

Care Quality Commission

Inspection Evidence Table

Hounsfield Surgery (1-879698093)

Inspection date: 10 October 2019

Date of data download: 07 October 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

The practice has been rated as inadequate for providing safe services because:

- There were insufficient systems for safeguarding children and adults.
- Appropriate recruitment checks had not been undertaken before employing new staff.
- Staff immunisation status was not fully monitored.
- The practice did not have clear systems in place to ensure staff maintained their professional registration.
- Fire drills and fire training had not been completed by all staff.
- No risk assessments for the storage of liquid nitrogen or oxygen were available to mitigate the risk of storing hazardous materials.
- Processes to minimise the risk of infection were not always followed.
- Medicines were not always safely managed and there was a lack of clinical oversight of the dispensary.
- The practice did not learn and make improvements when things did not go well.
- Safety alerts were not always received and acted on appropriately.

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 ¹

Safeguarding	Y/N/Partial
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial ²
Partners and staff were trained to appropriate levels for their role.	N ³
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	N ⁴
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	N ⁵
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 ⁶
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹Some staff could not easily access policies and procedures relating to safeguarding. ²Safeguarding policies had been regularly reviewed but did not contain the correct details for contacting the local authority safeguarding team. ³Training records were not available on the day of inspection to demonstrate that all staff had completed training to the appropriate level. Two personnel files were checked, and one did not contain any safeguarding training certificates, the other file did not include a safeguarding training certificate to the correct level. ⁴Vulnerable patients were not identified on individual clinical records. ⁵Training records were not available on the day of inspection to demonstrate that all relevant staff had completed chaperone training. ⁶The lead GP for safeguarding told us that they did not have regular formal meetings with other professionals to discuss vulnerable patients, however, they told us that they attended individual safeguarding meetings and would contact relevant professionals if they had concerns about the vulnerability of individual patients. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N ²
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N ³
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹Recruitment files contained gaps in documentation to demonstrate that all appropriate pre-employment checks had taken place. This included references and proof of qualifications. ²No system was in place for ensuring that staff had maintained all recommended vaccinations. 	

- ³The practice relied upon clinical staff to tell them when they had renewed their registration, the practice did not have a system for checking that clinical staff remained registered.

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: 4/08/2019	Y
There was a record of equipment calibration. Date of last calibration: 4/08/2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial ¹
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 9/07/2019	Y
There was a log of fire drills. Date of last drill:	N ²
There was a record of fire alarm checks. Date of last check: 26/06/2019 (six-monthly external check)	Y
There was a record of fire training for staff. Date of last training:	N ³
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 30/01/2015 and had been reviewed every six months since that date.	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹COSSH risk assessments were in place but no risk assessments had been completed for the storage of liquid nitrogen or oxygen. ²No record of fire drills was available on the day of inspection. Staff told us that a drill had taken place a few years ago. ³Training records were not available on the day of inspection to demonstrate that all staff had completed fire training. Two personnel files were checked and neither contained a fire training certificate. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 23/03/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	N
Explanation of any answers and additional evidence: No health and safety risk assessments for the premises were available on the day of inspection.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met; however, infection prevention and control systems were not fully implemented.

	Y/N/Partial
There was an infection risk assessment and policy.	Y ¹
Staff had received effective training on infection prevention and control.	N ²
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: November 2018	Partial ³
The practice had acted on any issues identified in infection prevention and control audits.	Partial ⁴
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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹An infection control policy was in place dated April 2018 but had not been reviewed annually as recommended in the policy. ²Training records were not available on the day of inspection to demonstrate that all staff had completed infection control training. The infection control lead last infection control training certificate was dated for 2013. ³Infection control audits had been completed by the CCG, however, the practice had not completed internal audits or other documentation to evidence cleaning standards. This documentation included cleaning schedules and equipment decontamination records. ⁴Most actions had been completed following the most recent infection control audit, however, an action to improve infection control training uptake had not been completed. The premises were clean and well maintained, however, we found that curtains in clinical rooms had not been replaced within recommended timeframes. 	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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.	Y

