Care Quality Commission

Inspection Evidence Table

Boleyn Road Practice (1-537763824)

Inspection date: 4 December 2019

Date of data download: 27 November 2019

Overall rating: Inadequate

At our previous inspection on 13 July 2018 we rated the practice inadequate overall as there were breaches in Regulation 17 Good Governance of the Health and Social Care Act for which warning notices were issued and the practice was placed in special measures. We carried out a follow up comprehensive inspection on 1 April 2019 following which we rated the practice as requires improvement overall as insufficient improvements had been made and the practice was unable to demonstrate an improvement with patient satisfaction with access to services. Therefore, the practice's period of special measures was extended.

At this inspection on 4 December 2019 we rated the practice as inadequate overall as insufficient improvements had been made since the previous inspections and we found areas where the services provided had deteriorated.

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

Safe Rating: Inadequate

At our previous inspection in July 2018 we rated the practice as inadequate for providing safe services as systems did not keep patients safe and safeguarded from abuse and issues were identified with medicines management, governance, staff training and learning from significant events. There was some improvement when we carried out a follow up inspection in April 2019, but the practice was unable to evidence the changes that had been made as a result of the initial inspection had been sufficiently embedded into routine practice. Therefore, the practice was rated as requires improvement for providing safe services.

At this inspection we rated the practice as inadequate for providing safe services because:

- The practice did not have clear systems and processes to keep patients safe and safeguarded from abuse.
- There were insufficient processes for sharing learning.
- There was a lack of risk mitigation.
- There was no evidence of clinical oversight and supervision.
- The overall governance arrangements were ineffective.
- There was a lack of a systemic approach for ensuring patient safety alerts had been actioned.

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.	No
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	No
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	No
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial

Explanation of any answers and additional evidence:

All clinical staff had completed safeguarding training at an appropriate level for their role. All non-clinical staff had completed safeguarding training at an appropriate level for their role except for the registered manager and the reception manager whose safeguarding children training expired the day before this inspection and there had been no plans made for this to be completed. However, post inspection we were provided with evidence of up-to-date safeguarding training for the reception manager.

In the absence of the single GP partner, the three locum GPs had signed a clinical governance document where they stated the days of the week for which they would be the clinical lead for the practice, this included the safeguarding lead. However, there were no named leads in the child safeguarding policy. This policy had not been updated to reflect the new arrangements following the absence of the GP partner. The policy was last reviewed in May 2018 and there was no stipulation of when it was next to be reviewed. There were also no named leads in the vulnerable adults' policy. This policy was not version controlled and referred to outdated agencies such as the PCT. When staff were asked who the leads for safeguarding were, some staff we spoke with still named the absent GP partner as the active safeguarding lead.

The practice manager was unable to access the safeguarding policies on the computer system and stated that this was because they had been newly added to their system.

We were told that MDT meetings where vulnerable patients were discussed were held on the third week of every month. We saw minutes of meetings for these, where in the absence of the GP partner, one of the locum GPs attended and the outcome for the patients discussed were entered into the patient record. However, the practice was unable to evidence that any internal discussions occurred about the

Safeguarding	Y/N/Partial
vulnerable patients discussed at the MDT meetings to ensure information was appropriately shared and assure that each locum GP was kept up to date with the care of these patients. Minutes of these meetings were password protected and saved on the shared drive, there was a document that included the monthly passwords for access to these, we found that not all relevant staff knew how to access this information. We asked the practice to provide us with evidence the out of hours service was informed of relevant safeguarding concerns, and whilst they told us this was done, they could not provide us with evidence of this. Our inspection found patients receiving palliative care were appropriately highlighted on the clinical system, however staff had failed to highlight vulnerable patients with learning disabilities and patients living with dementia to ensure these patients were identified by reception staff members to ensure they received priority treatment.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: We viewed a sample of two clinical and two non-clinical personnel files for staff members who were employed since the last inspection and found no record of an induction for non-clinical staff. The practice manager told staff to complete this, but they did not comply. For one of these non-clinical staff members there was no evidence of photographic proof of ID.	

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: 2 December 2019	Yes
There was a record of equipment calibration. Date of last calibration: 31 October 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Partial

There was a record of fire extinguisher checks. Date of last check: February 2019	Yes
There was a log of fire drills. Date of last drill: 29 August 2019	Yes
There was a record of fire alarm checks. Date of last check: weekly	Yes
There was a record of fire training for staff. Date of last training: various dates	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 21 November 2018	Yes
Actions from fire risk assessment were identified and completed.	Yes

Explanation of any answers and additional evidence:

The practice had safety sheets for the different hand washes that were used in the practice which included how to store them. However, items such as bleach, Dettol and multi-surface polish were named in a risk assessment template and marked as 'High Risk' but the risk assessment was incomplete with no further details including actions needed to be taken to mitigate the risks of these substances. The practice manager told us that risks were mitigated as these items were stored in a locked storage room and staff could read the instructions on the items.

The practice had documented fire drills; however, they did not document how long it took to evacuate the building or the outcomes of the drill, and this was not discussed with staff. The practice manager stated that any further documentation would be time consuming and a waste of NHS time and resources.

The practice had a fire policy which identified two named leads to manage the policy, but the policy was not bespoke to the practice and included blank spaces where the practice was meant to insert practice specific information such as the names of the fire wardens and the fire assembly point. However, we observed the fire assembly point was noted on a fire poster on the practice wall next to the fire exit door. The practice manager told us that the missing details were not required in the fire policy as the policy had leads who were in charge of it.

The practice manager told us there were two fire marshals. When they were unable to evidence that the second fire marshal had completed specific training for the role, the practice manager changed his mind and told us they only had one fire marshal. However, we saw posters displayed around the practice which named the two fire marshals that the practice manager originally identified.

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment:	N/A

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2018	Yes
Explanation of any answers and additional evidence: There were no actions as a result of the externally completed health and safety risk assessment which incorporated premises security risk.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	No
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: No date given by the practice	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Unknown
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: We were shown an infection control audit template/action plan however the date of this audit was not included on this document, but staff told us it took place in the last 12 months. The action plan recommended remedial actions the practice should consider taking, but the practice did not document the actions they agreed to take or any timeframes. However, the practice manager told us all the actions identified in the audit had been completed and a response by the practice stating the actions had been completed was sent to NHSE, but they had not received a reply. We asked to see evidence that the actions had been completed and we were not shown this. We were told that the three practice nurses and the three regular locum GPs were all the leads for infection control. We asked to see the specific training that had been completed to evidence competency for this lead role and the practice was unable to evidence this.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	No
There was an effective induction system for temporary staff tailored to their role.	No
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes

The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No
Explanation of any answers and additional evidence: The practice manager stated he was the person who covered staff duties when non-clinical staff were absent if there was no alternative, and locums were used when there was a GP absence. We were told that the practice did not have a protocol in place to manage poor staff attendance or low staffing levels. The practice had a clinical governance arrangement agreement that was signed by each of the three GP locums stating the lead roles they would take on each day in the absence of the GP partner. One of these lead roles included clinical supervision and oversight of all clinicians. However, we were told there were no formal arrangements for clinical supervision and the practice could not demonstrate how the oversight of clinical work was managed, there was no evidence that this occurred.	

Information to deliver safe care and treatment

Staff did not 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.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	No
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results..	Partial
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.	No

Explanation of any answers and additional evidence:

The practice was unable to demonstrate how they shared information with other staff and agencies, we asked to view examples of sharing information with external agencies and they were unable to provide any.

As part of our records review we identified 30 patient consultations which did not meet the recommended guidance which meant we could not be assured the care provided was safe.

The health care assistant completed clinical notes summarising.

We found test results were reviewed in a timely manner and were told the GP on duty was in charge of this process.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.33	0.71	0.87	Significant Variation (positive)
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). (01/10/2018 to 30/09/2019) (NHSBSA)	8.1%	9.6%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	7.00	5.72	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	0.44	1.47	2.08	Significant Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	No
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence: Our review of patient records found there was a lack of detail within consultation notes with regards to medication reviews undertaken for patients. The majority of patient records we reviewed did not have any detail when a medication review was undertaken and only stated 'Medication Review.' It was not clear therefore if any changes were required and if these were subsequently actioned; if the patient was complying with the medicine regime or if the patient was experiencing any problems or adverse side effects; and there was no information available for another clinician providing care for the patient.	

Medicines management	Y/N/Partial

Our review of patient records found patients prescribed Warfarin medicine were being appropriately monitored however, we found the practice did not follow national guidance which recommends patients being prescribed Direct Oral Anticoagulants (DOACs) are regularly monitored for adverse side effects in additional to annual blood tests.

