

# Care Quality Commission

## Inspection Evidence Table

### Westcotes GP Surgery (1-4056332034)

Inspection date: 14 and 15 October 2019

Date of data download: 07 October 2019

## Overall rating: Inadequate

The practice has been rated inadequate overall because:

Systems, processes and practices did not routinely keep patients safe. Patients care, and treatment did not entirely reflect current evidence-based guidance, standards and practices. There was limited monitoring of clinical outcomes and there were areas such as long-term conditions where outcomes were below local and national averages. There were occasions when staff were working outside their level of competence, and information needed to plan, and deliver effective care was not routinely available. The delivery of high-quality care was not assured by the leadership or governance framework. There were systematic shortfalls in the governance arrangements which hindered the delivery of safe and effective care.

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

## Safe

## Rating: Inadequate

The practice has been rated inadequate because:

Systems and processes to assess, monitor and manage risks to patient safety such as monitoring of high-risk medicines did not provide assurance that safety was routinely maintained. Non-clinical staff were coding medicine reviews and removing medicines from patients' medicines list. Risk assessments carried out in the absence of some medicines to respond to medical emergencies did not cover all potential risks.

### Safety systems and processes

**The practice had systems, and processes to keep people safe and safeguarded from abuse. However, processes were not operated safely and responsibilities were not clearly defined amongst staff. Premises security risk assessment had not been carried out**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not operate effective systems to enable staff to identify vulnerable patients. For example; a random sample of records showed safeguarding alerts were not routinely added to patients records. Furthermore, discussions with health visitors and safeguarding teams were not routinely added to patient records to ensure vital information was included in clinical records as well as minimise the risk of vital information being missed. The safeguarding lead explained they were not involved in analysis of relevant significant events. Staff in lead roles were unable to demonstrate how they accessed the safeguarding children's policy or vulnerable adults' registers. There was no evidence of formal clinical review with health visitors and staff explained this was carried out by non-clinical managers. Non-clinical staff we spoke with demonstrated awareness of the registers and were able to explain the number of patients listed on the registers at the time of our inspection.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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.	Partial
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>A random sample of recruitment records showed the practice did not routinely include up to date information regarding non-clinical staff immunisations or pre-employment health assessments.</p>	

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: 10/01/2019	Y
There was a record of equipment calibration. Date of last calibration: 11/10/2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 01/07/2019	Y
There was a log of fire drills. Date of last drill: 15/04/2019	Y
There was a record of fire alarm checks. Date of last check: 11/10/2019	Y
There was a record of fire training for staff. Date of last training: Completed in the last 12 months.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 27/03/2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Fire alarm system upgraded, and action completed October 2019. An A rated fire extinguisher was obtained, and fire drills were documented in the fire log book. Staff we spoke with explained equipment calibration had been booked for October 2019 and the practice provided evidence during our inspection to confirm this.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/03/2019	Y
Explanation of any answers and additional evidence: Actions carried out in line with risk assessment recommendations included replacing plastic bins with metal bins; blinds removed from clinical rooms. The practice was unable to demonstrate that a premise's security risk assessment had been carried out.	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice had a programme of annual as well as monthly Infection Prevention and Control (IPC) audits. Actions to ensure compliance with IPC audit recommendations were monitored and had been carried out.	

## Risks to patients

**There were systems to assess, monitor and manage risks to patient safety. However, there were areas where systems were not effective.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial
Explanation of any answers and additional evidence: We were told conflicting information from staff in the practice about the use of locums. For example, the non-clinical management team explained the practice had not used locums in the last 12 months; however, the clinical system showed locums had covered sessions, and clinicians we spoke with confirmed this. The management team did not operate an effective approach to managing periods such	

as annual leave. For example, clinical systems showed periods where there was no GP on site and clinics were covered by a single GP covering this practice as well as a neighbouring practice managed by the provider. Clinical staff explained in the absence of practice nurses, GPs had held additional clinics to carry out travel immunisations, vitamin B12 injections as well as childhood immunisations. However, the GPs were unable to provide evidence of how they ensured their competence to support them in this role, remained up to date and in line with updates or changes in guidelines as well as immunisation schedules.