There was a process in the practice for urgent clinical review of such patients.	Y
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:	

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.	Partial ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
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.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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.	Partial ²
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹Care records were managed securely but lacked detail at times. Regular clinicians had a good knowledge of their patients, but care records did not always provide sufficient detail for temporary staff being used by the practice. ²The practice shared information with other service providers, however, practice staff did not always check that patients were receiving regular blood tests from other service providers as required before repeat prescribing high-risk medicines. 	

Appropriate and safe use of medicines

The practice did not have fully effective 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)	1.29	0.94	0.87	Variation (negative)
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)	12.4%	8.3%	8.6%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	7.32	5.60	5.63	Variation (negative)
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)	2.81	2.44	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.	N ¹
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N ²
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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

Medicines management	Y/N/Partial
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 ³
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.	Y
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.	Y
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 ⁴
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial ⁵
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	N ⁶
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice's antibiotic prescribing levels were above local and national averages. This was monitored by the CCG and the practice and was considered to be appropriate considering the patient population and their needs. • ¹The dispensary located at the practice did not have its access restricted to authorised persons only. There was no risk assessment to consider the controlled access. • ²A record was not being kept of where blank prescriptions were being distributed to within the practice. Prescription stationery was also left unattended in unlocked clinical rooms at times. • ³There were effective processes in place for monitoring patients' health in relation to some high-risk medicines including lithium and warfarin. However, two patients receiving methotrexate had not received recent blood tests as required. • ⁴Adrenaline was available in all appropriate areas, however, no other emergency medicines were easily accessible in the event of a medical emergency. Staff told us that they would take any required emergency medicines from the dispensary. These medicines were not stored separately and there was a significant risk that staff would not be able to quickly gather all necessary medicines for use in the event of an emergency. There was no Glucagon, Glucagel or diclofenac in the practice and no risk assessment had been carried out to assess the risk of not stocking these medicines for use in the event of a medical emergency. • ⁵No documentary evidence was available to show that the medical emergency equipment was regularly checked to ensure it was fit for use. Some oxygen masks were out of date. • ⁶The procedure for monitoring temperatures of the vaccine refrigerator in the dispensary was not working effectively. The fridge temperature had exceeded the normal range on at least five occasions, but no actions were recorded to explain why or to indicate what follow-up had been 	

Medicines management	Y/N/Partial
undertaken.	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	N ¹
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Partial ²
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Partial ³
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Partial ⁴
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N ⁵
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> ¹A GP was identified as clinical lead for the dispensary, however, they did not provide effective clinical oversight of the dispensary. ²Staff were not receiving regular appraisal and competency checks. Training records were not available on the day of inspection to demonstrate that all staff had completed appropriate training in this area. ³A contract with a waste company was in place but waste records after 2014 were not available on the day of inspection. ⁴The procedure for monitoring temperatures of the vaccine refrigerator in the dispensary was not working effectively. ⁵Some medicines were added to medicines compliance aids cut from a foil blister pack, retained in the foil packing. Guidance recommends that medicines should not be repackaged within medicine compliance aids in their original strip or blister packaging, because of reports of patients swallowing the medicine and its packaging, resulting in patient harm. 	

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.	Partial ¹
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial ²
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial ³
There was evidence of learning and dissemination of information.	Partial ⁴
Number of events recorded in last 12 months:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹Systems to monitor and review safety were not fully effective. ²Not all staff knew how to identify and report concerns, safety incidents and near misses. ³Not all staff could easily access policies and incident forms to report incidents both internally and externally. ⁴Dispensary staff were aware of learning from incidents but there was no evidence of wider learning across the practice. Significant events and near misses had only been reported by the dispensary. No other incident or near miss reporting had taken place. Formal team meetings did not take place regularly and there was no evidence of learning from significant events at these meetings. 	