The management and storage of Patient Group Directions (PGD) was disorganised as the practice stored expired PGDs with current PGDs. We identified two PGDs which had not been signed by one of the practice nurses. We were told this was due to annual leave, but the two PGDs in question were in operation before their annual leave period.

There was no evidence of training for two of the practice nurses for the HPV conversion for cervical cytology in their files. However, post inspection this evidence was provided.

The practice could not evidence how they monitored their controlled drug prescribing and there were no systems to ensure any concerns were raised. We were told controlled drug audits were completed by the GP partner before their absence, but they could not be located during or after the inspection.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	No
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months: 7	
Number of events that required action: 7	

Explanation of any answers and additional evidence:

There was confusion over where the significant event policy was saved on the computer system, when was found it was dated February 2018 and named a staff member who no longer worked at the practice as the deputy lead in the absence of the registered manager. When asked, the practice manager was only able to name CQC as an external company where certain significant events were required to be reported. Some staff we spoke with were unaware of the significant event template and said they would just tell the practice manager if they thought there had been a significant event.

The practice was unable to demonstrate that learning and outcomes from significant events was effectively shared with staff members. We reviewed minutes of meetings that occurred two to three months after significant events had occurred which stated, 'significant event discussed,' with no further detail. Some staff we spoke with told us that minutes of meetings were not circulated, and they had no access to them. Staff also told us they had no knowledge of when practice meetings occurred or where these significant events had been discussed. We were also told that minutes were written up without an actual meeting occurring.

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

Event	Specific action taken
A patient was reviewed for a post Myocardial infarction (MI) and details such as pulse and medicine titration were not recorded in the medical record.	On the significant event summary template, the practice sent CQC prior to inspection, it stated that following this significant event this patient was followed up and the medicine dose was titrated to prevent a further heart attack and that staff should always use the MI template. The practice was unable to evidence that this had been discussed with staff where these actions had been agreed. We were shown minutes of a meeting which occurred three months later which read 'significant events discussed with staff' but included no further details.
A wrong read code was entered in a	On the significant event summary template, the practice sent us

patient record leading to potential patient distress.	prior to inspection, it stated that following this significant event the read code was correctly inputted in the clinical system and GPs and summarisers needed to be careful when adding read codes. The practice was unable to evidence that this had been discussed with staff where these actions had been agreed. We were shown minutes of a meeting which occurred two months later which read ‘significant events discussed with staff’, and no further detail was included.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial

Explanation of any answers and additional evidence:

We were told the practice manager and the lead GP for the day, received the safety alerts and passed them to the reception manager who cascaded them to the clinicians who decided whether there were any clinical actions required. The practice manager did not have access to the log of safety alerts, the reception manager accessed and also showed us emails that he sent to staff members with alerts attached. For example, there was an alert regarding Theophylline which affected three patients in the practice but there was no detail of actions taken in the email that was sent to staff members and there was no evidence that this was discussed in a meeting where actions and learning was identified.

We saw examples of actions taken on recent alerts for ranitidine, the practice provided minutes of meetings where this was discussed but the action identified was limited to patients being recalled for GPs to change to alternate medications, there were no actions highlighting what GPs should do in regard to this medicine in the future.

Effective Rating: Inadequate

At our previous inspection in July 2018 we rated the practice as requires improvement for providing effective services because reviews of the effectiveness and appropriateness of care was limited. There was some improvement when we carried out a follow up inspection in April 2019, but the practice had no formal programme for quality improvement. Therefore, the practice remained rated as requires improvement for providing effective services.

At this inspection the practice was rated the practice and all population groups Inadequate because:

- There were insufficient systems for clinical oversight and supervision.
- There were issues with quality improvement.
- The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.
- Some performance data was significantly below local and national averages.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	No
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
Explanation of any answers and additional evidence: As part of our records review we reviewed 30 patient consultations and found they did not meet the recommended guidance. This meant we were not assured the health care provision was effective. We were told the practice would share any new guidelines with clinical staff in paper form, the practice was not able to evidence occasions when this had been done and told us that due to time constraints and there only being locum GPs, this was not discussed in meetings.	

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) (01/10/2018 to 30/09/2019) (NHSBSA)	0.13	0.31	0.74	Significant Variation (positive)

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

Older people — Population group rating: Inadequate

Findings

- 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 did not always carry 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.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

People with long-term conditions — Population group rating: Inadequate

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, we were told that data was inputted into the patient record without evidence.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, there was no evidence of internal discussions regarding these patients.
- 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 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 (01/04/2018 to 31/03/2019) (QOF)	54.2%	72.6%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	2.1% (10)	7.9%	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)	79.1%	78.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	2.1% (10)	4.9%	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)	72.5%	80.2%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.4% (21)	7.0%	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)	86.1%	77.9%	75.9%	Variation (positive)
Exception rate (number of exceptions).	0.8% (2)	3.0%	7.4%	N/A
The percentage of patients with COPD who	96.0%	92.1%	89.6%	No statistical

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 31/03/2019) (QOF)				variation
Exception rate (number of exceptions).	0.0% (0)	7.8%	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)	76.1%	81.7%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.4% (8)	3.4%	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)	87.5%	90.2%	91.1%	No statistical variation
Exception rate (number of exceptions).	20.0% (2)	6.0%	5.9%	N/A

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

Families, children and young people Population group rating: Inadequate

Findings

- Childhood immunisations achievement was below national targets.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice could not demonstrate they had arrangements for following up failed attendance of children's appointments following an appointment in secondary care.
- 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)	7	75	9.3%	Below 80% uptake
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)	18	66	27.3%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	34	66	51.5%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	33	66	50.0%	Below 80% uptake

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

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

Working age people (including those recently retired and students) — Population group rating: Inadequate

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. 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. However, the practice did not have their own website where patients could find information.

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)	48.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	23.8%	55.0%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	31.1%	45.1%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	100.0%	80.4%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	50.0%	44.3%	51.9%	No statistical variation

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- Same day appointments and longer appointments were offered when required, but there was no system to highlight these patients to reception staff to enable this to be done.
- 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 but there was no evidence of internal discussions about these patients.
- 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.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. However, we were told that staff were told to input data without evidence into patient records such as smoking status.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	68.2%	90.4%	89.4%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.3% (1)	9.0%	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)	100.0%	91.9%	90.2%	Variation (positive)
Exception rate (number of exceptions).	4.3% (1)	6.2%	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)	87.5%	81.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.2%	6.7%	N/A

Any additional evidence or comments
The GP we spoke with was unable to give an explanation regarding areas of low achievement. We viewed the clinical system and found that currently of the six patients with dementia, two of them had a documented care plan agreed in the last 12 months.

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	467.5	No Data	539.2
Overall QOF score (as a percentage of maximum)	83.6%	No Data	96.4%
Overall QOF exception reporting (all domains)	2.7%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	No
The practice had a comprehensive programme of quality improvement and used	Partial

information about care and treatment to make improvements.	
Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice was in the process of taking part in local quality improvement activities and had signed up to complete an audit, but this was yet to be completed as the deadline for this was post inspection.

Any additional evidence or comments
The practice completed an audit which aimed to ensure all patients who were on the metformin had their renal function checked in the last 12 months and at least twice a year for patients with additional risk factors for renal impairment or if deterioration was suspected and heir dose is optimized as per their estimated glomerular filtration rate (eGFR). The first cycle of the audit in March 2019 found one patient with an eGFR of less that 30ml and metformin was stopped. The second cycle in November 2019 found one patient with an eGFR of less than 30ml who was on metformin. This was removed from their repeat medicines list; the patient was booked an appointment to discuss this but did not turn up, so administration staff were tasked to make an appointment for the patient. This audit did not include the details of who completed the audit, any patient identifiers and any background information such as the total number of patents found who were taking metformin, including the total number who had the appropriate testing in the right duration of time. There was no evidence that this audit was discussed with relevant staff members involved in the treatment of patients who were being prescribed this medicine or whether the removal of the medicine was completed with patient engagement. The practice also showed us an audit which looked at cervical cytology performance with the aim of monitoring, reflecting and improving cervical smear performance. We were told that this was a completed audit cycle, but the first cycle of the audit was not able to be found. The second cycle found that between January and December 2018 258 cervical smears had been taken, five of which were inadequate where four of those was due to insufficient cells (1.93%) and 44 patients refused a cervical smear (17%). The audit recommendations were to review the read-coding procedures, monitor inadequate specimens more closely and smear takers to attend a smear update. The audit stated that staff were trained on the recall procedure which included three patient invites and ceasing invites until the following year after the third invite, it also stated staff were trained on correct read-coding and that smear update training was booked. Other than nurses attending cytology updates, the practice was unable to evidence any other training in relation to this or that this was discussed with staff where actions were agreed. The audit did not consider any other ways to improve cervical uptake other than the routine three recall reminders.