Staff were unable to demonstrate that comprehensive medicine reviews were routinely being carried out. For example, a random sample of records viewed by the inspection team showed non-clinical staff were adding medicine review codes to patients records without any evidence that a review had taken place. In addition, receptionists were removing medicines without clinical oversight, and warfarin monitoring clinics were run by a member of staff who was not formally trained. Results and recommended medicine doses were not being checked by GPs before they prescribed medicines to patients.

The practice was unable to demonstrate that management plans for patients were routinely developed in line with national guidance as clinical records we viewed showed evidence of missed diagnoses of diabetes and prediabetes. Therefore, there was limited evidence to suggest patients were having appropriate monitoring and screening.

## Information to deliver safe care and treatment

**Staff did not routinely 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.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The systems for managing test results was not effective or safe. For example, clinicians were unable to demonstrate that, where necessary for patient safety, test results carried out in secondary care were being viewed prior to generating repeat prescriptions. Systems and processes did not provide assurance that results which might alter patient management were acted on and the management team did not provide assurance that non-clinicians who reviewed results understood the significance of the results. For example, a random sample of records showed tests results which indicated patients were in diabetic or pre-diabetic range had been recorded as satisfactory with no action required and no problems coded on patients records. As a result, the practice was unable to provide assurance that the practice disease registers were accurate to ensure patients received appropriate care. Members of the management team explained health care assistants held clinics to review warfarin dosages. Staff explained GP clinical advice would only be obtained if results were outside of recommended range. The member of staff had no training to support this role.</p> <p>Information about patients' conditions to support the delivery of safe care was not routinely added to patient's problem list or summary on the clinical system. For example, the nursing team carried out screenings and later identified patients had been diagnosed with an infection. Alerts had not been added to patients' problem list or summary to protect clinical staff from potential risk.</p>	

## Appropriate and safe use of medicines

### The practice did not operate a safe system for the appropriate and safe use of medicines, including medicines optimisation

Clinical system one Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.53	0.78	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	1.2%	8.4%	8.6%	Significant Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	4.04	4.79	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	3.04	2.14	2.08	No statistical variation

Clinical system two Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.53	0.78	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	5.6%	8.4%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and	3.21	4.79	5.63	Variation (positive)

Clinical system two Indicator	Practice	CCG average	England average	England comparison
Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	2.73	2.14	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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/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.	N
The practice had a process and clear audit trail for the management of information about Changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were	Y



Medicines management	Y/N/Partial
regularly checked and fit for use.	
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The system for controlling, monitoring and recording prescription form movement was not effective or in line with national guidance. For example, systems for recording serial numbers did not provide assurance that prescription pads and computer prescription paper were being appropriately monitored. Staff were unable to provide assurance that they were tracking the whereabouts of prescription pads as we found records were not reflective of the actual prescription pads located in clinical rooms and staff were unable to provide an explanation for this.</p> <p>The practice was not operating in accordance with legislation which requires a qualified prescriber to authorise and prescribe medicines. Records showed staff who were not a registered GP or independent prescribing nurse had authorised registered nurses to prescribe high-risk medicines. For example, within the warfarin monitoring clinic the practice was using a system of 'auto-consultation'. This meant that warfarin dosing details would be added to patients records after a patient had their blood checked by a health care assistant (HCA). These auto-consultations would include instructions to the prescriber to adjust the dose of warfarin and issue a prescription. The practice was unable to demonstrate that clinicians were reviewing the blood results and dosing recommendations before these auto consultations instructions were enacted and a repeat prescription was generated for the patient. During our inspection, staff explained the issues regarding the wording in auto consultation text had been identified and changes made prior to our inspection.</p> <p>There was limited evidence of structured medicine reviews for patients on repeat medicines recorded on two clinical systems operated by the provider. For example, the first clinical system showed a total of 247 medicine reviews had been coded as done since August 2019 with no evidence of a structured medicine review and we found 38 had been coded by non-clinical staff during October 2019. The second clinical system showed a total of 258 medicine reviews had also been coded as done since August 2019 with no evidence of a structured medicine review and we found over 100 of these entries had been carried out by non-clinical staff.</p> <p>There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines; however, the process did not facilitate practice assurance that appropriate monitoring and clinical review prior to prescribing was being carried out. For example, non-clinical staff were managing the blood monitoring recall dates for patients in receipt of high-risk medicines with no clinical oversight of this process and a lack of understanding regarding national guidelines for the frequency of the required testing. Blood due dates recorded by non-clinical staff were not in line with national prescribing guidelines. The clinical systems showed results from blood tests carried out in secondary care were not routinely added to patients records and clinicians were unable to demonstrate they had checked results were in date and in a safe range prior to generating repeat prescriptions.</p> <p>In the absence of emergency medicines recommended in national guidance; the practice had carried out a formal risk assessment which highlighted the emergency medicines were not required to be stocked. The risk assessment detailed emergency conditions being better managed in secondary care as well as close proximity to accident and emergency department with ambulance response times being seven minutes or less. However, the risk assessment did not entirely mitigate all potential risks such as considering actions to be taken in the event of any emergency service delays.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	20
Number of events that required action:	20
Explanation of any answers and additional evidence: Non-clinical management staff explained clinicians were made aware of incidents through meetings and circulating completed incident report forms as well as meeting minutes. The management team provided evidence of meetings where significant events were discussed. However; clinicians we spoke with were unable to demonstrate access to significant event logs and explained they were not routinely informed of significant events.	

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

Event	Specific action taken
Prescription had been authorised when secondary care had authorised the medication to be stopped.	Discussed with staff about the importance of checking all medication with GPs, not to issue medication as acute. Reminded to be vigilant regarding patients repeats and cross checking when medication has been requested to stopped by secondary care providers.
A course of medication with the wrong dose issued.	Medicine amended on patients records, staff reminded to be extra vigilant when prescribing medication and ensuring correct dose is accurately recorded.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We reviewed the system for receiving and sharing safety alerts within the practice and saw examples of actions taken to ensure patient safety. For example, actions had been taken in response to adrenaline pens as well as Rivaroxaban medicine. Members of the management team explained alerts were discussed during clinical meetings as a standing agenda item and then were added as a batch report which was carried out monthly.	

## Effective

## Rating: Inadequate

The surgery has been rated inadequate because:

Effective needs assessment, care and treatment were not routinely carried out. The practice was unable to demonstrate clinical oversight or effective processes in several areas. For example, there was no clear clinical oversight of medicine management; staff were carrying out additional roles with limited knowledge or clinical support and there was no clarity regarding who held responsibility for monitoring QOF performance. Records showed long-term condition diagnoses had either been missed or not documented on patients records and the practice did not operate an effective call and recall system to ensure patients conditions were being monitored effectively.

### Effective needs assessment, care and treatment

**Patients' needs were not routinely assessed, and care and treatment were not routinely delivered in line with current legislation, standards and evidence-based guidance or 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:  The practice had systems and processes to keep clinicians up to date with current evidence-based practice. However, records demonstrated national prescribing guidelines were being interpreted incorrectly. For example, we saw blood monitoring due dates recoded by the practice which were not in line with local or national prescribing guidelines.  A random sample of records showed patients' treatment was not regularly reviewed and updated. For example, non-clinical staff were recording reviews as completed and were removing medicines such as insulin from patients' medicine lists without clinical oversight. Records we viewed did not include evidence to demonstrate that a structured review had actually been carried out.	

Patients were not routinely told when they needed to seek further help and what to do if their condition deteriorated. For example, blood results which indicated patients were in the diabetic range had not been followed up and diagnoses were not being recorded in patients records. There was no evidence to show discussions or referral to pre-diabetic education programmes.

Clinical records showed patients with blood results which should have prompted the practice to review management plans had not been actioned and patients were not contacted.

Clinical system one Prescribing	Practice	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU)(01/07/2018 to 30/06/2019) (NHSBSA)	0.44	0.96	0.75	No statistical variation

Clinical system two Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.72	0.96	0.75	No statistical variation

## Older people

**Population group rating: Inadequate.**  
**This is because structured annual medicine reviews were not routinely carried out and there was limited evidence of quality improvement.**  
**Clinicians were unable to demonstrate assessment of frail patients.**

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. However, when asked clinicians were unable to demonstrate how they accessed the frailty register to evidence that those identified received a full assessment of their physical, mental and social needs.</li> <li>The practice followed up on older patients discharged from hospital. However, clinicians explained they were not updating care plans or care home notes. During day one of our inspection, clinicians were unable to demonstrate access to care plans. During the second day of our inspection, the non-clinical management team provided a list of patients who had care plans in place.</li> <li>The practice was unable to evidence that clinicians routinely carried out structured annual medication reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> </ul>

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

**Population group rating: Inadequate.**  
**This is because data showed clinical management of patients' conditions was below local and national averages. The management of clinical conditions was not carried out effectively and there was limited evidence of quality improvement.**

### Findings

- Patients with long-term conditions were not routinely offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, clinical oversight of coordinated care was not carried out effectively and QOF data showed patients conditions were not being controlled effectively.
- At the time of our inspection the 2018/19 Quality Outcomes Framework had not yet been published and there was some data which the practice was unable to access. However, 2017/18 QOF clinical indicators showed areas where patient outcomes were below local and national averages and clinicians were not aware of this or able to provide an explanation. The 2018/19 QOF data published following our inspection showed variations in the outcomes for patients across the providers two patient lists. For example; outcomes for the first patient list had improved; however, outcomes for the second patient list had further declined.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. However, non-clinical staff who supported the practice to monitor and recall patients had not received training to support them in this role and we found recall dates were not in line with national guidance.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had systems to share information with relevant professionals when deciding care delivery for patients with long-term conditions. However, records showed information was not always accurate. For example, patients' problem lists were not routinely updated; therefore, records showed patients were being prescribed medicines with no diagnoses to support the need for the medicine being prescribed.
- The practice was unable to 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 routinely assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.

Clinical system one Diabetes Indicators	Practice	CCG average	England average	England comparison
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The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	60.3%	77.4%	78.8%	Variation (negative)
Exception rate (number of exceptions).	7.9% (5 )	8.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	51.8%	75.8%	77.7%	Variation (negative)
Exception rate (number of exceptions).	11.1% (7 )	7.6%	9.8%	N/A
<b>Clinical system one Diabetes Indicators 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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) <small>(QOF)</small>	71.2%	78.6%	79.3%	No statistical variation
Exception rate (number of exceptions).	6.3% (4 )	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) <small>(QOF)</small>	64.8%	75.2%	78.1%	No statistical variation
Exception rate (number of exceptions).	14.3% (9 )	6.7%	9.4%	N/A

<b>Clinical system one Diabetes Indicators</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	51.8%	80.1%	80.1%	Significant Variation (negative)
Exception rate (number of exceptions).	11.1% (7 )	8.7%	13.5%	N/A
<b>Clinical system one Diabetes Indicators 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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) <small>(QOF)</small>	76.7%	83.1%	81.3%	No statistical variation
Exception rate (number of exceptions).	4.8% (3 )	6.7%	12.7%	N/A

<b>Clinical system two Diabetes Indicators</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is	75.8%	77.4%	78.8%	No statistical variation



64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	10.8% (8)	8.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	66.7%	75.8%	77.7%	No statistical variation
Exception rate (number of exceptions).	10.8% (8)	7.6%	9.8%	N/A
<b>Clinical system two Diabetes Indicators 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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) <small>(QOF)</small>	59.2%	78.6%	79.3%	Variation (negative)
Exception rate (number of exceptions).	1.4% (1)	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) <small>(QOF)</small>	59.2%	75.2%	78.1%	Variation (negative)
Exception rate (number of exceptions).	1.4% (1)	6.7%	9.4%	N/A

<b>Clinical system two Diabetes Indicators</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	59.4%	80.1%	80.1%	Variation (negative)
Exception rate (number of exceptions).	13.5% (10)	8.7%	13.5%	N/A
<b>Clinical system two Diabetes Indicators 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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) <small>(QOF)</small>	68.6%	83.1%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.8% (2)	6.7%	12.7%	N/A

<b>Clinical system one Other long-term conditions</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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	54.3%	76.6%	76.0%	Variation (negative)



RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	18.6% (8 )	3.5%	7.6%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	55.6%	88.8%	89.7%	Variation (negative)
Exception rate (number of exceptions).	5.3% (1 )	9.5%	11.5%	N/A
<b>Clinical system one Other long-term conditions 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	75.0%	77.7%	75.9%	No statistical variation
Exception rate (number of exceptions).	4.3% (2 )	4.8%	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 31/03/2019) (QOF)	100.0%	90.5%	89.6%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0 )	10.1%	11.2%	N/A

<b>Clinical system two Other long-term conditions</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	52.5%	76.6%	76.0%	Variation (negative)
Exception rate (number of exceptions).	13.0% (6)	3.5%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	75.0%	88.8%	89.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.9% (2)	9.5%	11.5%	N/A
<b>Clinical system two Other long-term</b>	<b>Practice</b>	<b>CCG average</b>	<b>England</b>	<b>England</b>

conditions 2018/19 Published data			average	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) <small>(QOF)</small>	89.2%	77.7%	75.9%	Tending towards variation (positive)
Exception rate (number of exceptions).	11.9% (5)	4.8%	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 31/03/2019) <small>(QOF)</small>	100.0%	90.5%	89.6%	Variation (positive)
Exception rate (number of exceptions).	13.3% (4)	10.1%	11.2%	N/A

Clinical system one Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	63.4%	82.5%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.8% (5 )	4.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>	90.0%	93.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0 )	7.0%	6.7%	N/A
Clinical system one Indicator 2018/19 Published data	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) <small>(QOF)</small>	82.1%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (5 )	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) <small>(QOF)</small>	92.9%	92.9%	91.1%	No statistical variation
Exception rate (number of exceptions).	0.0% (0 )	4.9%	5.9%	N/A

Clinical system two Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	72.8%	82.5%	82.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.4% (2)	4.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.0%	90.0%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	7.0%	6.7%	N/A
Clinical system two Indicator 2018/19 Published data	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)	82.4%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.4% (2)	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)	100.0%	92.9%	91.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.0% (0)	4.9%	5.9%	N/A

### Any additional evidence or comments

#### Quality Outcomes Framework (QOF) indicators for long-term conditions:

We have showed separate data in our evidence table for the two clinical systems operated by Westcotes GP surgery. The data reflects the provider's two separate patient lists for patients registered at Westcotes GP surgery one and Westcotes GP surgery two (WC one and WC two). QOF performance for the providers first patient list were below local and national averages for diabetes indicators and other long-term conditions. Despite patients from both patient lists being seen in the same building and managed by the same staff there were variations in QOF data, with the provider's first patient list showing areas of significant negative variation. It was unclear as to who held responsibility for monitoring QOF performance as well as exception reporting patients. For example, non-clinical staff explained exception reporting was carried out by GPs; however, the principle GP explained exception reporting was carried out by members of the non-clinical management team. The practice was unable to provide an explanation regarding areas where QOF performance was below local and national averages or able to demonstrate awareness of more recent data.

Patients diagnosed with a long-term condition were not routinely having the diagnosis added to patients' problem lists and summaries were not up to date; the inspection team also identified new diagnoses were not being recorded in patient records. As a result, identified patients were not being

called, recalled and their conditions were not being monitored effectively.

The 2018/19 QOF data was published following our inspection. Data showed variations in performance between the two patient lists. For example, the first patient list showed clinical indicators for patients diagnosed with diabetes had improved; however, the second patient list showed clinical indicators had further declined. Other clinical indicators such as patients diagnosed with hypertension, atrial fibrillation, asthma and COPD showed improvements across both patient lists.

## **Families, children and young people**

**Population group rating: Inadequate. This is because childhood immunisation uptake was below minimum target and staff were unable to demonstrate how they kept up to date with knowledge to carry out immunisations. There was limited evidence of quality improvement.**

### **Findings**

- Data from the first clinical system showed the provider had not met the minimum 90% target for three of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% for all four childhood immunisation uptake indicators. The practice demonstrated awareness of this and discussed actions taken to improve uptake; however, unable to demonstrate impact of actions taken.
- Data from the second clinical system showed the provider had not met the minimum 90% target for one of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% for two of four childhood immunisation uptake indicators. The practice demonstrated awareness of this and discussed actions to improve uptake; however, unable to demonstrate impact of actions taken.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff mainly had the appropriate skills and training to carry out reviews for this population group. However, GP who carried out childhood immunisation in the absence of practice nurses were unable to demonstrate recent training in childhood immunisations or how they remained up to date with latest immunisation schedule.
- Bi-weekly midwife lead clinics were available at the practice.

Clinical system one 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)England)	18	20	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)(01/04/2018 to 31/03/2019) (NHS England)England)	17	19	89.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)(01/04/2018 to 31/03/2019) (NHS England)England)	16	19	84.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)(01/04/2018 to 31/03/2019) (NHS England)	17	19	89.5%	Below 90% minimum

Clinical system two 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)	15	18	83.3%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	22	23	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and	22	23	95.7%	Met 95% WHO based target

Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)				
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)	21	23	91.3%	Met 90% minimum

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

### Any additional evidence or comments

The practice operated a call and recall system to enable follow up of children who had not received their childhood immunisation. Staff explained they engaged with the National screening service who provided the practice with a list on a weekly basis of patients who were due their immunisation. Non-clinical staff contacted parents and legal guardians to arrange appointments with the nursing team. Members of the nursing team explained that they provided parents and legal guardians with information to enable them to make an informed decision regarding the uptake of childhood immunisation. We saw information available in up to five different languages; staff were multilingual, and the practice also requested that the screening service send appointment letters out in various languages. The practice worked with health visitors to manage patients who missed multiple appointments.

**Working age people (including those recently retired and students)**

**Population group rating: Inadequate. This is because access to national screening programmes was not managed effectively.**

### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The uptake of cervical screening was below local and national averages and there was a six week wait for cervical screening appointments. The management team explained this had been identified and practice nurses working hours were being increased with an aim of reducing waiting times to four weeks.
- Data showed the uptake of breast and bowel cancer screening for patients registered at WC two was below local and national averages.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Clinical system one 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	64.7%	N/A	80% Target	Below 70% uptake



aged 25 to 49, and within 5.5 years for women aged 50 to 64)(01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	75.3%	63.1%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	51.6%	42.7%	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. (PHE)	100.0%	60.2%	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)	33.3%	53.2%	51.9%	No statistical variation

Clinical system two 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)	66.8%	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)	53.7%	63.1%	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)	28.2%	42.7%	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. ( to ) (PHE)		-		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)	33.3%	53.2%	51.9%	No statistical variation

#### Any additional evidence or comments

Data showed variations between the providers two patients lists uptake of national screening programmes. Staff explained that some patients were reluctant to engage in national screening programmes. Staff explained they actively signposted identified patients to walk-in screening clinics held in secondary care. The management team contacted Public Health England (PHE) who produced recall



letters in various languages for patients who failed to attend their screening appointments. Staff explained the CCG were running a screening pilot which involved a drop-in clinic where patients would receive awareness of the needs of having the screening as well as access to the tests. Staff explained the clinics were held at the local Genital-urinary Medicine and Sexual Health Clinic as well as secondary care and staff were actively promoting the service.

The practice clinical system enabled staff to identify women who required a test and invitation letters were sent out to patients. The clinical staff discussed screening during consultations and screening was also carried out opportunistically. Staff we spoke with were trained and aware of appropriate read codes such as verbal smear test reminder discussion and recall codes. There was limited availability of female sample takers with a six week wait for appointments. The practice was aware of this and were in discussion with staff to increase practice nurses working hours. The practice was part of a Hub arrangement which enabled patients to access appointments outside of normal working hours as well as weekends, this included access to cervical screening.

**People whose circumstances make them vulnerable**

**Population group rating: Inadequate. This is because clinicians were unable to evidence involvement in planning patients care and treatment.**

## Findings

- