

Care Quality Commission

Inspection Evidence Table

Bulbanks Medical Centre (1-5719000558)

Inspection date: 17 and 30 September 2019

Date of data download: 16 September 2019

Overall rating: Requires improvement

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

Safe

Rating: Requires improvement

At the last inspection on 12 August 2015 we rated the practice as Good for providing safe services. At this inspection we have rated the practice as requires improvement because:

- Staff did not always assess, monitor or manage risks to people who use the service.
- There was no oversight of safety alerts to ensure there was a record of alerts received and a log of actions taken.

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.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	P ¹
Partners and staff were trained to appropriate levels for their role.	P ²
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.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

Safeguarding	Y/N/Partial
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.	Y
Explanation of any answers and additional evidence: 1 – Practice specific policies were in place in some cases. However, in others, the policies were incomplete templates that had not been adapted to the practice. Policies were not kept under regular review. For example, policies were not reviewed to indicate essential training required for staff to perform their role. The practice explained that the Practice Manager had been in post since April 2019 and was still sorting through the previous Practice Manager's files. The practice manager told us they had started to review and update all practice policies in April when they took over the role. The practice had started using a practice management resource tool to update the practice's policies and procedures. At this inspection, the Practice Manager was still in the process of finding where the old practice manager had filed policy documents so that they could be updated. 2 – Clinical staff were trained to an appropriate level for their role. However, one new member of the reception staff had not yet received safeguarding training. This staff member had been in post for three months. The practice told us the new receptionist had previously worked in a hospital and had completed essential training there. We saw evidence of emails requesting the CCG to set up the new member of staff with an NHS account for online training. Staff told us there had been a delay in the CCG's IT department setting up the NHS account for this new member of staff. At the time of our inspection, the practice manager had received adult safeguarding training but had not undertaken safeguarding children. Following our inspection on 07/10/2019, the practice manager sent us evidence of completed safeguarding children training Level 1 and evidence of online safeguarding adults Level 1 completed by the new member of reception staff. There was a Chaperoning protocol and we saw a notice in the waiting room advertised to patients that the practice nurse could act as a chaperone. The practice nurse had received chaperone training and a Disclosure and Barring Service (DBS) check. At the time of our inspection, the practice nurse was the only member of staff acting as a chaperone.	

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

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Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 18 March 2019	Y
There was a record of equipment calibration. Date of last calibration: 18 March 2019 Included baby scales, thermometer, pulse oximeter, BP monitor, Otoscope, medical scale, spirometer, defibrillator, nebuliser, ear syringe, vaccine fridges x 2, ECG machine	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N ¹
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 31/05/2019	Y
There was a log of fire drills. Date of last drill: Not known	N ²
There was a record of fire alarm checks. Date of last check: 10/09/2018	Y
There was a record of fire training for staff. Date of last training: 11/09/2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 1/09/2019 done internally by PM	Y
Actions from fire risk assessment were identified and completed.	P ³
Explanation of any answers and additional evidence: 1 -- COSHH: There was no risk assessment in place for <i>the storage of hazardous substances</i>. We saw a blank risk assessment template for managing hazardous products held on the premises. COSHH. 2 – Staff were unable to recall whether there had been a fire drill, and there was no record. Staff were clear about the fire evacuation procedure and the assembly point at the surgery site. 3 – The building was part owned by the GP partner. The practice had smoke alarms fitted and had undertaken their own fire and premises risks assessments. Not all fire safety actions identified from the fire safety risk assessment had been completed. For example, there was no log of fire training drills and fire alarm tests. We spoke to staff who told us they did not know how to test the fire alarm system. Immediately following our inspection, the practice manager carried out a fire evacuation drill and sent us a log of the completed fire drill including the next planned drill for 20/12/2019.	

