff files. The files were well organised, and recruitment checks were in place. The operations manager had oversight of all staff training and recruitment.</p>	

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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: 1 February 2019	Yes
There was a record of equipment calibration. Date of last calibration: 1 February 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: 18 July 2019	Yes
There was a log of fire drills. Date of last drill: 5 June 2019	Yes
There was a record of fire alarm checks. Date of last check: 15 October 2019	Yes
There was a record of fire training for staff. Date of last training: March/April 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 12 March 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: All staff had received appropriate fire safety training and the practice had one fire warden. We saw evidence that an additional staff member was booked on fire warden training for November 2019. The practice undertook monthly emergency lighting testing and recorded appropriately.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 4 October 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 6 February 2019	Yes
Explanation of any answers and additional evidence: We saw evidence of legionella risk assessment and action plan in place. We reviewed the gas safety certificate and lift maintenance which was current and up to date.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
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: 8 March 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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in February 2019 we found:</p> <ul style="list-style-type: none"> • there was an undated infection prevention and control policy and no risk assessment had been undertaken relating to infection prevention and control. • staff including the infection control lead had not received training. • there were no audits relating to infection control had been undertaken and there was no protocol in place for cleaning of the treatment room in respect of minor surgery. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> • the practice had an in-date infection prevention and control policy and safe practice guidance. This included recognition and management of an outbreak of infection. • the practice had oversight of infection prevention and control auditing however this was not always up to date and complete. For example, the practice had an audit log of clinical sharp boxes checks but was incomplete from July 2019. • the practice had employed a new trained infection control lead. <p>The practice carried out infection control audits every three months and we saw evidence of the annual infection control statement dated March 2019. This was to ensure systems were in place to manage and monitor the prevention and control of infection.</p> <p>The external clinical waste bin had been secured to the building following our previous inspection.</p> <p>At the time of the inspection the practice had employed a new cleaning company who were providing services and audits.</p>	

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.	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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not undertake audits against national guidance.</p> <p>We found in the emergency trolley that the adrenaline had several strengths available that could lead to confusion and error in an emergency setting. The practice was notified and immediately rectified this.</p> <p>We saw that the practice had an effective staff annual leave and sickness leave buddy system in place for clinical oversight of results and correspondence.</p> <p>There was a new locum checklist in place and all new staff were given an induction booklet which included useful information such as practice staff structure and lists of services provided.</p> <p>All staff were aware of how to identify a deteriorating patient.</p>	

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	Yes

needed for their ongoing care was shared appropriately and in line with relevant protocols.	
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Appropriate and safe use of medicines

The practice had 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.13	0.88	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	11.2%	9.6%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	4.82	5.16	5.63	Tending towards variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	3.49	2.32	2.08	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.	Partial ¹
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).	Partial2
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial 3
For remote or online prescribing there were effective protocols for verifying patient identity.	NA
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 last inspection in February 2019 we found that the practice:</p> <ul style="list-style-type: none"> • Did not have in place an effective system or process for the management of high-risk medicines with appropriate monitoring and clinical review prior to prescribing. • There were no formal systems to give assurance regarding the prescribing competence of non-medical prescribers or regular review of their prescribing practice. We were unable to determine whether there was an adequate system for assurance for competence of the non-medical prescribers • There were over 200 patients diagnosed with hyperthyroidism and prescribed thyroxine. There was no system to check if this cohort of patients had received annual thyroid function tests • Medicines which had been initiated in secondary care had not been added to patients records which meant that clinicians may not have been aware of highlighted interactions. • There was no process in place to log prescriptions coming in to the practice or track prescriptions through the practice. The room where boxes of blank prescriptions was unlocked. There was no effective system relating to prescription security. <p>At the inspection in October 2019:</p>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • There was a system in place for management of high risk medicines and we corroborated this with three members of staff. We saw evidence that the GP was involved in checking bloods and requesting that the patient is contacted when monitoring was not completed. • We checked blood monitoring of patients with thyroid problems and found that it was up to date and there was a process for recall. • We saw evidence that prescribed medicines were added to patients records to ensure their full prescribing record was available and we spoke to the pharmacist responsible. • We saw a process for handling repeat prescriptions in place and effective. We saw evidence of an effective system to ensure prescription security and prescriptions tracked through the practice in accordance with national guidance. <p>P1 We saw evidence of nurses discussing cases with GPs on an ad hoc basis and told that individual consultations were discussed at practice meetings but we did not see evidence of structured competence reviews.</p> <p>P2 The practice had control of the prescribing of controlled drugs to ensure under or over use was monitored however, they did not yet have a process for internal review of the prescribing patterns of the clinicians. We were told such review was planned but no date was provided.</p> <p>P3 The practice were aware that their prescribing of antimicrobials was higher than national and CCG average. We were told that the CCG had downloaded searches to examine antibacterial prescribing but the practice had not started to assess their prescribing as yet.</p> <p>The practice had a local Clinical Commissioning Group (CCG) cold chain policy which was dated 2017. Alongside this they had a cold chain protocol that was in date, which they told us they used. The practice had refrigerator temperature checks in place.</p> <p>Not all clinical staff were aware of where the emergency medicines and equipment were held.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	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.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	21
Number of events that required action:	0
Explanation of any answers and additional evidence: We were not assured that there was sufficient learning from significant events. We found that there was	