Example of significant event recorded and actions by the practice.

Event	Specific action taken
Near miss regarding dispensing medicine to incorrect patient	Staff reminded of importance of checking patient information/identification before dispensing.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Partial ²
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹The system for recording and acting on safety alerts was not effective. Not all patient safety alerts were being received and acted on appropriately. An alert regarding the use of Carbimazole had not been received and acted upon. We identified one patient who was of potential childbearing age and had not received advice in line with the safety alert. We also identified five patients who had not been reviewed for acute pancreatitis in line with the safety alert. A safety alert regarding the use of sodium valproate was not promptly responded to. The alert was circulated in April 2018 and the practice completed an audit in September 2019. ²The system for recording and acting on safety alerts was unclear. The practice manager had 	

started to collate safety alerts but there were no records of historic safety alerts and any actions taken.

Effective

Rating: Requires improvement

The practice has been rated as requires improvement for providing effective services because:

- The clinical audit process did not always identify actions or timescales for actions to address areas of shortcoming found by audits.
- There was no effective system for monitoring or recording staff training and not all staff received regular appraisals.
- These requires improvement areas impacted all population groups and so we have rated all population groups as requires improvement.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial ¹
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial ²
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • ¹We checked the records of six patients with diabetes. Three of the patients had blood sugar results outside of their recommended range and a change in their medicines had been made. None of the three patients had received a review or been booked in for a review. Patients with blood sugar results outside of their recommended range should receive a review within three months of a change in their medicines to assess the effectiveness of any changes. • ²Clinicians could explain the advice they would give to patients on when they needed to seek further help, however, clinical records did not contain details of this advice. 	

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) (NHSBSA)	1.15	0.65	0.75	No statistical variation

Older people

Population group rating: Requires improvement

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Training records were not available on the day of inspection to demonstrate that all staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires improvement

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, patient recall systems were not fully effective. Some patient recalls were being carried out by phone but not recorded on patient notes. This meant that there was a greater risk that patients would not be recalled for reviews in a systematic way and may not attend for reviews at the appropriate times.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Training records were not available on the day of inspection to demonstrate that all staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	83.1%	81.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	15.3% (32)	14.8%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.3%	75.1%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.1% (19)	11.6%	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) <small>(QOF)</small>	83.3%	82.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	13.9% (29)	15.7%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	68.3%	79.3%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.0% (7)	11.4%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	65.8%	87.0%	89.7%	Variation (negative)
Exception rate (number of exceptions).	5.0% (2)	14.0%	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)	86.2%	84.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.9% (9)	5.7%	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)	100.0%	93.1%	90.0%	Significant Variation (positive)
Exception rate (number of exceptions).	1.5% (1)	6.5%	6.7%	N/A

Any additional evidence or comments

QOF data for 2018/19 was published after the inspection visit. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that included an assessment of asthma control using the 3 RCP questions had remained in line with the previous year. The practice told us that there had been a decline in performance due to nursing capacity but that they would be arranging a COPD clinic in order to improve these figures.

Families, children and young people

Population group rating: Requires improvement

Findings

- Training records were not available on the day of inspection to demonstrate that all staff had appropriate knowledge of treating families, children and young people.
- The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Interviews with staff suggested that they had the appropriate skills and training to carry out reviews for this population group, however, training records were not available on the day of inspection to demonstrate that all staff had completed appropriate training in this area.

