

Care Quality Commission

Inspection Evidence Table

Dr Paramjit Wasu (1-526774472)

Inspection date: 25 June 2019 and 23 July 2019

Date of data download: 23 July 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

The practice was rated Inadequate for providing safe services because:

- The practice did not have clear systems, practices and processes to keep people safe.
- The practice did not have adequate infection control systems in place.

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

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- Staff did not always have the information they needed to deliver safe care and treatment.
- The practice did not have systems for the appropriate and safe use of medicines.
- The practice did not have an effective system to learn and make improvements when things went wrong.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	N
Partners and staff were trained to appropriate levels for their role.	N

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	N
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	Partial
Explanation of any answers and additional evidence: • There was no vulnerable adults or children at risk register. • Safeguarding policies were not accessible to all staff. One clinician told us that they did not have access to the policies due to ongoing IT issues which had not been resolved at the time of inspection. • There was no evidence provided to show policies took account of patients accessing online services. • Not all staff were trained to appropriate levels of their role. For example, one clinician had last received level three safeguarding training in 2014. There were gaps in safeguarding training for three other staff, with no evidence provided of any recent safeguarding training. • It was not clear how often safeguarding policies would be reviewed. • There was no evidence provided that the out of hours service was informed of relevant safeguarding processes. However, the lead GP told us that he was accessible out of hours, particularly for the care home patients. • There were no regular discussions between the practice and school nurses and community midwives. However, referrals were made to external clinics where required and there was evidence of discussions with health visitors. • The practice did not always effectively engage in local safeguarding processes. This is in relation to a safeguarding incident whereby the practice had failed to notify the external safeguarding lead until eight months after the incident, missing the opportunity for safeguards to be put in place.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N

Explanation of any answers and additional evidence:

- There were no effective recruitment and selection processes. The practice told us references were not usually sought for new staff which had led to staff dismissal during a probation period.
- When we reviewed three new staff recruitment records, we found one recently recruited clinician did not have a CV, full employment history or references. Two other recently recruited staff members only had one reference on file despite the practice recruitment policy stating that two references should be obtained.
- There was no evidence to show how the registration of nursing staff was continuously monitored. The practice had registration records that had expired in 2017 and had no checking system in place to ensure clinicians remained appropriately registered with their professional body and national performers list.
- There was no system in place to monitor that staff were up to date with their immunisations. When we reviewed staff immunisation records, there was no evidence that staff received all the required immunisations as per PHE guidelines. This included measles, mumps, rubella, typhoid, diphtheria and chicken pox. There were also no immunisation records obtained for three recently recruited staff members.

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: July 2018	Y
There was a record of equipment calibration. Date of last calibration: 8 April 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check:	Not inspected
There was a log of fire drills. Date of last drill: 18 June 2019	Y
There was a record of fire alarm checks. Date of last check:	Not inspected
There was a record of fire training for staff. Date of last training:	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Not inspected
Actions from fire risk assessment were identified and completed.	Not inspected
Explanation of any answers and additional evidence:	

There was no evidence that all staff had received fire safety training. When we viewed four training records, we saw only one staff had received fire safety training.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Not inspected
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3 June 2019	Partial
Explanation of any answers and additional evidence: • The health and safety risk assessment identified that a COSHH risk assessment was required. This had not been carried out at the time of inspection. • A disability access audit was carried out; however, not all actions had been completed. For example, the audit identified that a visible alarm was required in the downstairs patient toilet and this had been classified as high risk. The practice told us that this had been overlooked. • An electrical installation check was carried out on 5 September 2018. • A legionella risk assessment was carried out in June 2019. The recommended actions such as water temperature checks had been carried out.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21 June 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence: • The practice used the GP TeamNet system to remind staff of their update training. Staff were sent a link via email that they were required to acknowledge. When we reviewed the training records stored on this system, there were gaps in infection control training. • Clinical waste bins were not labelled. • Although there was an infection control policy there were gaps as there was no sharps injury	

policy displayed in the clinical rooms and not all staff were aware of the action to take in the event of a sharps injury.