Immediately following our visit on 17 September, the practice arranged for an electrical contractor to inspect the fire alarm system. The contractor sourced a Fire alarm test guide for the practice's fire alarm system and trained the practice manager on how to test the fire alarm. The practice confirmed that they had completed a successful fire drill and tested the fire alarm and did an emergency lights test. We saw a log of the fire drill and fire alarm tests when we inspected the practice on 30 September 2019. We saw fire evacuation procedures and instructions in the event of a fire were clearly displayed throughout the building. New staff were given a copy of the Fire Safety protocol. There were three fire marshals who had completed relevant training.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Empty premises security risk template seen and no record of last one available.	N ¹
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: No record could be found of last site Health and Safety risk assessment done.	N ²
Explanation of any answers and additional evidence: 1 – Premises/security: The provider part owned the building. There was no evidence the provider had conducted appropriate premises and security risk assessments. We saw evidence of annual security maintenance and intruder alarm test dated 24/05/19. 2 – Health and safety: There was no programme of Health and safety risk assessment. The practice manager we spoke to had recently been promoted to the role and could not show us any up to date record of health and safety risk assessments. The practice manager told us they carry out weekly walk rounds to identify hazards, but this was not documented. Legionella checks: We asked the provider how legionella risks were assessed and managed. The provider told us no legionella risk assessment had been carried out. There was a record of a legionella test in December 2018 but no evidence that the water temperatures in the building were being monitored.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 08/06/2016	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y ¹
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: Responsibility for infection control at the practice was allocated to a member of the nursing team. The practice used a checklist template to ensure any actions identified in the latest infection control audit would be actioned and monitored. 1 – We saw a record of an infection control audit dated 8/6/2016 carried out by Bexley CCG assessor. There was an IPC action plan with a list of remedial actions recommended to resolve the problem identified. For example, all items of sterile equipment should be within their use-by date. We checked the action plan and saw all items of sterile equipment were checked and were within use-by date. We saw a copy of the Infection Prevention and Control (IPC) policy, but this had not been reviewed since 2015. Following our inspection, the practice told us the IPC policy was reviewed in May 2019 and an updated policy was stored on their practice system. The IPC policy included sharps injury guidance for staff. .	

Risks to patients

There were 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.	P 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.	P ¹
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.	P ¹
Explanation of any answers and additional evidence:	
1 – The practice did not have effective systems in place to ensure that all patients with mental health conditions had appropriate reviews and clear notes on their records to ensure that they remained safe. In some of the records we reviewed, we saw that there were no detailed notes for care plans completed on patients' records. For example, we looked at three patient records with dementia care plans and saw the reviewing GP had not ensured that their care plans were updated in sufficient detail to reflect any extra or changed needs. We saw that there was no copy of the patient review saved in the clinical record so that it was available for all who may be involved in the patient's care. We spoke to the GP who indicated that there was likely to have been a discussion with the patient but there was no information to support this.	

Appropriate and safe use of medicines

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

including medicines and placed patients at risk in the event of a medical emergency.

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)	0.96	0.83	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	9.8%	9.9%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	7.98	6.30	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)	2.24	1.69	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.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
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.	P ¹
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	P ²
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	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
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 ³
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: 1 –The practice did not always assure themselves of the competence of all nursing staff employed. The practice did not regularly assess and monitor the competence of the practice nurses. The nurse prescriber told us they meet once a week with a GP to review their caseload. However, there was no record or minutes of peer review meetings or evidence of audits of their decisions making and consultations. 2 – The process of scheduling and recording medication reviews was managed in line with current guidelines. We looked at 18 patient records. We found medication reviews were mostly well documented however, we saw two patient records where a medication review was overdue. Records we looked at showed a lack of detail in recording what the review covered and what was discussed with the patient. We were not assured that patients were always receiving the correct care, treatment and monitoring for their conditions. 3 – The provider did not have appropriate systems in place for the safe management of medical emergencies. There was an emergency drugs checking protocol, but this had not been followed. There were a number of emergency medicines unavailable and no risk assessment in place should these be needed. For example, Chlorphenamine and hydrocortisone for injection. During our inspection, the GP ordered the missing emergency medicines. The practice had developed a <i>dependence forming medicines</i> protocol and shared this with staff.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
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.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	4
Number of events that required action:	1
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
Poor communication processes between the practice staff and cytology screening lab had led to lab not testing a sample and patient having a repeat smear test. Patient had complained to previous PM.	The practice implemented staff training about how to follow up cytology results. Staff had a clinical meeting with the GP partner and the sample taker and the event was discussed and minutes were taken. Following investigation, the practice sent the patient an apology explaining why the lab did not test the sample. The learning was discussed in staff meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P ¹
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
1 – There was not a system to ensure there was a record of alerts received or a log of actions taken. The provider told us safety alerts were received by email by the GP partner and the practice manager. Staff told us the practice manager forwarded the safety alerts on to the nursing staff but they were left to individual clinicians and nurses to action. We were told safety alerts were discussed in clinical meetings every fortnight. We asked the provider about action taken following a recent MHRA safety alert for Carbimazole but there was no evidence of searches undertaken. We saw one example of actions taken on recent alerts for example, regarding sodium valproate. We asked the practice to run a search of women of child bearing age on Sodium Valproate and this identified 0 patients. Following our inspection on 07/10/2019 the practice sent us a copy of a safety alert spreadsheet which staff will use to log safety alerts received and actions taken.	