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)	30	31	96.8%	Met 95% WHO based target
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)	31	31	100.0%	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)	31	31	100.0%	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)	30	31	96.8%	Met 95% WHO based target

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"> Training records were not available on the day of inspection to demonstrate that all staff had appropriate knowledge of treating working age people. The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who	79.2%	N/A	80% Target	Below 80% target

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)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	81.6%	78.7%	72.1%	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)	69.0%	63.1%	57.3%	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)	77.1%	63.4%	69.3%	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)	61.5%	52.7%	51.9%	No statistical variation

Any additional evidence or comments

The practice were lower than the 80% cervical screening target. The lead GP and the nurse carried out cervical screening at the practice.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- Training records were not available on the day of inspection to demonstrate that all staff had appropriate knowledge of treating people whose circumstances make them vulnerable.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. All 19 patients had been offered a health check and 15 of those patients had received an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health

Population group rating: Requires improvement

(including people with dementia)

Findings

- Training records were not available on the day of inspection to demonstrate that all staff had appropriate knowledge of treating 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.
- Same day and longer appointments were offered when required.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Training records were not available on the day of inspection to demonstrate that all staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	20.6%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	94.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	18.1%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.1%	83.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	10.9%	6.6%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of some of the care provided, however, it was

not fully effective.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	545.6	544.6	537.5
Overall QOF score (as a percentage of maximum)	97.6%	97.4%	96.2%
Overall QOF exception reporting (all domains)	4.0%	6.0%	5.8%
Any additional evidence or comments			
QOF data for 2018/19 was published after the inspection visit. The practice's overall QOF score was 542.49 (out of maximum 559). This was an achievement percentage of 97.05% which was slightly below CCG averages and slightly above national averages.			

	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 ¹
Quality improvement activity was targeted at the areas where there were concerns.	Partial ²
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

We did not see any evidence of any improvements demonstrated because of clinical audits or other improvement activity. No two-cycle audits were seen.

Any additional evidence or comments	
<ul style="list-style-type: none"> ¹The practice completed audits which identified shortcomings, but actions were not always identified to address these shortcomings and timescales for any identified actions were not always stated. An undated nonsteroidal anti-inflammatory (NSAID) medicines review was completed which identified improvements that needed to take place. There were no timescales set for the identified actions. A sodium valproate audit was completed on 6 September 2019, it identified improvements that needed to take place, but no timescales were set for these actions. ²The practice completed an audit in response to a safety alert but no other audits had been completed in response to identified concerns. 	

Effective staffing

The practice was unable 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.	Partial ¹

The learning and development needs of staff were assessed.	Partial ²
The practice had a programme of learning and development.	N ³
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial ⁴
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/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial ⁵
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹Evidence of some training completed by some staff was seen but comprehensive training records were not available on the day of inspection to demonstrate that all staff had received had received all relevant training. The practice had an online training package available, but few staff were completing this training and online training records were not being monitored and acted upon to improve staff uptake. ²Some consideration of staff learning and development needs had taken place but not in a systematic way to ensure that all staff needs were identified. ³A limited programme of training and development took place but it did not cover all staff in a systematic way. ⁴Some staff had received a form of appraisal but not all staff were receiving regular appraisal. ⁵The poor staff uptake of training courses made available by the provider had not been addressed. 	

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)	Y
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.	Y
Explanation of any answers and additional evidence:	

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
Explanation of any answers and additional evidence:	
The practice provided a number of healthy living initiatives from the practice including smoking cessation as due to their geographical location patients were less likely to travel to other healthcare providers for these services.	

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)	95.2%	96.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (5)	1.5%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and	Y

recorded a patient's mental capacity to make a decision.	
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Training records were not available on the day of inspection to demonstrate that all relevant staff had received consent training including the Mental Capacity Act.</p>	

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.	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
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	33
Number of CQC comments received which were positive about the service.	33
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient comment cards	Patients commented that they were treated with care by all staff. They commented that staff were very kind and that they received excellent care.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4228.0	240.0	125.0	52.1%	2.96%

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)	98.1%	88.4%	88.9%	Variation (positive)
The percentage of respondents to the GP patient survey who stated that the last time	98.8%	86.7%	87.4%	Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
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)				
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)	100.0%	95.9%	95.5%	Variation (positive)
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)	98.1%	81.6%	82.9%	Variation (positive)

Any additional evidence or comments

Patient comment cards were very positive commenting that all healthcare professionals were very good at listening and could be trusted. A number of patients stated that the care they received was excellent.

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

Any additional evidence

Friends and Family test results for the last six months showed very high levels of respondents who would recommend the practice (100% for 5 of the 6 months, 97% for the other month).

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
Explanation of any answers and additional evidence: Easy read information was available.	

Source	Feedback
Patient comment cards	Patients commented very favourably regarding having time to discuss any concerns, being listened to and receiving clear explanations and being given options for

	treatment.
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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)	100.0%	93.8%	93.4%	Variation (positive)

	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.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	81 carers had been identified which constituted 1.9% of the practice population.
How the practice supported carers (including young carers).	The practice had a carers champion. A carers pack was given to carers, but the information was also tailor-made for each carer containing relevant information including cancer and dementia support groups. Carers were invited for annual flu vaccinations. Alerts were placed on carers' clinical records, so clinicians were aware of carer responsibilities and able to offer additional support as required.
How the practice supported recently bereaved patients.	The practice would call, visit and/or send cards to recently bereaved patients. Staff would also provide patients with information of bereavement support groups.

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
Explanation of any answers and additional evidence:	

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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice worked closely with the local community and had links to the local school and community groups. The practice had developed a falls group in conjunction with the CCG. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm
Appointments available:	
Monday	Various times depending on clinician within opening hours.
Tuesday	Various times depending on clinician within opening hours.
Wednesday	Various times depending on clinician within opening hours.
Thursday	Various times depending on clinician within opening hours.
Friday	Various times depending on clinician within opening hours.
Weekday evening appointments were available at practices in Newark. Weekend morning appointments were also available in Newark. These were as part of a locally commissioned extended access scheme.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4228.0	240.0	125.0	52.1%	2.96%

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)	100.0%	94.4%	94.5%	Variation (positive)

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice provided effective care coordination to enable older patients to access appropriate services. There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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 and community matrons to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. Wound dressing and INR monitoring was available at the practice to improve access for patients.

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> Additional nurse appointments were available for school age children so that they did not need to miss school. We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this. All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

- A weekly ante-natal clinic was held at the practice and a midwife was in attendance.

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.
- Pre-bookable weekday evening and weekend morning appointments were available to all patients at additional locations within the area.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. GPs offered regular home visits to some patients who wanted to receive end of life care at home and not hospital. The lead GP gave her personal mobile number to families caring for patients on end of life care so that they can contact her at any time for support. The lead GP was on the board of directors of the local hospice.
- 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: Good

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.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	

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)	99.2%	N/A	68.3%	Significant 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)	95.4%	63.8%	67.4%	Variation (positive)
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)	93.8%	59.4%	64.7%	Significant Variation (positive)
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)	95.8%	72.3%	73.6%	Variation (positive)

Any additional evidence or comments

Staff told us that extended access to appointments was available to patients at other practices in the area, however, patients did not tend to use this access as they were happy to have appointments at their own practice.

Source	Feedback
Patient comment cards	Patients commented that it was easy to get appointments and that staff always tried to fit them in the same day where possible.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	2
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.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: Complaints records were disorganised. The initial practice response to one of the complaints was inappropriate but the clinician response to this complaint was appropriate. One of the complaints was not acknowledged within timescales. Complaints information was not comprehensive and did not consistently refer to the patients' rights to contact NHS England and the Parliamentary and Health Service Ombudsman. Staff knowledge of the complaints process was inconsistent.	

Example(s) of learning from complaints.

Complaint	Specific action taken
No clear learning had been identified from the complaints seen.	

Well-led

Rating: Inadequate

The practice has been rated as inadequate for providing well-led services because:

- The delivery of high-quality care was not assured by the leadership, governance or culture in place.

Leadership capacity and capability

Leaders could not fully 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 ¹
They had identified the actions necessary to address these challenges.	Partial ²
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• ¹Leaders were not fully aware of the issues identified at this inspection.• ²Not all actions were in place to address the challenges to quality and sustainability.• A business development plan for 2019-2022 was in place and annual business development meetings took place annually. The meetings considered workforce planning and working arrangements in the future.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care, however, monitoring of the strategy was not fully effective.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial ¹
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice's vision and values were, 'Cure sometimes, relieve often and comfort always.'• ¹Meetings took place to consider delivery against the strategy, however, ineffective assurance systems meant that monitoring of the strategy was not fully effective.	

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.	Partial ¹
The practice encouraged candour, openness and honesty.	Partial ²
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial ³
The practice had access to a Freedom to Speak Up Guardian.	N ⁴
Staff had undertaken equality and diversity training.	N ⁵
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹No policies or procedures were in place to support the duty of candour. ²Training records were not available on the day of inspection to demonstrate that all relevant staff had completed duty of candour training. Not all staff were aware of the duty of candour. ³The practice's speaking up policy gave contact details of some external bodies to contact but it did not include the CQC. ⁴There was no external freedom to speak up guardian was identified in the whistleblowing policy. ⁵Training records were not available on the day of inspection to demonstrate that all relevant staff had completed equality and diversity training. 	

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

Source	Feedback
Staff interviews	Staff felt they worked well together and that any concerns were addressed by management.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial ¹
Staff were clear about their roles and responsibilities.	Partial ²
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹Governance structures and systems were in place but were not effective. A range of concerns 	

were identified during this inspection which had not been identified and addressed by the practice's governance arrangements.

- ²Policies and procedures were not easily accessible for all staff. Staff knowledge of their role and responsibilities was inconsistent.

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 ¹
There were processes to manage performance.	Partial ²
There was a systematic programme of clinical and internal audit.	Partial ³
There were effective arrangements for identifying, managing and mitigating risks.	Partial ⁴
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N ⁵
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • ¹Assurance systems were not effective. • ²Performance processes were not used to hold staff to account. • ³There was a programme of audit but it was not comprehensive or effective. • ⁴Arrangements for identifying, managing and mitigating risk were not effective as demonstrated by the range of concerns identified at our inspection. • ⁵Formal staff meetings did not take place regularly and minutes of those meetings lacked detail. It was not clear that significant events and complaints were discussed at the meeting. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial ¹
Performance information was used to hold staff and management to account.	Partial ²
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial ³
There were effective arrangements for identifying, managing and mitigating risks.	Partial ⁴
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • ¹Clinical performance data was used to monitor and improve QOF performance. However, information obtained from audits was not effectively used to improve performance. • ²Staff had not been held to account for poor completion of training. 	

- ³Information regarding training was not accurate or reliable.

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
Explanation of any answers and additional evidence:	

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.	Y
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: <ul style="list-style-type: none"> • Patient satisfaction with the practice was high. • The practice attended the Primary Care Network meetings to discuss needs of the local population and to plan services to meet those needs. 	

Feedback from Patient Participation Group.

Feedback
8-10 patients attended quarterly PPG meetings. A range of practice staff including the lead GP, nurse and practice manager attended the meetings. The PPG found the practice staff to be approachable and that they listened to their comments. The PPG's role was generally limited to discussions with staff at the PPG meetings and contributing to the practice newsletter. The PPG had not carried out any surveys or other work in the practice.

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.	N ¹
Learning was shared effectively and used to make improvements.	N ²
Explanation of any answers and additional evidence:	

- ¹Limited quality improvement work taking place. 'Should' identified at previous CQC inspection regarding significant events had not been addressed.
- ²Documented evidence of meetings limited and no reference to learning seen in meeting minutes.

Examples of continuous learning and improvement

Limited evidence of continuous learning and improvement. Audits taking place but no clear timescales for actions identified and no two-cycle audits to demonstrate improvements made.

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

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.