- There was no cleaning schedule for the spirometer or nebulizer. The cleaning schedule in place was only for the ear irrigator.
- The practice was a registered yellow fever centre and carried out yellow fever vaccinations. One of the nurses had been trained to administer yellow fever vaccinations. However, there was no evidence of risk assessments carried out for patients receiving this vaccine. We reviewed one yellow fever travel vaccine record, a risk assessment had not been carried out.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
Clinicians knew how to identify and manage patients with severe infections including sepsis.	N
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.	N
There was a process in the practice for urgent clinical review of such patients.	N
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

- There was evidence of a locum induction checklist
- We were not assured that comprehensive risk assessments were being carried out for patients. Ten of the patients records we reviewed during our visit on 25 June 2019 and 22 of the records we reviewed during our visit on 23 July 2019 showed significant gaps in record keeping such as, minimal history taking, suboptimal examinations and lack of follow ups.
- Not all risk management plans were developed in line with national guidance. For example, we saw evidence of using the guidance in the management of patients presenting with hypertension. However, when asked about the management plans for patients presenting with sepsis, the GP suggested carrying out a blood test, instead of ensuring the patient immediately attended the emergency department, demonstrating a lack of understanding of the process of urgent assessment of patients with presumed sepsis according to the recommended guidelines.

- There was no policy on how to deal with medical emergencies. Staff told us in the event of an emergency they would notify the GP and call emergency services if required.
- There were no sepsis posters displayed in the practice. Not all non-clinical and clinical staff had recent training in identifying and managing sepsis. There was no evidence of sepsis discussions at practice meetings.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	N
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
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.	Y

Explanation of any answers and additional evidence:

- The practice told us that patient records, with the exception of new patient notes were being stored electronically offsite, using a secure offsite storage service. However, 0% of new patient notes had been summarised at the time of inspection.
- There was no evidence of a monitoring system of two-week wait referrals when we carried out the visit on 25 June 2019. When we reviewed one two-week wait referral, it did not contain adequate information, such as a complete history and examinations and risked rejection. When we carried out the second site visit on 23 July 2019, we saw that the practice had improved and there were no issues identified with the five two-week wait referrals that we reviewed.
- There was no specific policy on the management of test results, although results were checked daily and actioned where required. There were no concerns identified on inspection relating to the actioning of abnormal results.

- When we reviewed cervical smear consultation records, we found minimal records of the screening consultations in five of the six records we reviewed. For example, 'cervical smear taken', with no further details were recorded. There were no red flag discussions for all six records and there were missed opportunities to discuss contraception and sexual health screening. We saw evidence that one nurse attached a smear request form as their consultation.
- The clinicians were not aware of their inadequate smear rate and an audit had not been carried out. There was no failsafe system in place and when we spoke to one clinician, they were not aware of their uptake rate.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	1.08	0.72	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)	10.3%	12.1%	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)	6.29	6.25	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	0.88	0.96	2.07	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
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.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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.	Y
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	N
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	N
Explanation of any answers and additional evidence: - Emergency medicines were stored in a locked cupboard with the key kept in an adjacent cupboard and therefore not easily accessible in an emergency. - Blank prescriptions were kept securely, with evidence of serial number logs and monitoring of distribution. However, serial numbers were only logged when the prescriptions were refilled and not when they were redistributed throughout the practice. - During the inspection of 25 June 2019, we saw Patient Group Directions (PGDs) were not being signed by the GP and at times by both nurses at the practice. We reviewed a sample of 13 PGDs and found 11 had not been signed at all by an authorising manager and some of the PGDs had either been signed by just one nurse or both nurses. When we carried out the second site visit on 23 July 2019, we saw that all the PGDs had now been appropriately signed by both the GP and practice nurses.	