Effective staffing

The practice was unable to effectively 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	Partial

taking for the cervical screening programme.	
The learning and development needs of staff were assessed.	No
The practice had a programme of learning and development.	No
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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.	No
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	No

Explanation of any answers and additional evidence:

On the day of inspection, the practice manager told us that his staff do not always comply with what he requests they do. He told us that in the past he tried to follow policies in order to manage staff performance, but it did not work. For example, there was no system for oversight of completion of staff induction. We viewed the personnel files of the two most recently employed non-clinical staff members and found that these did not include evidence of induction, we were told that the practice manager had asked for this on numerous occasions but did not receive it. We were also told that there was no probation period for staff and this was not included staff contracts.

The practice did not have assurance that staff who had lead roles in fire safety and infection control had completed training to ensure their competence.

The practice manager told us that one of the administration staff members completed the appraisals for non-clinical staff we were told that she had training to do this but were not provided with evidence to support this. We found only two non-clinical staff members had completed an appraisal in the last 12 months, one long-term staff member told us they had never received an appraisal.

There was no clinical supervision of the work being completed by clinical staff members.

Coordinating care and treatment

Staff did not always work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or	Yes

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence: We reviewed minutes of clinical meetings where patient treatment plans were discussed and entered directly into the patient record. However, there was no internal discussions about these patients to ensure their treatment was managed consistently.	

Helping patients to live healthier lives

Staff were not consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Partial
Explanation of any answers and additional evidence: Whilst the practice promoted healthy lifestyles, we were told that non-clinical staff members were asked to input data such as smoking status into the clinical record of patients with long-term conditions without obtaining up to date information from patients, which had the potential of stopping them from getting the support they required and increasing the practice's QOF scores.	

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) (QOF)	100.0%	96.2%	95.0%	Significant Variation (positive)

Exception rate (number of exceptions).	0.8% (8)	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Partial
Policies for any online services offered were in line with national guidance.	N/A
Explanation of any answers and additional evidence: There was no process to monitor and audit that consent was appropriately sought, we viewed a sample of clinical records and found consent details were correctly inputted.	

Caring Rating: Inadequate

At our previous inspection in July 2018 we rated the practice as inadequate for providing caring services as there was little action to improve low patient satisfaction with services provided, this was the same at our follow up inspection in April 2019 where the practice was still rated as requires improvement for providing caring service.

At this inspection the practice was rated inadequate for providing caring services because:

- There was continued limited action as a result of low national GP patient satisfaction results resulting in a continued poor experience for patients.

Kindness, respect and compassion

Feedback from patients was mixed about the way staff treated people.

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

CQC comments cards	
Total comments cards received.	37
Number of CQC comments received which were positive about the service.	34
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	The majority of the comment cards were positive about staff members and the care they received, three comment cards mentioned difficulty in making an appointment.
Patients	Patients we spoke with told us that reception staff members were not always helpful.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5977.0	463.0	39.0	8.4%	0.65%

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)	66.3%	83.7%	88.9%	Significant Variation (negative)
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)	65.3%	81.0%	87.4%	Significant Variation (negative)
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)	81.6%	91.3%	95.5%	Variation (negative)
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)	57.8%	75.6%	82.9%	Variation (negative)

Any additional evidence or comments
The practice manager told us the practice had not carried out any actions as a result of the national GP patient survey stating that the numbers of patients that completed the survey were insignificant and the practices own survey was more representative of the practice population.

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

Any additional evidence
The practice completed their own internal GP patient survey over a six-week period between October and November 2019 where there were 200 respondents. This survey mimicked the questions from the national GP patient survey. The results found 82% of patients stated the healthcare professional was good or very good at listening to them, 81% of patients said that health care professionals were good or very good at treating them with care and concern, 94% of patients had confidence and trust in the last healthcare professional the saw and 76% of patients described their overall experience at the practice a good or very good. As a result of the outcomes of the practices patient survey they documented on their action plan sheet that they would remind healthcare professionals to listen to patients and to treat them with care and concern. They also stated they would discuss with the healthcare professionals how to improve trust and continue to promote the survey. The practice could not evidence that this was discussed with all relevant staff members where actions were agreed. We were shown an agenda for a practice meeting which had no date on it but included the GP patient survey as an agenda item, but staff members were not able to locate any minutes to support this and one staff member we spoke with told us that if there were minutes to this meeting they would not detail the discussion and that staff members required training on minute taking.

Involvement in decisions about care and treatment

Staff did not always help patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Patient leaflets were available in the patient waiting area.	

Source	Feedback
Interviews with patients.	We spoke with two patients during the inspection, one told us they were given enough time during consultations, the other said they feel rushed and had been told by the GP to hurry up, one also said they do not feel that the GP listens to them and the other commented on rude staff attitude. We asked the patients about their overall opinion of the practice and one rated the practice five out of ten and the other rated it four, reception staff not being helpful was also noted.

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)	82.1%	87.9%	93.4%	Variation (negative)

Any additional evidence or comments
The practice's own internal patient survey found 94% of patients felt involved in decisions made about their care and treatment. The practice action plan said they would maintain a person-centred approach and discuss alternative treatments with patients. There was no evidence that this had been discussed with all relevant staff members.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	N/A
Explanation of any answers and additional evidence: The practice did not have a dedicated practice website, however, the practice manager insisted this was not the case and insisted on searching for this website with staff members even though they confirmed there was not one. As well as interpreters, the practice team spoke six different languages and staff were used as interpreters when required.	

Carers	Narrative
Percentage and number of carers identified.	63 (1%)
How the practice supported carers (including young carers).	Carers were offered a flu vaccine and an annual health check. These patients were also offered information and referrals when necessary and had access to priority appointments
How the practice supported recently bereaved patients.	The practice had a bereavement policy, which included sending sympathy letters to patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	N/A
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	N/A
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	N/A
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	N/A

Responsive Rating: Inadequate

At our previous inspection in July 2018 we rated the practice and all population groups as inadequate for providing responsive services as the practice had a limited understanding of the population to tailor services in response to those needs and there was low patient satisfaction with services. This had not improved when we undertook a follow up inspection in April 2019 where the practice and all population groups were still rated inadequate for providing responsive services.

At this inspection the practice and all the population groups were rated inadequate because:

- There had been little improvement with improving access to appointments at the practice.
- There was continued limited action to improve patient satisfaction with services provided.
- Evidence of shared learning from complaints was limited.

Responding to and meeting people's needs

Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The practice had increased their opening hours since the last inspection in April 2019 but had reduced the times in which appointments took place. There were still no appointments provided at the practice before 9am and after 5:30pm for working patients, or patients who could not attend the practice during normal working hours. However, patients had access to appointments provided outside of the practice opening times at the local HUB service.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Appointments available:	
Monday	9:30am to 11:45am and 3:30pm to 5:20pm

Tuesday	9:30am to 11:20am and 3:30pm to 5:10pm
Wednesday	9:30am to 11:30am and 3:30pm to 5:20pm
Thursday	9:30am to 11:30am
Friday	9:30am to 11:30am and 3:30pm to 5:20pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5977.0	463.0	39.0	8.4%	0.65%

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)	90.7%	90.6%	94.5%	No statistical variation

Any additional evidence or comments

The practice told us they were part of the GP co-operative group scheme which provided seven-day access when the practice was closed for patients who were unable to attend the practice during normal opening hours. There had been no consideration of continuity of care for patients who were unable to attend the practice during normal working hours.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

Older people — Population group rating: Inadequate

Findings

- All patients had a named GP and were supported in whatever setting they lived.
- Home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

People with long-term conditions — Population group rating: Inadequate

Findings

- 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. Learning and outcomes of these meetings were not discussed internally.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services, but there was no evidence of internal discussions regarding these patients.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

Families, children and young people — Population group rating: Inadequate

Findings

- Nurse appointments were not available at the practice outside of normal working hours.
- 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. However, there was no evidence of internal practice discussions regarding these patients including after MDT meetings where only one practice GP was in attendance.
- Parents with concerns regarding children under the age of five were offered a same day appointment.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

Working age people (including those recently retired and students) — Population group rating: Inadequate

Findings

- There were no appointments available at the practice outside of normal working hours for working patients who could not attend at these times.

- Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a GP co-operation. Appointments were available Saturday and Sunday from 8am to 8pm.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

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

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health during normal working hours only.
- 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 not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: Patients who required a home visited were requested to contact the practice before 10:30am and their details were passed to the GP on duty who made the clinical decision to complete the home visit.	

