

Care Quality Commission

Inspection Evidence Table

Ryalls Park Medical Centre - Yeovil (1-553822687)

Inspection date: **5 November 2019**

Date of data download: 11 November 2019

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

This inspection was a focussed inspection to ensure the requirements within the previously issued warning notices had been addressed. We have not applied new ratings to the practice, following this inspection.

Safe

Safety systems and processes

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

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
Explanation of any answers and additional evidence: At our inspection in July 2019, we found: <ul style="list-style-type: none">Not all staff who acted as chaperones had received a DBS check. At our inspection in November 2019, we found: <ul style="list-style-type: none">The practice had updated their chaperone policy to include that these duties should be conducted by clinically trained staff.The practice told us reception staff no longer acted as chaperones.All necessary staff had received a DBS check. We also saw evidence that a risk assessment had been conducted for members of staff who did not require a DBS check.The practice was unable to evidence that all staff had received safeguarding training appropriate to their role and in line with national guidance. For example, the practice was unable to evidence that two GPs had completed level three safeguarding adults training.	

Recruitment systems	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019, we found:</p> <ul style="list-style-type: none"> • Systems to ensure recruitment checks and employment records were maintained in line with national guidance, were not effective. • We reviewed seven employment records and found that information held by the practice was not consistent. We identified gaps relating to employment references, work history and confirmation of identity. • There was not effective oversight of the immunisation status of staff. <p>At our inspection in November 2019 we found;</p> <ul style="list-style-type: none"> • Improvements had been made to ensure recruitment checks were consistently sought and maintained. The practice had transferred all personnel files to an online portal. We saw evidence that employment records for all staff had been brought up to date and in line with national guidance. • We saw evidence that the practice was in the process of bringing information relating to the immunisation status of staff, up to date. We saw evidence that where necessary, staff had been referred to provider's occupational health service. • On inspection, we identified that one member of staff had declined immunisation for Hepatitis B. We saw evidence that the practice had started to risk assess the impact of this but was waiting for information from occupational health services. Following inspection, the practice sent us a risk assessment dated 6 November 2019 relating to this member of staff. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 24 September 2019	Y
There was a record of equipment calibration. Date of last calibration: 24 September 2019	Y
There was a fire procedure.	Y
There was a log of fire drills. Date of last drill: 5 September 2019	Y
There was a record of fire alarm checks.	Partial
There was a record of fire training for staff.	Partial
There were fire marshals.	Y
A fire risk assessment had been completed.	Y

Date of completion: 12 July 2019	
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> The practice did not have an effective system to ensure all necessary equipment received the appropriate checks. The practice could not evidence that all items requiring action on the fire risk assessment were completed. The practice was unable to evidence that all staff had received fire safety training. <p>At our inspection in November 2019 we found;</p> <ul style="list-style-type: none"> The practice had a comprehensive asset list which identified all equipment used by the practice. This was accessible on the practice's online portal and we saw evidence that all equipment had received the necessary checks. We reviewed the practice's fire risk assessment and saw that items identified as requiring action, had been completed. We saw evidence that regular fire alarm checks were conducted but these were not consistently recorded. We reviewed records dating back to October 2019 and identified that no fire alarm check was recorded for the week commencing 14 October 2019. The practice told us that the check had been completed but it had not been recorded. The practice was still unable to demonstrate that all staff had received fire safety training. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found that no overall health and safety risk assessment had been completed for the practice.</p> <p>At our inspection in November 2019 we found that the practice was still unable to evidence that an overall health and safety risk assessment had been conducted. However, the practice was working with an external company to help improve their understanding of what was required for health and safety compliance. We saw evidence that risk assessments had been conducted for individual concerns. For example, a legionella risk assessment had been completed.</p>	

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.	Partial

Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 23 October 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> Practice processes for infection prevention and control (IPC) were not embedded. An infection control audit had been completed on 21 June 2019, however this did not provide appropriate detail to evidence what had been reviewed and what actions had been identified. The practice had also been unable to evidence audits completed prior to the one undertaken in June 2019. <p>At our inspection in November 2019 we found;</p> <ul style="list-style-type: none"> The practice had appointed an IPC lead who had been in post since 2 October 2019. They told us that they were due to attend a training day with the clinical commissioning group on 7 November 2019. We saw evidence that an IPC audit had been completed in October 2019. When we inspected on 5 November 2019 we saw that some items identified as requiring action, had been completed. For example, cloth chairs had been replaced and a handwashing audit had been completed. The practice was unable to evidence that all staff had completed IPC training. For example, records showed that four members of non-clinical staff had not completed this training. 	