- During the inspection on 25 June 2019, we saw that one patient prescribed methotrexate (immunosuppressant) did not have up to date blood tests and one patient prescribed warfarin (anticoagulant) did not have documented blood test results on their records. However, when we carried the second site visit on 23 July 2019, this had now been resolved by the practice.
- There was no evidence of arrangements for raising concerns regarding controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. There was no reference to this in their prescribing policy.
- The practice did not hold all appropriate emergency medicines and risk assessments were not in place to determine the range of medicines held. For example, there was no atropine (for slow heart rate) stocked by the practice despite carrying out minor surgery and they did not stock benzylpenicillin, or alternative for meningitis.
- There was medical oxygen and defibrillator at the practice. However, systems to ensure the oxygen and defibrillator were regularly checked and fit for use were inadequate. Staff were not clear of their responsibilities to monitoring these items and the checklist in place was outdated as it contained names of staff no longer working at the practice.
- There was no evidence of historic checks of the emergency medicines and oxygen.
- When we checked the defibrillator, we found that it had failed its test and indicated that batteries required changing. Staff were not clear of how to change the batteries and when the battery compartment was opened, we saw that the batteries had expired three months prior and there were no spare batteries readily available at the practice.
- One of the clinicians told us they had not been trained to operate the defibrillator despite a possibility that they would be the most senior clinician at the practice if the GP had to attend a home visit.
- Staff could not demonstrate an understanding of the cold chain process despite available guidelines. When we checked the vaccines fridge temperature monitoring records, we saw fridge temperature readings for the previous month in both fridges were consistently the same. For example, the maximum reading for one fridge was 9.8°C, outside the normal temperature range of 8°C, with a minimum reading of 3°C. The second vaccines fridge had a minimum reading for the entire month of June where the maximum temperature was 1.5°C and the minimum temperature reading was 0.3°C, outside the normal ranges of 2-8°C. There was no evidence of any action taken, such as raising a significant event, or whether both the fridges were being reset each time and the practice continued to administer vaccines despite this. There were no data loggers at the practice. Staff were unclear whose responsibility it was to monitor the vaccine fridge temperatures.
- Temperature readings for both vaccines fridges had not been checked on a total of six occasions in June 2019.
- At our second site visit on 23 July 2019, the practice had purchased a data logger but staff were unclear on how to use it. The fridge temperatures for both vaccines fridges were still out of temperature range for half the month of July despite nurse checks and no action had been taken. The practice was advised to inform NHSE urgently due to risk that the vaccines were no longer viable due to the amount of times both vaccines fridges had been out of the appropriate temperature range. The inspection team also contacted NHSE who took the required appropriate action.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	N
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	N
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: - Not all staff knew how to identify and report safety incidents. We found that some clinical and non-clinical staff were unclear about learning from incidents. - There was a system for recording on significant events; however, the system for acting on significant events was not always clear. We saw evidence of learning outcomes but there was insufficient evidence to show what actions were taken to embed that learning. For example, when a sample missed a collection due to being left in the clinical room, learning was to ensure tasks were completed at the time they were carried out. It was not clear what safeguards were put in place to embed this learning. - The practice did not report incidents to external bodies in a timely manner. This was in relation to a safeguarding incident whereby the practice had failed to notify the external safeguarding lead until eight months after the incident, missing the opportunity for appropriate action to be taken. - Although there were meeting minutes, we did not see evidence that learning from significant events were shared during these meetings. The practice had not ensured staff unable to access their emails or the shared drive were provided with learning from significant events.	

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

Event	Specific action taken
Sample left in clinical room	Learning was to not leave incomplete tasks and relevant staff to attend further training. There was no clear evidence of action taken or follow up that the staff member had received

	training.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: Staff understood how to deal with alerts; however, the practice had not ensured that all safety alerts were shared with all clinicians. For example, not all clinicians could attend clinical meetings due to their working hours and one clinician did not have access to the practice system or their emails due to ongoing IT issues. No arrangements were in place to ensure that these clinicians were aware of the alerts.	

Effective

Rating: Inadequate

The practice was rated inadequate for providing effective services because:

- Patients' needs were not always assessed and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.
- There were significant gaps in patient care and treatment.
- The monitoring of outcomes of care and treatment was not operating effectively.
- The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.

These areas affected all population groups so we rated all population groups as inadequate.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	N
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	n/a
Explanation of any answers and additional evidence: • There was no evidence to show the practice had systems in place to keep clinicians up to date with current evidence-based practice. The practice told us that meetings were held and meeting minutes circulated to all staff. The practice did not monitor staff who did not attend meetings had read the circulated meeting minutes. When we spoke to one member of staff who was unable to attend meetings due to their working hours, they could not recall receiving any meeting minutes.	

- We saw evidence that patients immediate and ongoing needs were not always fully assessed. For example, when we reviewed clinical records on the 25 June visit, we saw evidence of significant gaps in record keeping in 10 clinical records we reviewed. This included limited history taking and examinations, with no evidence of advice or follow up arrangements in most of these notes. When we carried out the second site visit on 23 July, we reviewed 67 clinical records, over all the population groups in found significant gaps in ensuring patient needs were fully assessed.
- Patients presenting with symptoms which could indicate serious illness were not always followed up in a timely way. For example, one patient referred via the two-week wait pathway was not followed up. We also saw that one COPD patient had no arranged follow up appointment with the GP after a nurse consultation.
- Although we saw that clinicians were aware of the NICE guidelines, not all clinicians were aware of how or if they were being used at the practice.
- We did not find evidence of clinical supervision or adequate support for newly recruited nursing staff in practice.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	1.62	0.56	0.77	Tending towards variation (negative)
Any additional evidence or comments				
• The GP was aware of the high hypnotics prescribing but it was not clear what action had been taken to improve this. They told us that patients were advised on sleep hygiene and prescriptions were provided only when required, with a one month's supply.				

Older people

Population group rating: Inadequate

Findings
• The practice looked after older patients in two care homes. The GP would attend ward rounds once a week on Wednesdays. • 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, including patients looked after at the care homes. • 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. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

Findings

- There was no specific monitoring of unplanned admissions including any recall system for asthma patients admitted into hospital. The practice told us unplanned admissions were only discussed at the patient's next appointment. The practice told us that they would rely on the hospital to signpost the patient to the GP or wait for the patient to attend the practice.
- Patients with long-term conditions were offered an 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. However, there significant gaps in this system. While we saw evidence of adequate reviews for some patients with long-term conditions, some reviews were incomplete and did not contain adequate information. For example, when we reviewed 13 consultation records for patients diagnosed with diabetes, we found evidence of limited recorded examinations in two records and evidence of missed opportunities to carry out average blood sugar level testing in one record.
- Not all pre-diabetes patients were referred to diabetes prevention programmes, instead they were signposted to online resources or given verbal advice.
- When we reviewed eight consultation records for patients diagnosed with asthma, we found evidence of limited history taking and limited examinations in four of the records. We also saw peak flow measurements and inhaler techniques were not recorded in three of the consultations.
- When we reviewed seven consultation records for patients diagnosed with chronic obstructive pulmonary disease (COPD), we found evidence of limited history taking, no peak flow monitoring or arranged follow ups for findings on examination.
- There was evidence of clear and accurate information shared with relevant professionals when deciding care delivery for patients with long-term conditions. However, we saw evidence of limited recorded history on one COPD patient's referral letter to the hospital, making it difficult to establish the reason for the referral.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. However, there was no evidence of up to date long-term condition training for one clinician, despite them carrying out reviews.
- Patients with suspected hypertension were offered blood pressure monitoring at the surgery.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

		average	average	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)	71.4%	79.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	5.0% (16)	8.8%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) ^(QOF)	79.6%	78.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.3% (23)	7.6%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) ^(QOF)	81.9%	80.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	6.0% (19)	9.6%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) ^(QOF)	87.0%	79.7%	76.0%	Variation (positive)
Exception rate (number of exceptions).	3.8% (7)	4.8%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) ^(QOF)	61.5%	92.2%	89.7%	Variation (negative)
Exception rate (number of exceptions).	50.0% (13)	8.3%	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)	81.8%	83.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.0% (15)	3.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	80.6%	83.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	24.4% (10)	8.2%	6.7%	N/A

Any additional evidence or comments

- Overall exception reporting was 7%, higher than CCG and national averages of 6%. There was no evidence to show what action had been taken to analyse and improve on low QOF scores and high exception reporting.
- The practice were unable to explain the low COPD performance figures.

Families, children and young people

Population group rating: Inadequate

Findings

- 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.
- 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), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	22	25	88.0%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	11	18	61.1%	Below 80% uptake
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)	13	18	72.2%	Below 80% uptake
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)	13	18	72.2%	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

Childhood immunisation uptake rates were not in line with the World Health Organisation (WHO) targets. There was no evidence provided to show the practice had analysed their childhood immunisations uptake. We found that lack of nursing hours had a negative impact on immunisations uptake. The practice told us that there were no specific baby clinics; however, patients were sent text message appointment reminders and were contacted when they missed their appointments.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- 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.
- Patients could 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)	59.7%	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)	67.4%	69.4%	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)	38.1%	48.5%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	40.0%	75.4%	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)	50.0%	57.9%	51.9%	No statistical variation

Any additional evidence or comments

- The practice was aware of the low cervical screening uptake. They told us that despite active recall, patients would decline and therefore uptake was low. However, we found lack of nursing hours had an impact on uptake for cervical screening.
- There was no evidence provided to show how the practice would improve bowel cancer screening uptake.

People whose circumstances make them vulnerable

Population group rating: Inadequate

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 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

- 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 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) (QOF)	85.3%	92.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	15.0% (6)	8.3%	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)	97.3%	92.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.5% (3)	6.3%	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) (QOF)	93.0%	88.1%	83.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	6.5% (7)	6.1%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	498.5	540.9	537.5
Overall QOF score (as a percentage of maximum)	89.2%	96.8%	96.2%
Overall QOF exception reporting (all domains)	6.8%	5.8%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N
Quality improvement activity was targeted at the areas where there were concerns.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N

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

- At our previous inspection on 6 September 2019, the practice did not have an established programme of clinical audit to drive improvement. At this inspection, although we saw evidence of a programme of quality improvement using clinical audits, they were not comprehensive and they did not demonstrate improvements. For example, when we reviewed the COPD and two-week wait audits, which discussed treatment and two-week wait guidelines respectively; however, there were no clear aims or outcomes and unclear how these audits were used to improve patient care.
- There was no evidence quality improvement activity was targeted at the areas where there were concerns. The practice was aware of their low cervical screening uptake but had not carried out any quality improvement in this area.
- There was no specific monitoring or regular reviews of unplanned admissions. The practice told us unplanned admissions were only discussed at the patient's next appointment.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- At our previous inspection of 6 September 2018, there were gaps in induction processes. At this inspection, we found although there was an induction programme in place, there were no induction records on file for three new staff. There was no oversight of nursing staff training records and the practice could not demonstrate how they assured the competence of staff, particularly nursing staff. They were unable to provide evidence of CPD training or clinical supervision for the nursing staff at the start of and during their employment.
- The practice did not ensure staff had the skills, knowledge and experience to carry out their roles and the learning and development needs of staff were not assessed effectively. This was due to concerns identified in monitoring the vaccines fridge temperatures. Despite evidence showing some clinicians had received training in monitoring of the cold chain, there was no system to ensure they were competent with this process. Non-clinical staff had not received any training in monitoring of the cold chain.
- The practice was unable to demonstrate if all staff had received up to date mandatory training. The training record submitted by the practice as part of their pre-inspection return was out of date as it contained names of staff no longer employed at the practice and did not include staff employed six months prior to the inspection. Some training records had been exported to their GP TeamNet system; however, this also contained incomplete training records. For example, there were no nurse continued professional development (CPD) records stored on this system. Training records were only produced by the practice after the second site visit.
- A review of staff training records on 25 June 2019 showed gaps in sepsis, information governance and fire safety training.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	n/a
Explanation of any answers and additional evidence: There was multidisciplinary team working; however, there were no recorded meeting minutes.	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	98.5%	96.3%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0.9% (6)	0.6%	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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	16
Number of CQC comments received which were positive about the service.	15
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Comment cards	Patients felt the GP was kind and the practice provided a caring service and staff were courteous and helpful. One comment card highlighted issues with high staff turnover and management.
NHS Choices	Mixed reviews relating to patient care. Some patient reviews showed patients were satisfied with the service, whilst other reviews highlighted issues with staff attitude.