Effective

Rating: Requires improvement

At the last inspection in August 2015 we rated the practice as Good for providing Effective services. At this inspection we rated the practice as requires improvement for effective because:

- The practice was unable to show that staff had the skills, knowledge and training to carry out their roles.
- There was a system to ensure staff appraisals were undertaken on a regular basis.
- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the target of 95% in all of the four areas where childhood immunisations are measured.
- The practice had not demonstrated it had an effective strategy to improve their performance for cervical screening which was lower than CCG and England averages.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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.	P 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.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
1 – In some of the records we reviewed, we did not see that detailed notes for care plans were completed on patients' records. We looked at three patient records with dementia care plans and saw the reviewing GP had not ensured that their care plans were updated in sufficient detail to reflect any extra or changed needs.	

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)	0.65	0.57	0.75	No statistical variation

Older people

Population group rating: Requires improvement

Findings

- The training and staff appraisal issues in the Effective key question affected all population groups so we rated all population groups as requires improvement. The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients aged 75 or older had care plans and patients with long term conditions received a medication review at least annually.
- There were processes to review rates of polypharmacy (that is, where patients may be at risk of adverse effects associated with taking multiple medicines).

People with long-term conditions

Population group rating: Requires improvement

Findings

- The training and staff appraisal issues in the Effective key question affected all population groups so we rated all population groups as requires improvement.
 - Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
 - Staff who were responsible for reviews of patients with long-term conditions had received specific training.
 - GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- 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) (QOF)	81.6%	82.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	18.1% (47)	14.7%	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)	84.8%	80.9%	77.7%	No statistical variation
Exception rate (number of exceptions).	11.2% (29)	10.9%	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)	85.6%	81.0%	80.1%	No statistical variation
Exception rate (number of exceptions).	19.7% (51)	13.9%	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	79.0%	75.6%	76.0%	No statistical variation

(01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	12.7% (18)	8.5%	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)	94.3%	92.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	12.5% (5)	12.1%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	88.1%	83.7%	82.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.9% (20)	5.2%	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)	96.4%	87.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.7% (3)	6.8%	6.7%	N/A

Families, children and young people

Population group rating: Requires improvement

Findings

- The training and staff appraisal issues in the Effective key question affected all population groups so we rated all population groups as requires improvement.
- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Uptake rates in 2018/2019 for the vaccines given were below the WHO target of 95% in all of the four areas where childhood immunisations are measured. Staff told us that they were aware of these results and all delayed and childhood immunisation decliners were contacted by letter or telephone in a bid to improve uptake of childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	50	55	90.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	41	46	89.1%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	41	46	89.1%	Below 90% minimum
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)	40	46	87.0%	Below 90% minimum

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

Any additional evidence or comments

We discussed the low performance for child immunisation with the practice. We were told by the practice that when babies were seen during their six-week checks, a discussion was held with the parents about the need for immunisation. The practice telephoned parents if their child was overdue their immunisation and where they did not attend an appointment, a letter was sent to patients. We saw evidence of alerts being placed on the patients' notes so that immunisation could be offered opportunistically when patients attended the practice. Children could be booked in for pre-school immunisations walk in clinic as well as other appointment slots.

Working age people (including those

Population group rating: Requires

Findings

- The training and staff appraisal issues in the Effective key question affected all population groups so we rated all population groups as requires improvement.
- 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.
- The practice rates for cervical screening were low. The practice had recognised this and told us they had taken action to address low uptake but there was not yet evidence of improvement. There was a failsafe system to check that results were received for all tests taken and that any abnormal results were followed up.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. The practice had extended hours opening on Monday evenings until 7.30pm.
- Patients could email the GP using eConsult which helps working people to avoid having to take time off work.

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)	71.6%	N/A	N/A	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	72.5%	76.9%	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)	44.7%	54.5%	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)	50.0%	70.2%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a	66.7%	54.1%	51.9%	No statistical variation

two week wait (TWW) referral) (01/04/2017 to 31/03/2018) ^(PHE)				
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Any additional evidence or comments

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The training and staff appraisal issues in the Effective key question affected all population groups so we rated all population groups as requires improvement.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. We saw evidence of effective provision of services for people whose circumstances make them vulnerable.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The training and staff appraisal issues in the Effective key question affected all population groups so we rated all population groups as requires improvement.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. However, in some of the records we

reviewed, we did not see that detailed notes for care plans were completed on patients' records. We looked at three patient records with dementia care plans and saw the reviewing GP had not ensured that their care plans were updated in sufficient detail to reflect any extra or changed needs.

- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services. A health and wellbeing officer from Community Connect works at the service on Wednesdays seeing patients by appointment and drop in. Staff had access to the Café from Crisis handouts signposting patients to a safe haven project that offered out of hours coffee and support.
- Reception and admin staff were given guidance on registering armed forces veterans and their families.

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)	90.0%	94.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	4.8% (1)	11.4%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.7%	90.0%	Variation (positive)
Exception rate (number of exceptions).	4.8% (1)	9.2%	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)	89.5%	81.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.0% (1)	5.4%	6.6%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	547.1	523.9	537.5
Overall QOF score (as a percentage of maximum)	97.9%	93.7%	96.2%

Overall QOF exception reporting (all domains)	9.1%	6.3%	5.8%
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	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.	P ¹
Quality improvement activity was targeted at the areas where there were concerns.	Y
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:

There was evidence of some measures to review the effectiveness of the service provided and improve patient safety. Polypharmacy review: We saw evidence the practice had audited prescribing in line with current clinical guidance. Staff had carried out a polypharmacy review audit in July 2019 This was a shared project with the CCG Medicines Management team. We saw evidence of findings which were tasked to the GP to action. We asked the GP to show us evidence of audit of antibiotic use but the GP was not able to find it on his computer. The GP told us the business manager monitored the practice's performance and could show us evidence of quality improvement activity, but that member of staff was not available on the dates we inspected the practice. We saw evidence of the provider conducting two audits each year as part of their annual appraisal process
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Any additional evidence or comments

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.	Y ¹
The learning and development needs of staff were assessed.	Y

The practice had a programme of learning and development.	Y
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.	P ²
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	P ³
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: 1 – Staff training: We found the practice did not have oversight of staff training and could not easily evidence the training undertaken by staff. The practice did not maintain a schedule of role specific training that all staff needed to complete to ensure they demonstrated the skills and competence to fulfil their role. Files we reviewed showed that one non-clinical member of the reception staff, who had been in post for three months, had not yet received any role specific training in basic life support, infection control or information governance. The practice told us the new receptionist had previously worked in a hospital and had completed essential training there. We saw evidence of emails requesting the CCG to set up the new member of staff with an NHS account for online training. Staff told us there had been a delay in the CCG's IT department setting up the NHS account for this new member of staff. The practice manager had not updated their infection prevention and control (IPC) role specific training since 2017. Staff showed us the online training account which the practice manager was responsible for administering. We saw staff could access the online training account for copies of certificates of training completed. When we spoke to the practice manager about this they told us they were waiting to be booked on to the next Bexley CCG IPC training event. On 07/10/2019 the practice sent us evidence that the non-clinical member of staff had started to complete online courses for role specific training. 2 – Staff appraisals: The Practice Manager was new to their role and had started in April 2019 and was still sorting through the previous Practice Manager's files. Staff told us the previous Practice Manager had no system for appraisals to hand over. The practice manager told us they had started a new system of staff appraisals. All three staff appraisals we reviewed were up to date, signed off and an appraisal was scheduled for next year. The practice manager told us they had received an appraisal but when we asked to look at the record they were not able to find it. The Practice Manager explained their appraisal was not due until March 2020. Their last appraisal had been carried out when they had worked as the administrator and was carried out by the previous Practice Manager. Staff were not able to find where the previous Practice Manager had filed it. We reviewed the appraisal of a clinical member of staff and found it contained relevant information that could assure the practice of the competence of staff employed. 3 – Competence of staff: The practice did not always assure themselves of the competence of all	

nursing staff employed. The practice did not regularly assess and monitor the competence of the practice nurses. There was an online training account which the practice manager administrated. We saw staff could access the online training account for copies of certificates of training completed. However, the Practice Manager was not able to show us up to date training records and proof of qualifications for the Advanced Nurse Practitioner (ANP). The ANP was self-employed but was contracted to work full time at the practice. We spoke with the ANP who showed us evidence of their competences and update training attended.

The practice nurse who did immunisations and cervical screening had attended an immunisation webinar update on 17 September 2019 and Cervical screening update on 4 June 2019. Both nurses had completed Consent training.

We saw an induction pack for new staff. There was a health questionnaire to record the employee's immunisation history. There was a staff induction manual with reception SOPs and staff had signed a confidentiality agreement. All new staff have a training buddy. There was a training checklist for reception staff to go through with their training buddy.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor had regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.)	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 ¹
Explanation of any answers and additional evidence: 1– Information was shared between services, with patients' consent, using a shared care record. The GP attended integrated team meetings with the district nurses, palliative care nurses, health visitor, practice nurses when care plans were routinely reviewed and updated for patients with complex needs. All children on the at risk register and any other children the team had concerns about were discussed and appropriate care plans were agreed. All patients on the gold list and Coordinate my care register were discussed and appropriate care plans put in place. The practice secretary attends the integrated care meeting and keeps the 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	Y

risk of developing a long-term condition and carers.	
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:	

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)	99.2%	95.0%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0.8% (6)	0.9%	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.	P ¹
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.	N/A
Explanation of any answers and additional evidence:	
1 – Staff supported patients to make decisions. Where appropriate, they told us that they would assess and recorded a patient's mental capacity to make a decision. We were not able to see that consent was documented. We asked to see a signed consent form, but the GP could not find an example to show us. We were told the nurse who fits coils, records in the notes that consent was discussed with the patient.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was wholly 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.	39
Number of CQC comments received which were positive about the service.	39
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
Comment cards	We received 39 comment cards which were all positive about the service experienced. Patients commented that the receptionists were calm and friendly and always tried to help them. Patients said they felt listened to and that they were treated with respect and dignity during their consultation.

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
4041	404	124	30.7%	3.07%

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)	92.1%	88.0%	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)	91.9%	85.6%	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)	98.2%	95.8%	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)	96.5%	80.6%	82.9%	Tending towards variation (positive)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	P ¹

Any additional evidence
1 – The practice did not seek feedback from patients in relation to how the practice was run. There was no active patient participation group and no meetings had taken place in the last year. Patient feedback received by the practice was through national patient surveys. The practice told us it uses IPLATO for documenting patient feedback. There was a Friends and Family survey box in reception, so patients could complete feedback forms. Staff encouraged patients to email suggestions or contact the practice through the website or speak to reception staff.

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: Patients could be referred to bereavement counselling if they needed it.	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	96.1%	92.0%	93.4%	No statistical variation

Any additional evidence or comments

	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.	The practice had identified 67 patients who were also carers. This represented approximately 2.7% of the practice's patient population.
How the practice supported carers.	The practice advised and gave information to carers on the different avenues of support available to them.
How the practice supported recently bereaved patients.	Families were offered an appointment at a convenient time to them and this was usually followed by a home visit.

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:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 – 19:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30
Appointments available:	
Monday	08:00 – 13:00 and 14:00 – 19:30
Tuesday	08:00 – 13:00 and 16:30 – 18:30
Wednesday	08:00 – 13:00 and 14:30 – 18:30
Thursday	08:00 – 13:00 and 16:00 – 18:30
Friday	08:00 – 13:00 and 14:00 – 18:30

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4041	404	124	30.7%	3.07%

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%	94.2%	94.5%	Variation (positive)

Any additional evidence or comments

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.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

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 and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available until 7.30pm on a Monday 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.

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 monitored the number of patients using online services and encouraged them to use more of this facility.
- The practice was open until 7.30pm on a Monday. Pre-bookable appointments were also available to all patients at additional locations within the area. Patients registered with a Bexley GP could access GP appointments in the evening and at weekends, Monday to Friday 6.30pm – 8pm, Saturday and Sundays 8am – 8pm through the Bexley Heath Neighbourhood Care GP Hub (BHNC) at Queen Mary's Hospital and Erith Hospital.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**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)	73.4%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	80.6%	61.4%	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 appointment times (01/01/2019 to 31/03/2019)	77.3%	60.6%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	82.6%	68.2%	73.6%	No statistical variation

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	6
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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.	Y
Explanation of any answers and additional evidence: The practice monitored complaints. Information about how to complain was available on the practice website and in the practice leaflet. Staff we spoke with knew how to advise patients about how to make a complaint. We found regular clinical and all staff meetings were taking place and the agenda included the dissemination of learning from complaints to staff.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient came in to reception very agitated and anxious. Patient asked for a telephone consultation and was told by the receptionist that the GP does not usually do telephone consultations. Patient became distressed. The receptionist did not handle situation well and situation escalated.	A written acknowledgement was sent to the patient and the complaint was investigated. The Practice Manager then wrote to patient to apologise and a telephone consultation was booked. Staff helped the patient to sign up for online services to enable them to book appointments from anywhere. Staff also explained Econsult tool for the patient to communicate more easily with the surgery. Patient was happy with practice's suggestions.
Received an email complaint from a patient with a long term condition for which they were being seen by a hospital consultant. The patient complained they had received an invite for an annual check from the practice despite being seen by hospital consultant	Patient's complaint came in via practice web address. Patient complained previously but it happened again. Staff looked into the workflow process. It is standard procedure to send patients with a long-term condition an invitation for annual health check. The patient wanted to continue to stay under care of hospital. The practice removed the patient's name off the health check list so staff no longer send out reminders.

Well-led

Rating: Inadequate

At the last inspection in August 2015 we rated the practice as requires improvement for providing Well Led services. At this inspection we have rated the practice as inadequate because:

- There were ineffective arrangements for identifying, managing and mitigating risks. The practice did not have oversight of safety risk assessments.
- The policy framework of the practice was not effective because there was no oversight of safety alerts to ensure there was a record of alerts received which had been acted on and there were no procedures in place to monitor legionella.
- The provider had not ensured that processes were happening in line with policy or legal requirements. For example, policies were not reviewed to indicate essential training required for staff to perform their role. This was a concern identified at the last inspection.

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.	P ¹
They had identified the actions necessary to address these challenges.	N 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:	
1 – Leaders were working with a number of organisations to improve the stability and sustainability of their current operating model.	
2 – We found where the practice were aware of data which affected the quality and sustainability of care provided, they had not always acted upon this data to drive improvements. For example, Quality Outcomes Framework data from 2018/19 evidenced lower performance than the CCG and England averages for childhood immunisations in all of the four areas where childhood immunisations are measured. The practice told us they had a plan to improve this during the following year.	