Risks to patients

There were systems to assess, monitor and manage risks to patient safety were not embedded.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> Patient appointments had been cancelled and rebooked due to the lack of clinical cover. Feedback from patients included that access to GP appointments was difficult. <p>At our inspection in November 2019 we found;</p> <ul style="list-style-type: none"> The practice advised that they were actively recruiting for a GP and an advanced nurse practitioner. The practice told us that appointments were only cancelled when necessary. We saw evidence that since 1 September 2019 there had been five occasions when appointments had to be rescheduled due to staff illness. On inspection, feedback from patients included that access to GP appointments was still a concern. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including

medicines optimisation. However these were not always embedded and formalised.

Medicines management	Y/N/Partial
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
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> • The practice was not monitoring prescribing of non-medical prescribers or providing them with appropriate clinical supervision. • There was not an effective system to support the prescribing of high-risk medicines. We identified two patients prescribed these medicines who had not received the necessary checks. <p>At our inspection in November 2019 we found;</p> <ul style="list-style-type: none"> • The practice did not have a formal process to ensure the competency of non-medical prescribers. We requested the practice policy on this. They provided us with best practice guidance formulated by their primary care network. However, the practice could not evidence that they were compliant with this guidance. • On inspection, the practice told us that their process to monitor non-medical prescribers was to use the Royal College of General Practitioners (RCGP) audit process. We saw that two searches had been prepared which looked at five random consultations conducted by non-medical prescribers. One of these had been reviewed by a GP using the RCGP audit toolkit. However, there was no evidence that this had been discussed between a clinical staff member and a non-medical prescriber to ensure their competencies. • On inspection, we spoke with one non-medical prescriber who advised they had previously received ad hoc meetings with a GP to discuss clinical care. However, the practice was unable to evidence this as formal documentation was not available. • We reviewed records of patients prescribed high risk medicines and found that they had received the appropriate monitoring. However, the practice did not have a practice specific protocol for monitoring patients prescribed high risk medicines. This meant that temporary and new staff did not have clear guidance. • On inspection we found that repeat prescriptions requested by secondary care, were not always reviewed by a GP before they were issued. For example, we identified one patient who had been prescribed an antibiotic following discharge from secondary care. This had been added to the patient record as a repeat prescription. There was no evidence that this discharge summary had been reviewed by a clinical pharmacist or GP. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> We identified one patient whose prescription for Methadone (an opioid used for opioid maintenance therapy) had been increased by a local drug and alcohol service. There was no evidence that this had been reviewed by a GP. (Methadone is a controlled medicine subject to additional prescription safety management.) On inspection we found that the practice's emergency medicines were not held securely. The emergency medicines were held in an unlocked cupboard in a patient accessible hallway. We raised this with the practice on inspection. By the end of the day, they had moved the emergency medicines to the reception office and had sent a notification round to all staff advising of this change. 	

Effective

This inspection was a focussed inspection to ensure the requirements within the previously issued warning notices had been addressed. We have not applied new ratings to the practice, following this inspection.

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. However, pathways and tools to support this were not always embedded.

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients' treatment was regularly reviewed and updated.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> There was not an effective method of identifying patients' needs. Gaps in clinical coding in patient records meant the practice was unable to identify patients with specific health needs or conditions to ensure they were reviewed regularly, and their needs were met. The practice was unable to evidence that patients with long term conditions and mental health conditions had received the appropriate monitoring. <p>At our inspection in November 2019 we found;</p> <ul style="list-style-type: none"> We saw evidence a recall process had been implemented inviting patients with long term conditions and mental health conditions, to attend the practice for a review of their health conditions. We found improvements had been made to the clinical coding applied to patient records. The practice told us they had audited all patient records, identifying those where clinical data or prescribed medicines were suggestive of a long-term condition. This process identified 80 patients. The patients' records were then reviewed and if appropriate, the necessary code was added to their record. However, our inspection indicated that appropriate codes were not always added to patient records. For example, the practice told us that patients who attended for a 	

diabetic review were coded as having received a diabetic foot check.

- On inspection, we identified that the practice could not evidence that mental health reviews conducted in secondary care, had been reviewed by a practice GP. For example, we reviewed records of six patients on the practice's mental health register who had received a review in secondary care. The practice had received correspondence from the mental health service advising of these reviews. They had been processed by the practice's workflow team however, there was no evidence that these had been reviewed by a GP.