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
2530	444	84	18.9%	3.32%

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)	80.7%	88.2%	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)	79.6%	86.1%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	88.9%	94.9%	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)	77.7%	81.2%	82.9%	No statistical variation

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

Any additional evidence
- The practice carried out their own Friends and Family Test survey. Results for May and June 2019 showed that 85% of patients would recommend the practice to friends and family. - There was no evidence that the practice had analysed the GP national patient survey which showed patient satisfaction was lower than local and national averages.

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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

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)	86.7%	92.5%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice told us that there was a book with a list of carers kept in the reception; however, this was not reviewed during the inspection.
How the practice supported carers (including young carers).	The practice developed a 'carers passport' for their carers at the practice. This included information about useful contacts and summarised the carer's entitlements at the practice, such as access to health checks, flu immunisations and the flexibility to request prescriptions over the telephone if appropriate.
How the practice supported recently bereaved patients.	The GP contacted bereaved patients and provided support where required.

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.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	N
Explanation of any answers and additional evidence: - There was no evidence of an Accessible Information Standard policy. - There was a hearing loop at the practice but not all staff were aware of how to operate it.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am – 6.30pm
Tuesday	8:00am – 6.30pm
Wednesday	8:00am – 6.30pm
Thursday	8:00am – 6.30pm
Friday	8:00am – 6.30pm
Extended hours:	
Monday	6:30pm – 7:30pm
Friday	6:30pm – 7:30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2530	444	84	18.9%	3.32%

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)	88.4%	93.9%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings

- 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.
- Patients were offered longer appointments and community support.
- The practice provided effective care coordination to enable older patients to access appropriate services. Two of the staff members were designated care home co-ordinators and care home patients could access the lead GP out of hours where deemed necessary.
- The GP supported patients to access day care centres to prevent isolation.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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 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: Good

Findings

- The practice told us that 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.
- All parents or guardians calling with concerns about a child were offered a same day or urgent appointments when necessary.
- The practice implemented a children's medical passport for parents to update in case of emergency treatment or hospital admissions. This would be reviewed periodically with parent participation.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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 7.30pm on a Monday and Friday. Patients could access appointments, view their medical records and request prescriptions online.
- The practice implemented a text messaging system for appointment reminders, invites and targeted messages following results.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice did not hold a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. However, 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. Patients were offered longer appointments.

People experiencing poor mental health (including people with

Population group rating: Good

dementia)

Findings

- 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 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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Partial
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Explanation of any answers and additional evidence:

At our previous inspection on 6 September 2018, the practice had allowed parallel processes to develop to govern home visit requests. At this inspection on 25 June 2019, we found this had not improved. Staff told us that all home visit requests were recorded in the home visit request book and visit dates added to this book. When we reviewed this book, we saw four entries and only two patients had home visit dates recorded. When we looked at the patient records, there was no evidence that these home visits had been carried out or that the GP had reviewed these requests. When we carried out a second site visit on 23 July 2019, this had improved as we saw evidence from the patient notes of a home visit being carried out in the five records we reviewed.

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)	88.4%	N/A	68.3%	Variation (positive)
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)	74.6%	65.5%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	72.8%	64.3%	64.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment times (01/01/2019 to 31/03/2019)				
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)	78.1%	69.6%	73.6%	No statistical variation

Source	Feedback
NHS Choices	Patients felt there was no difficulty in obtaining appointments.
Comment cards	Patients were happy with access to the service, although one highlighted issues with waiting times.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care; although sharing of learning was not evident.

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.	Y
There was evidence that complaints were used to drive continuous improvement.	N

Explanation of any answers and additional evidence:

- There was no evidence provided to show learning from complaints was shared with staff. Practice meeting minutes did not show complaints discussed and there was no evidence of dissemination of learning from complaints to staff.

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding patient care	Complaint that signs of illness were missed. Learning was that patients with complex needs must receive continuity of care by the same GP instead of locums. An apology was issued to the patient.

Well-led

Rating: Inadequate

The practice was rated inadequate for providing well-led services because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice vision was not supported by a credible strategy to provide high quality sustainable care.
- 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.