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	N ¹
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.	P ²
Explanation of any answers and additional evidence:	
1 – The provider did not have a detailed strategy or business plan to address the lack of systems and processes in place locally to ensure the service operated safely and as intended, for example in relation to monitoring legionella.	
2 – There was no documented evidence that delivery against the strategy was being monitored, however we were told this was discussed at practice meetings.	

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.	N ¹
There were systems to ensure compliance with the requirements of the duty of candour.	Y
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:	

1 – At the time of our inspection there had been no health and safety risk assessments carried out and fire safety procedures were inadequate.

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

Source	Feedback
Staff interviews	Staff were committed to providing a high-quality service to patients. They told us that leaders were approachable and felt staff at the practice worked well together as a team.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: 1 – At our last inspection Governance arrangements were in place at the practice, but in some instances outcomes of meetings and policies and procedures were not documented. The practice explained that the Practice Manager was new to their role and had been in post since April 2019 and was still sorting through the previous Practice Manager's files. The practice manager told us they had started to review and update all practice policies in April when they took over the role. The practice had started using a practice management resource tool to update the practice's policies and procedures. At this inspection the overarching governance framework had not ensured there was oversight of: • Safety alerts to ensure these were managed effectively. • Medicines for dealing with medical emergencies were adequate and in line with recommended guidelines. • The provider had not ensured that processes were happening in line with policy or legal requirements. For example, policies were not reviewed to indicate essential training required for staff to perform their role. This was a concern identified at the last inspection. • Staff files we reviewed showed not all staff had received an appraisal or had an appraisal date scheduled	

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.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N ²
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: 1 – Leaders had not ensured they had oversight of systems and processes so that risks were managed effectively in the practice. For example, there was no oversight of monitoring legionella to ensure these had been logged and acted on. 2 – The practice was not managing all risks (for example in relation to fire safety). When we raised this with the managers, they acknowledged that this had been overlooked and immediately following our inspection managers carried out a fire drill and tested the fire alarm system. The provider did not have appropriate systems in place for the safe management of medical emergencies. There were a number of emergency medicines unavailable and no risk assessment in place should these be needed. During our inspection, the GP ordered the recommended emergency medicines that were not in stock. We asked the provider how legionella risks were assessed and managed. The provider told us no legionella risk assessment had been carried out. The practice had a disaster handling and business continuity plan in place. There was an arrangement with a local surgery to use its facilities if the main premises of Bulbanks Medical Centre became unavailable for use for any reason. The provider had a buddy system with a local GP practice to ensure continuity of services both clinically and administratively when Dr Nandra was away from the practice.	

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.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	P ¹
There were effective arrangements for identifying, managing and mitigating risks.	N ²
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: 1 – Individual care records were not always written and managed securely and in line with current guidance and relevant legislation. 2 – Leaders had not ensured they had oversight of systems and processes so that risks were managed effectively in the practice. The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not operated effectively, in particular in relation to Fire safety, Medicines management and Legionella control. Fire safety was a concern identified at our last inspection	

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.	P ¹
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: 1 – The practice did not have an active patient participation group. The Practice Manager was new to their role and had been in post since April 2019. Staff told us the PPG had not engaged well with the practice under the previous Practice Manager. The new Practice manager had been working with the CCG to start a virtual PPG, pending the merge with another surgery. Staff told us they had contacted a local PPG forum for help with recruiting new members. We saw a suggestion box in the reception area. Monthly clinical and non-clinical meetings were taking place which enabled staff to provide feedback or concerns to the practice leadership team.	

Feedback from Patient Participation Group.

Feedback
The practice did not have an active patient participation group at the time of the inspection.

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.	P ¹
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: 1– Although the practice had regular clinical meetings, there were limited opportunities for development as there was no formal peer review or audits of decision making. The provider had not established an effective system of staff appraisals where the learning needs of staff were identified. We saw evidence of the provider conducting two audits each year as part of their annual appraisal process.	

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.