no overall oversight on all significant events. All significant events were saved on the shared drive however, one GP partner did not know where this was stored. We found that 'near misses' were recorded as significant events. Post inspection the practice provided us with a full oversight significant events document.

The practice audited all expected deaths, surgery significant events and unexpected deaths. These were discussed at the weekly practice meetings.

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

Event	Specific action taken
Potential fridge temperature breach in treatment room – practice unable to retrieve to download temperature of fridge for a brief period of time	As a result of this the vaccinations were disposed of to prevent patient risk and all staff were reminded to document in the specified fridge temperature chart and to ensure data logger is placed at the back of the fridge.
Clinical blood bottle found in clinical waste bin	Staff were informed that all blood bottles were to be disposed in the sharps bin and to be destroyed. Spot checks have now been put into place to prevent reoccurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
We saw that the practice had a safety alerts spreadsheet however, this was not fully completed. Actions were not always recorded. We saw that an alert received in July 2019 had been discussed in a clinical meeting but no actions had been recorded and we identified two patients who should have been identified as affected by this alert. This was addressed by the clinicians during the inspection.	
It was not clear that there was an effective system for all safety alerts to be received and reviewed in the practice although alerts were received by a variety of surgery staff. This had the potential to cause problems if individuals receiving the alerts were away and urgent actions was required.	

Effective

Rating: Requires improvement

At our previous inspection in February 2019, we rated effective as requires improvement. This was because:

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

- The system used to recall patients with long-term conditions for a structured annual review to check their health and medicines needs were being met was not effective.

Although the service had improved since our last inspection, we found areas where the practice had not fully implemented systems and processes. We have rated the practice requires improvement in effective because:

- There was limited evidence of shared clinical audits and learning within the practice. We found there was limited monitoring of the outcomes of care and treatment.
- The system used to recall patients with long-term conditions for a structured annual review to check their health and medicines needs were being met was not effective.
- The practice did not have arrangements for following up failed attendance of children's appointments following an appointment in secondary care
- The practice had higher than average exception reporting for some indicators relating to people experiencing poor mental health.

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.	Partial
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: Staff did not share learning within the team and we did not see any evidence of clinical audits monitoring. Nurses attended education events and had protected learning time however we found that learning was not always shared between staff.	

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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	1.44	0.69	0.75	Tending towards variation (negative)

Any additional evidence or comments

The practice told us that they approached new patients by offering and prescribing sedating anti-histamines (Promethazine/Hydroxyzine) in preference to hypnotics. The practice had a clinical pharmacist and were planning to utilise the sessions to do further work with this going forward.