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.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: • Leaders were aware of some of the challenges relating to quality of care. For example, they had taken action to reduce demands on clinical capacity by reducing the number of care homes to which it provided services from six care homes to two. However, they had not recognised and acted on some current issues with the quality of care they provided; particularly, relating to safety systems, gaps in clinical records, lack of appropriate patient follow ups and referral concerns. and clinical performance. • They had taken minimal action to address some of the areas highlighted in the previous inspection which included induction processes and making policies accessible to all staff. • There was no succession plan in place.	

Vision and strategy

The practice had a 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.	Partial
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Explanation of any answers and additional evidence: - The practice had aimed to provide 'high quality primary medical service which is responsive to the needs of the local community'. However, there was no strategy in place to deliver this. - We saw evidence of collaboration with staff and patients in care delivery. They aspired to deliver high-quality care but had not established effective and sustainable systems to deliver it.	

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	N
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: The practice did not always comply with the requirements of the duty of candour. This was in relation to a safeguarding incident that required the practice to notify the relevant body. The practice had not complied with this duty until they were prompted to do so.	

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

Source	Feedback
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Practice staff interviews	Staff felt happy and found the managers were approachable and helpful.
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Governance arrangements

The overall governance arrangements were inadequate.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

- At our previous inspection of 6 September 2018, some key policies were not tailored to the practice and were of limited practice use. At this inspection, the practice had developed a new GP TeamNet system, where all policies were stored centrally and accessible to staff. However, there were gaps in this new system as there were no available policies such as the medical emergency policy, Accessible Information Standard policy, cold chain monitoring policy, or a managing test results policy.
- At our previous inspection of 6 September 2018, some staff did not know how to access current policies. At this inspection, we found this had not improved. We found that the new GP TeamNet system was not accessible to one clinician who had no access to this system due to unresolved IT issues. The practice had not taken any action to resolve this.
- Structures, processes and systems to support good governance were not well embedded in the practice. This was in relation to safeguarding processes, significant events and ensuring that staff responsible for monitoring the cold chain were adequately trained, competent to do so and aware of their responsibilities.
- Further ineffective governance arrangements were found in relation to poor staff communication in relation to emergency equipment checks, sharing guidelines, patient safety alerts, learning from significant events and complaints. Other gaps in governance included, lack of staff supervision, gaps in mandatory training and lack of adequate monitoring of when training was due. Gaps were found in fire safety, sepsis, information governance and infection control training.
- The practice did not maintain oversight over nursing records in particular, continuing professional development training. Staff were not always clear about their roles and responsibilities ensuring patient consultations were adequate and records were complete.

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.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: - There were no comprehensive assurance systems in place to identify, manage and mitigate risk. This was in relation to recruitment and selection, staff immunisations, health and safety risk assessments, fire safety, infection control, yellow fever vaccines, dealing with emergencies, medicines management, as well as ensuring that previous high-risk recommendations from the disability access audit were actioned. - There were also no assurance systems in the monitoring of unplanned admissions, cervical screening and at-risk patients. - Patients were put at significant risk of harm due to incomplete record keeping for care records, clinical findings, decisions made and lack of appropriate examinations in some cases. These failures put patients at risk of not being appropriately treated, followed up and reviewed. - A business continuity plan was in place but not all staff were aware of this.	

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.	N
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Partial
Explanation of any answers and additional evidence: Whilst we saw evidence that some data was used to adjust and improve performance, this was not applied in all areas. For example, exception reporting, some areas of prescribing, childhood	

immunisations and cervical screening indicators were not analysed to identify areas for improvement.

- Our inspection indicated that information was not always reliable and timely. This was in relation to incomplete patient care records and the lack of recorded clinical meeting minutes.
- The practice was aware of how to make statutory notifications; however, they were not always made. This is in relation to notifying the relevant body of safeguarding notifications.

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

The practice involved involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

- Patient views were sought but there was no evidence of how they were acted on to improve services.

Feedback from Patient Participation Group (PPG)

Any additional evidence

- There was evidence of regular PPG meetings and collaborative working with the practice.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: The practice did not provide evidence of continuous learning activities and learning from a range of sources such as complaints and significant events was not shared with all staff members effectively.	

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.