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)	35.4%	N/A	68.3%	Significant Variation (negative)
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)	27.1%	62.3%	67.4%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	45.1%	63.0%	64.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	54.4%	66.9%	73.6%	Tending towards variation (negative)

Any additional evidence or comments
The practices own patient survey found 64% of patients responded positively to being able to get through to the practice by telephone, 70% of patients responded positively to their overall experience of making an appointment, 73% of patients were satisfied or fairly satisfied with the GP practices opening times and 95% were satisfied with the type of appointment they were offered. The practice's action plan stated they would keep promoting the additional capacity scheme and provide additional in-house training as well as increasing the number of staff to two receptionists answering the telephone at certain times and improve their services by offering appointments with particular clinicians relevant to the patients' medical conditions. The practice could not evidence that learning and outcomes of their survey was shared with all relevant staff members.

Source	Feedback
NHS Choices	There was one comment left on this website since the last inspection, which was complimentary to clinical and non-clinical staff, but noted difficulty in getting through to the practice by telephone.
Patients	Both patients we spoke with told us it was not easy to get an appointment and one stated they were not aware of new access to online appointments. Both patients also told us they do not have access to the GP of their choice

Listening and learning from concerns and complaints

Complaints were listened and responded to but were not effectively 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.	Partial
There was evidence that complaints were used to drive continuous improvement.	No

Explanation of any answers and additional evidence:

There was a complaints leaflet held in the reception area.

We were told that the practice manager and the reception manager managed complaints, when asked, they were both unable to find the complaints policy on the computer shared drive or on the online platform. The registered manager in front of the reception and inspection team verbally abused a reception staff member, threatening to fire them for having not made a complaints policy in time for the inspection.

The practice dealt with complaints appropriately but could not demonstrate when asked that learning from complaints was shared with all relevant staff members. We found an administration staff member completed a final complaints response and the practice was unable to demonstrate they had training for the role.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained about not being able to receive an appointment for their vaccinations and the rude manner of staff members.	We saw that the complainant received an acknowledgement email with an offer of an appointment. The final response letter from one of the practice administrators detailed a meeting with the patient following the complaint where the practice stated that they had recruited more practice nurses. We asked to see evidence that this complaint was discussed with all staff where learning and outcomes were achieved but was told that this was not done because of the conflicting information in the complaint. However, the complaints template stated that all customer services training needed to be completed, we found all staff had completed conflict resolution training but only two staff members had completed customer care training.
A patient complained due to difficulty in making an appointment and booking an appointment online with the wrong clinician and the appointment being cancelled without their knowledge.	We saw this complaint was acknowledged and the complainant received an apology from the practice. There was no evidence that this was discussed as a practice where learning and outcomes were shared. The practice manager told us there was no learning required as there was conflicting information in the complaint.

Well-led Rating: Inadequate

At our previous inspection in July 2018 we rated the practice as inadequate for providing well-led services because leaders did not have the capacity or skills to deliver high quality services and there were ineffective governance arrangements with limited systems to share learning. There was some improvement when we carried out a follow up inspection in April 2019, but issues were still identified with overall governance and the practice was unable to demonstrate how changes made could be sustained. The practice was rated as requires improvement for providing well-led services.

At this inspection we rated the practice as inadequate for being well-led because:

- There were no formal arrangements or effective processes in place for overall clinical oversight and clinical supervision.
- There was limited capacity and skills demonstrated by members of the management team.
- The practice did not have clear and effective processes for managing and mitigating risks including performance.
- The practice culture did not support honesty, openness and transparency.
- There were limited systems to act on and share information in response to patient satisfaction surveys.
- The overall governance arrangements were ineffective.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	No
There was a leadership development programme, including a succession plan.	Partial

Explanation of any answers and additional evidence:

The practice did not have a specific succession planning document but stated this was part of the business plan sent to the CQC following the last inspection which stated the practice was recruiting a new GP partner. We reviewed all of the documents sent to the CQC by the practice post the last inspection and no such document was found. The business plan we were shown on inspection dated 10 September 2019 did not include succession planning other than mentioning their anticipation of two clinical partners joining the practice in December 2019.

Not all staff we spoke with stated that the management team were approachable, and they did not feel comfortable raising concerns. The CQC team witnessed the practice manager verbally abusing staff members as well as raising his voice at members of the CQC team.