Older people

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in effective and this applies to all population groups.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.
- All patients over 80 years old were colour coded on the computer system on arrival and prioritised.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in effective and this applies to all population groups.
- The system used to recall patients with long-term conditions for a structured annual review to check their health and medicines needs were being met was not effective. The operations manager was in the process of developing a new recall system to address this.
- 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
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension
- 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

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)	69.5%	79.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	10.4% (53)	11.4%	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)	65.6%	74.9%	77.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	9.2% (47)	10.3%	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)	64.7%	79.4%	80.1%	Variation (negative)
Exception rate (number of exceptions).	11.4% (58)	12.8%	13.5%	N/A

Any additional evidence or comments				
<u>Diabetes indicators</u>				
We reviewed the Quality Outcomes Framework (QOF) data and found variance from 2017/18 and 2018/19 data which is reported below:				
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 (01/04/2018 to 31/03/2019) (QOF) had risen from 66.6% to 71.2% which showed no statistical variation.				
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) had risen from 64.7% to 73.1% which showed no statistical variation.				

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)	83.0%	75.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	12.3% (84)	6.7%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a	87.1%	87.9%	89.7%	No statistical variation

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)				
Exception rate (number of exceptions).	17.4% (36)	12.1%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	78.1%	82.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.3% (31)	3.9%	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)	96.0%	92.3%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.9% (6)	5.8%	6.7%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> The practice has been rated requires improvement in effective and this applies to all population groups. Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets. The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines These patients were provided with advice and post-natal support in accordance with best practice guidance The practice did not have arrangements for following up failed attendance of children's appointments following an appointment in secondary care Young people could access services for sexual health and contraception All patients under 5 years old and patients with children were colour coded on the computer system on arrival and prioritised

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	87	90	96.7%	Met 95% WHO based target

type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	109	114	95.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	109	114	95.6%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	108	114	94.7%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> The practice has been rated requires improvement in effective and this applies to all population groups. 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. We were told that 43.5% of patients had signed up for online services.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	76.5%	N/A	N/A	Below 80% target *
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	70.8%	77.1%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in	65.5%	62.4%	54.4%	N/A

last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) <small>(PHE)</small>				
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) <small>(PHE)</small>	65.0%	68.1%	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) <small>(PHE)</small>	65.6%	57.4%	51.9%	No statistical variation

Any additional evidence or comments

*Cervical screening:

The practice told us they had added an extra cytology clinic once a month and they provided unverified updated figures for cervical screening, for 25-49 year olds, which were at 79.4% and 50-64 was currently at 83.3%.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in effective and this applies to all population groups.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. There was a palliative care register for patients.
- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. The practice worked with the Salvation Army to provider acute medical advice out of hours.
- 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
- The practice reviewed young patients at local residential homes and undertook ward rounds weekly.
- The practice had patients who were resident in a local home for those with acquired brain injuries and carried out weekly ward rounds.
- The practice provided general medical services to women and children at a local women's refuge. These patients were always offered same day appointments.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in effective and this applies to all population

groups.

- The practice had higher than average exception reporting for some indicators relating to people experiencing poor mental health.
- 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.
- 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.
- The practice hosted a mental health facilitator and Let's Talk Wellbeing Therapists (Improving Access to Psychological Therapies [IAPT]) to provide local access to these services for patients
- All staff had received dementia friendly training. We found that the practice did not undertake routine care plans for dementia patients.

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)	100.0%	92.6%	89.5%	Variation (positive)
Exception rate (number of exceptions).	68.6% (48)	37.3%	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)	100.0%	93.3%	90.0%	Variation (positive)
Exception rate (number of exceptions).	65.7% (46)	30.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	88.9%	79.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	10.0% (9)	8.0%	6.6%	N/A

Any additional evidence or comments

The practice employed an allied mental health facilitator who ran clinics and oversaw the QOF register. Although the exemption rate was high we saw evidence that it has dropped from 68.6% to 46% as of 31 March 2019. This data is unverified.

The practice had a plan for health care assistants to become more proactive in patients attending or annual assessments rather than patients having the three-invite rule then exempt. The practice were currently piloting a courtesy call to all patients who have a 20 minute appointment a day before to check they are still attending or if not rebooking the appointment. This included patients with asthma, chronic obstructive pulmonary disease, diabetes, mental health and dementia.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	522.5	534.0	537.5
Overall QOF score (as a percentage of maximum)	93.5%	95.5%	96.2%
Overall QOF exception reporting (all domains)	5.6%	5.4%	5.8%

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

Any additional evidence or comments

The practice did not have an annual audit plan to monitor audit cycles or track learning.

We found that the practice had not undertaken any guidance-based audits. Staff were individually auditing their clinical practices, but this was not shared across the practice. The practice was not aware of the impact of audits and unable to demonstrate outcomes for patients.

Effective staffing

The practice was able to demonstrate that 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.	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.	Partial1
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	No
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in February 2019 the practice were in the process of upskilling some staff but overall there was not a system to assess the learning and development needs of staff and only a limited number of appraisals had been completed. At this inspection we saw evidence of staff appraisals undertaken.</p> <p>The practice manager had an overview of all staff training to assist them in the monitoring and completion of training.</p> <p>P1 Staff told us that the protected learning time was being reviewed and implemented. Staff could attend training days off site in order to upskill themselves in their roles.</p> <p>There were opportunities for staff to job shadow colleagues and staff told us of an open-door policy for guidance and support. As part of the practice meeting agenda staff could discuss and review consultations peer to peer.</p>	

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.	NA
<p>Explanation of any answers and additional evidence:</p> <p>We saw there were 44 patients on the palliative care register. We were told that the practice were monitoring monthly and reporting on vulnerable patients, looked after children, child in need, child on a protection plan and patients with a do not resuscitate plan.</p> <p>The practice held quarterly Gold Standard Framework meetings however the minutes of these meetings were not saved onto the clinical system. Gold standard Framework is to enable earlier recognition of patients receiving end of life care.</p>	

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.	Yes

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>	100.0%	95.0%	95.1%	Significant Variation (positive)
Exception rate (number of exceptions).	0.4% (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.	NA

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.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

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
10294	270	116	43%	1.13%

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)	86.8%	88.8%	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)	85.7%	86.4%	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)	94.5%	95.7%	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)	77.7%	82.7%	82.9%	No statistical variation

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

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: To ensure that vulnerable adults received appropriate support the practice signposted or made referrals to District Nurses, Cruise, local counselling services and First Contact Plus which was a Leicestershire wide service that enabled a number of agencies to work together.	

Source	Feedback
Interviews with patients.	We spoke with six patients who told us that they were happy with the service provided by the practice. Patients felt engaged in their care decisions and recommended the practice.

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)	94.5%	94.9%	93.4%	No statistical variation

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

The practice had a member of staff who spoke many languages including Gujarati, Hungarian, Punjabi and Arabic.

Carers	Narrative
Number of carers identified.	The practice had 93 carers which is 1% of the patient list.
How the practice supported carers (including young carers).	The practice had a carers lead that led an annual assessment including coping mechanisms and there were appropriate referrals made for example; staff undertook depression scores for carers and would refer to the GP if needed. The practice prioritised flu vaccinations for carers.
How the practice supported recently bereaved patients.	Condolence letters were sent to patients next of kin. The practice had added an icon onto the clinical system for bereaved patients and they were offered same day appointments. There was a 'recent bereavement reminder' on the computer home screen and this detailed the relationship to patient and the date they had passed away. This ensured staff were aware to be sensitive when speaking to bereaved patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Requires Improvement

At our previous inspection in February 2019, we rated responsive as requires improvement. This was because:

- Patients feedback that they were not always able to access care and treatment in a timely way.

Although the service had improved since our last inspection, we found areas where the practice had not fully implemented systems and processes. We have rated the practice requires improvement in responsive because:

- The practice did not have clear oversight of complaints and we were not assured risk was being monitored
- We found that the practice did not undertake routine care plans for patients with dementia.
- The practice did not have a system in place to improve their GP patient survey results.

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:	
As a result of the last inspection and the PPG survey feedback the practice had implemented a new patient telephone system with queue positioning.	
The practice had a hearing loop in place and following the last inspection the practice had advertised this service with posters for patients. The practice welcomed guide and therapy dogs. We saw the check in screen had multiple language options and staff had access to translation services for patients.	