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 (01/04/2018 to 31/03/2019) (QOF)	56.5%	70.1%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	3.2% (11)	8.0%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	54.1%	68.5%	78.1%	Significant Variation (negative)
Exception rate (number of exceptions).	3.2% (11)	6.8%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	66.4%	76.4%	81.3%	Variation (negative)
Exception rate (number of exceptions).	6.5% (22)	11.1%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	13.5%	63.5%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	2.0% (7)	6.7%	7.4%	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 (01/04/2018 to	37.8%	74.1%	89.6%	Significant Variation (negative)

31/03/2019) (QOF)				
Exception rate (number of exceptions).	5.8% (6)	8.1%	11.2%	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 (01/04/2018 to 31/03/2019) (QOF)	70.1%	78.2%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	4.0% (31)	3.7%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	84.2%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.0% (1)	5.0%	5.9%	N/A

Any additional evidence or comments

Prior to April 2019 the practice had opted out of fully using the national Quality and Outcomes Framework (QOF), (QOF is a system intended to improve the quality of general practice and reward good practice). The practice used an alternative local quality improvement, the Somerset Practice Quality Scheme (SPQS). SPQS monitored quality and outcomes differently with an emphasis on quality improvement activities. Under the SPQS framework reporting on some indicators such as the QOF data was not used. This meant data for 2018/19, which showed a negative variation, in achievement shown was not representative of the quality work undertaken at the time. Consequently, this practice showed more negative variation for long-term conditions and mental health when compared with other practices for 2018/19.

QOF indicators from 1 April 2019 were updated and some of the indicators shown above have been retired.

Following inspection, the practice sent us unverified data for the above indicators from 1 April 2019 to 4 November 2019 as follows;

- 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 was 67%.
- 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 was 50%.
- 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 was 58%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less was 82%.
- 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 was 89%.

Although the information is unverified, it demonstrated that the practice was working to improve data and improve the monitoring of patients with a long-term condition.

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 (01/04/2018 to 31/03/2019) (QOF)	3.1%	51.5%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	9.8%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	40.6%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	8.5%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	40.5%	61.6%	83.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.3% (1)	6.4%	6.7%	N/A

Any additional evidence or comments

QOF indicators from 1 April 2019 were updated and some of the indicators shown above have been retired.

Following inspection, the practice sent us unverified data for the above indicators from 1 April 2019 to 4 November 2019 as follows;

- 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 was 75%.

Monitoring care and treatment

The practice had a programme of quality improvement activity however systems to routinely review the effectiveness and appropriateness of the care provided were not embedded.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	298	No Data	539.2
Overall QOF score (as a percentage of maximum)	53.3%	No Data	96.4%
Overall QOF exception reporting (all domains)	3.2%	No Data	No Data

	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.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> • The practice did not have an effective system of quality improvement. • The practice was unable to evidence that they had an embedded programme of clinical audit. <p>At our inspection in November 2019 we found that the practice had implemented a programme of clinical audits. However, we found that these audits contained limited information. For example, two of the eight audits we reviewed did not show improvements and no action plan had been identified to address this. Two further audits we reviewed showed limited improvements and no actions had been identified to improve positive outcomes.</p>	

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

We reviewed an audit which looked to ensure the appropriate diagnosis coding was applied to patients records who were at risk of developing diabetes (pre-diabetic). The practice had run a search to identify patients whose blood sugar levels were within the pre-diabetic range. These results would then be reviewed by a GP who would assess whether a pre-diabetic diagnosis was appropriate. The first cycle identified 14 patients and the second cycle identified 11 patients. There was no information available on the audit to determine why 11 patients had not had this coding added to their records. The practice was also unable to evidence that the findings of this audit had been discussed between clinicians to identify learning and drive improvement.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p>	

- The practice was unable to evidence that all staff had received training appropriate to their role.
- The practice was unable to evidence how they were assured of the competency of non-medical prescribers.

At our inspection in November 2019 we found that some improvements had been made to the practice's oversight of staff training as it was held centrally on an online portal. However, the practice was still unable to evidence that all staff had completed necessary training.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	80.8%	89.8%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	1.5% (20)	1.1%	0.8%	N/A

Any additional evidence or comments

Following inspection, the practice sent us unverified QOF data for the above indicators from 1 April 2019 to 4 November 2019 as follows;

- 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 was 62%.

Responsive

This inspection was a focussed inspection to ensure the requirements within the previously issued warning notices had been addressed. We have not applied new ratings to the practice, following this inspection.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received since July 2019.	4
Number of complaints we examined.	4
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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found;</p> <ul style="list-style-type: none"> There was not an effective system for responding to and acting on patient feedback. <p>At our inspection in November 2019 we found practice processes to receive and respond to complaints required improvement.</p> <ul style="list-style-type: none"> Not all complaints were responded to in a timely way and in line with practice policy. For example, we reviewed one complaint where the final response had been issued outside the 20-day investigation period. No additional update was provided to the patient in line with practice policy. Practice policy did not include information relating to the Parliamentary and Health Service Ombudsman (PHSO) should a patient be dissatisfied with the practice's final response. This information was also not included in the practice's final response letters to patients. <p>Following inspection, the practice sent us evidence to show that they had updated their policy. They also evidenced that they had been in further contact with the complainants and advised them of the next steps available to them should they be dissatisfied with the practice's response.</p>	