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.	No
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No

Explanation of any answers and additional evidence:

When asked, the practice told us they had the vision to provide good care to patients but could not identify any priorities or strategy to achieve this. We were shown a business plan template which identified a number of ways to establish learning, improvement and safety into the fabric of the practice. This included regular monthly clinical meetings where vulnerable patients or patients with complex needs could be discussed, but other than the MDT meetings where only one GP attended, there were no internal meetings where these patients and any updates were discussed with relevant staff members. The plan also stated that ten clinical notes would be selected randomly by the practice manager and sent to a clinician for assessment, we found that this was not being done and the practice manager was unable to demonstrate that he understood the requirements and importance of effective clinical oversight.

The practice provided us with an improvement plan for the introduction of telephone consultations however there were no timelines against any of the 14 identified actions, which were all the responsibility of the practice manager who stated they had limited capacity to complete them.

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.	No
Staff reported that they felt able to raise concerns without fear of retribution.	No
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	No
The practice's speaking up policies were in line with the NHS Improvement Raising	No

Concerns (Whistleblowing) Policy.	
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

The practice had not completed a risk assessment for a staff member who due to an injury was not meant to type for long periods of time. The practice showed us risk assessments for things such as trip hazards which we were told were staff safety risk assessments.

Staff found it difficult to find a whistleblowing policy and found one that was last updated in 2017 but did not contain details of the freedom to speak up guardian. The practice manager told us they did not have a freedom to speak up guardian as they were not notified that they needed to do this as the commissioners did not inform them. We asked the practice manager for a copy of the whistleblowing policy from 2017 and he refused to provide this to the inspector. In front of the inspector a whistle blowing policy from an external agency was downloaded, the practice's name was put on it and it was dated as being reviewed by the practice in April 2018. We were told this was the right date as that was when the company that designed the policy had made it.

A lack of honesty was demonstrated when there was no evidence of training to ensure the competence of a staff members role as a fire marshal. It was denied the staff member had that role even though they were initially named, and their name was on posters around the practice identifying them as such.

We asked the practice why they did not have a website, the practice manager insisted there was a website even though administration staff said there was not one and the practice manager proceeded in making staff search online for a practice website which was not found.

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

Source	Feedback
Staff member	A staff member we spoke with told us about verbal abuse they experienced from the practice manager, this type of behaviour was also witnessed by the CQC inspection team.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

In the absence of the sole GP partner the three regular locums signed a clinical governance arrangement documenting which days they would lead on various clinical areas. The practice was unable to demonstrate any communication between these GPs including sharing learning and outcomes as a result of meetings where vulnerable patients were discussed, there was also no evidence of clinical

supervision or overall clinical oversight, which was also documented as being required in the practice's business plan.

We found that the practice was unable to demonstrate the competence of staff carrying out some roles such as responding to or leading on complaints and lead roles in fire safety and infection control.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	No
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No

Explanation of any answers and additional evidence:

We found there to be no oversight of policies that governed activities at the practice. These were not routinely updated, were not all bespoke to the practice and contained empty spaces where the practice was meant to put their specific information and when they were updated they were sometimes done by staff members who the practice could not demonstrate had training or was competent to do so.

We witnessed a member of the management team shouting at reception and administration staff members including threats to fire them and hanging up the phone when documents could not be found.

The practice provided us with evidence of clinical audit, but these were not comprehensive, and the practice was unable to demonstrate that learning from audits was effectively shared with all relevant staff members to enable learning and new practise to be adopted.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	No
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No

Staff whose responsibilities included making statutory notifications understood what this entails.	No
Explanation of any answers and additional evidence: The practice manager was unable to demonstrate any processes that would be used to hold staff to account and there was limited evidence of shared learning when performance was low. We were told that staff were told to input data in patient records without evidence for the data input. We found that staff members including members of the management team found it difficult to navigate the practices computer systems to find the documentation they needed. Not all risk assessments were comprehensive, including the risk assessment for hazardous substances. The practice manager was unaware of any external agency other than the CQC where certain significant events were required to be reported.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	N/A
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Not inspected
Staff views were reflected in the planning and delivery of services.	No
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Explanation of any answers and additional evidence: The practice manager told us the practice did not act on the low patient satisfaction results as identified by the national GP patients survey as he said the number of respondents was too small to be significant. Staff we spoke with were unable to give examples of when their views were acted upon and the practice was unable to give us examples of this.

Feedback from Patient Participation Group.

Feedback
We were unable to discuss the patient participation group with a member of the leadership team as we had intended.

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.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: There was limited evidence that the practice shared learning and changes in practise and there was little evidence of continuous learning and improvement.	

Examples of continuous learning and improvement
No evidence was obtained to demonstrate continuous learning or improvement.

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.