Practice Opening Times

Opening times:

Day	Time
Monday	08.30am to 1.00pm 2.00pm to 6.30pm
Tuesday	08.30am to 1.00pm 2.00pm to 6.30pm
Wednesday	08.30am to 1.00pm 2.00pm to 6.30pm
Thursday	08.30am to 1.00pm 2.00pm to 6.30pm
Friday	08.30am to 1.00pm 2.00pm to 6.30pm

Appointments available:

Monday	8.30am to 10.30am sit and wait clinic. Pre-bookable appointments in the afternoon
Tuesday	8.30am to 10.30am sit and wait clinic. Pre-bookable appointments in the afternoon
Wednesday	8.30am to 10.30am sit and wait clinic. Pre-bookable appointments in the afternoon
Thursday	8.30am to 10.30am sit and wait clinic. Pre-bookable appointments in the afternoon
Friday	8.30am to 10.30am sit and wait clinic. Pre-bookable appointments in the afternoon
	Bookable appointments for elderly and vulnerable patients were offered at the end of the sit and wait clinic.
	The practice offered the working age population appointments after 5.00pm.
Extended hours	This service was commissioned by the CCG and appointments were available in early morning, evenings and weekends at the following locations and could be made through the practice:

Loughborough Urgent Care Centre at Loughborough Community Hospital Coalville Community Hospital Centre Surgery, Hinckley
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National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10294	270	116	43%	1.13%

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)	98.8%	94.1%	94.5%	Tending towards variation (positive)

Older people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> The practice has been rated requires improvement in responsive and this applies to all population groups. 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. Health care assessment invites are sent to patients over 75. Practice nurses visited housebound patients to provide an anti-coagulation service and flu vaccinations. Practice nurses also carry out chronic illness management for house bound patients i.e. COPD and diabetes. GPs carried out ward rounds at local care homes. Seasonal flu vaccinations were prioritised to these patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> The practice has been rated requires improvement in responsive and this applies to all population groups. The practice had implemented a quarterly combination chronic illness clinic. This enabled patients with multiple conditions to have their needs reviewed in one appointment. The practice provided a fortnightly combination clinic for patients with diabetes and chronic heart disease. The practice liaised regularly with the local district nursing team to discuss and managed 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 and the practice used the Gold Standard Framework.

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in responsive and this applies to all population groups.
- Nurse appointments were available outside of school hours for school age children so that they did not need to miss school.
- Parents or guardians with concerns about a child could attend the daily sit and wait clinic which ensured children were seen the same day and prioritised in clinic.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in responsive and this applies to all 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.
- Pre-bookable appointments were also available to all patients at additional locations within the area, through a service commissioned by the local CCG. Appointments were available in early morning, evenings and weekends.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement in responsive and this applies to all population groups.
- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. The practice had a travelling family registered permanently with them.
- People in vulnerable circumstances were easily able to register with the practice. The practice had patients in a local women's refuge. They were prioritised and seen the same day
- 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: Requires Improvement

Findings

- The practice has been rated requires improvement in responsive and this applies to all population groups.
- Priority appointments were allocated when necessary to those experiencing poor mental health. Patients, for example with anxiety, could sit and wait in a private room if necessary.
- The practice was aware of support groups within the area and signposted their patients to these

accordingly.

Timely access to the service

People were 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice prioritised patients care and took into account vulnerable, elderly, young and patients with complex health needs.</p> <p>This is a dementia friendly practice and all staff had dementia awareness training.</p>	

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)	57.2%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	47.9%	66.1%	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)	34.9%	61.7%	64.7%	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)	57.9%	75.2%	73.6%	Tending towards variation (negative)

Any additional evidence or comments

For the National GP Patient Survey, 270 surveys were sent out and 116 were returned. There was a 43% completion rate, which reflected 1.13% of the practice population

Source	Feedback
For example, NHS Choices	There were seventeen ratings for this surgery on NHS Choices and they were rated 4.5 stars. The last review was September 2019. The practice has responded to feedback on NHS choices. Feedback on the website was positive.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	1
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
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>We were not assured that there was learning from complaints and saw the process was not fully embedded across the wider team. Post inspection the practice provided evidence that this had been put in place including detailed and dated progress and outcomes. We were not assured that these had been used to drive continuous improvement.</p> <p>The practice had a fully embedded complaints flowchart process and information was available for patients. We saw evidence of a complaint's information sheet for patients.</p>	

Well-led

Rating: Requires Improvement

At our previous inspection in February 2019, we rated well led as inadequate. This was because:

- Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- While the practice had a clear vision, that vision was not supported by a credible strategy.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- We saw little evidence of systems and processes for learning, continuous improvement and innovation.

Although the service had improved since our last inspection, we found areas of where the practice had not fully implemented systems and processes. We have rated the practice requires improvement in

well led because:

- The practice did not have effective governance systems and processes in place.
- Although the practice were developing a business plan there was not one in place at the time of inspection.
- Although there were systems in place for identifying, managing and mitigating risks, these needed to be strengthened and become embedded

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.	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: The practice had employed an operations manager since February 2019 who was embedding new leadership processes and procedures. At the time of our inspection the practice could not provide a current business plan with a clear strategy for the future. The practice had a risk register in place, but we were not assured that there was clear oversight from all leaders. Following our inspection, the practice provided us with a business plan which included practice sustainability, succession planning and their values. The practice did have a business continuity plan.	

Vision and strategy

The practice did not have a clear vision and was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
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.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: The practice told us that they were developing a comprehensive strategy and future business plan. The practice told us that they had planned to meet post last inspection in February 2019 to develop this but had yet to meet. The business plan was provided post inspection.	

The practice told us that their challenges ahead were reduction in clinical staff, peer support and referrals meetings. We did not see any evidence of this on the risk register.

The practice had a mission statement which was displayed in the waiting room and on the website.

Culture

The practice had a culture which drove 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.	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.	NA
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a good ethos. Their vision included providing patients with high quality, evidence based, comprehensive range of holistic and patient centred services. They told us that they encouraged patients to take responsibility for their own health and well being and have strong communication across the whole practice team. However, there was a lack of documented strategy to support this.</p> <p>We were told by staff that there was a no blame culture and staff had good working relationships with external agencies.</p>	

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

Source	Feedback
Staff interviews	<p>A staff member told us that they felt there were enough staff and felt supported by the leadership team.</p> <p>Staff told us that the partners were approachable and the practice was a good place to work.</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial

There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<p>Following our inspection in February 2019 the practice together with the CCG implemented an action plan advising how they would comply with the requirement notices. We saw evidence that the practice had made significant improvements and were compliant with the action plan they had submitted. However, we identified that oversight of practice procedures was not always effective.</p> <p>Staff were not always clear on their roles and responsibilities. For example, the infection control lead had not attended training to enable them to fulfil the role.</p> <p>Governance structures were in place and implemented by the operation manager. We found a review of them had not been fully effective but this was an ongoing process.</p> <p>The practice did not undertake internal audits. We saw a lack of clinical input and leadership oversight, for example non-medical prescribing and a lack of structured review of nurses' clinical decision making.</p>	

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.	Yes
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.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No
Explanation of any answers and additional evidence:	
<p>We saw internal audits and risk assessments for the practice were carried out. There was limited evidence of clinical audits. We were told by staff that they undertook individual audits for example; cytology but this was not audited as a wider practice.</p> <p>The practice did not have a formal process to assure themselves of the competencies of non-medical prescribers. There were no systems to review the clinical activity of staff to ensure practices were appropriate and that staff worked within their competencies.</p>	

Processes to ensure all staff completed training identified as necessary by the practice were embedded. The practice was aware that all staff had completed training in line with practice policy.

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	
Although there were some systems in place for identifying, managing and mitigating risks, these needed to be strengthened and become embedded.	
There were limited risk assessments in place and where they had been carried out, not all actions identified had been acted upon.	

Engagement with patients, the public, staff and external partners

The practice involved 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.	Yes
The practice had an active Patient Participation Group.	Yes
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:	
We spoke to the chairperson of the Patient Participation Group (PPG) who told us that the practice worked well with them and kept them informed of the developments in the service. They told us that the practice listened to them and were involved supporting them to raise health awareness to patients.	
The PPG met every three months and shared information from locality meetings. The chairperson attended the locality PPG meetings to feedback and share learning.	

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.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
There was limited evidence of quality improvement work and no evidence of discussions at practice meetings. We were not assured that learning was shared across the wider practice to encourage improvement.	
We found that discussion and learning from significant events and complaints was discussed at the weekly practice meetings attended by nursing and reception / administration staff and could be accessed but actions were not clear, or progress logs documented.	
We saw a structured training plan for staff within the practice.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England

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