	Y/N/Partial
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <p>On inspection, the practice was unable to evidence that complaints were used to drive continuous improvement. They advised that complaints were not discussed at team meetings, however we saw evidence that some learning points from complaints were shared with practice staff by email on an ad hoc basis.</p> <p>The practice also did not keep a record of informal complaints and so was unable to spot trends and identify learning.</p>	

Well-led

This inspection was a focussed inspection to ensure the requirements within the previously issued warning notices had been addressed. We have not applied new ratings to the practice, following this inspection.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: Following our inspection in July 2019, the practice had formulated an action plan to address the concerns identified. At our inspection in November 2019 the practice was unable to evidence that progress against the action plan was monitored. For example, the action plan identified that additional training had been conducted to improve systems for responding and acting on patient feedback. However, on inspection we spoke with staff who advised that they had not received training on complaint management. Our inspection indicated that the action plan did not adequately address all concerns to enable improvement. For example, it did not address how the practice would address the gaps in staff training and monitor this going forward. The practice told us that they held weekly quality improvement meetings. However, they did not have a process to formally minute these meetings so were unable to evidence items discussed and learning identified was disseminated to relevant staff. In November 2019 we found that the practice had introduced an online management system. We saw that information such as practice policies, complaints and staff files had been or were in the process of being uploaded to this system. The online portal gave the practice improved oversight of areas raised as a concern at our inspection in July 2019. For example, oversight of staff employment records and immunisation status.	

Governance arrangements

The overall governance arrangements were not always embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence:	

Our inspection in November 2019 identified that the practice did not have effective oversight of staff training. The practice could not evidence that they were compliant with their training policy. For example, they could not evidence that all clinical staff had completed training in infection control, fire safety and information governance. Following inspection, further information was requested to demonstrate staff had completed this training. This was not received.

The practice told us they held monthly operations meetings, however these were not formally minuted to demonstrate actions and learning identified.

Evidence obtained on inspection demonstrated that policies and procedures were not embedded and effectively communicated to staff. For example;

- On inspection we spoke with a non-medical prescriber and requested to review the policy for clinical supervision. They were unable to find one. We requested that the practice send us their policy in the two working days following inspection. The practice sent us a best practice document formulated by their primary care network. Evidence obtained on inspection identified that the practice was not compliant with this guidance.
- Feedback received from clinical staff on inspection identified that they had not been told of quality improvement processes or audit cycles undertaken by the practice.
- On inspection we spoke with reception staff who told us that they were not aware of the process should a patient not attend for their appointment.
- Complaints were not always responded to in line with practice policy and national guidance. The practice did not have a process to discuss complaints as a team to identify themes and learning.

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.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found that there was not an effective system to identify and mitigate risk in regard to fire safety, infection prevention and control (IPC) and health and safety.</p> <p>At our inspection in November 2019 we found that improvements had been made to how risks were identified and acted on. The practice had appointed a new IPC lead and we saw that an effective policy had been introduced. All actions identified on the fire safety risk assessment had been completed. The practice was working with an external company in regards to health and safety, however they were unable to evidence an overall health and safety risk assessment.</p> <p>The practice had introduced a team to optimise effective document workflow. However, governance structures to support this team were not embedded. For example, there was no evidence of a quality assurance process to ensure staff performed within their competence.</p> <p>The practice could not demonstrate how they were assured of the competence of non-medical prescribers.</p>	

We saw no practice oversight of clinical audit. They could not demonstrate how clinical audit was used to drive improvement.

Appropriate and accurate information

There was a commitment to using data and information proactively to drive and support decision making but this was not embedded.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	partial
Explanation of any answers and additional evidence: In November 2019 we found processes had improved to ensure clinical coding on patient records were applied. Improvements in QOF (quality outcome framework) data demonstrated this. However, the practice was unable to demonstrate that they had effective oversight of this. For example, there was no evidence that coding or QOF data was discussed at practice meetings or clinical meetings and our inspection identified that coding was not always appropriate and accurate.	

Engagement with patients, the public, staff and external partners

The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice 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: At our inspection in July 2019 we found that there were not effective systems for responding to and acting on feedback received from patients and other health care professionals. This included providing effective access to the service for patients. At our inspection in November 2019 we saw that the practice had implemented some changes to gather feedback from patients. For example, they had introduced an electronic feedback facility where patients could press a button showing different smiley faces to represent how they felt their experience at the practice had been. Feedback received by this facility had been largely positive but did not allow for comment for patients to give detail on their experience. The practice had not conducted any information gathering exercises to get feedback from patients on access to appointments. On inspection we spoke with eight patients who all feedback that access to appointments was problematic and that the appointment system didn't work. Patients provided us with examples and where possible we corroborated their experiences with practice records. The practice could not evidence that they had discussed patient feedback and were using it to improve services.	

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. 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.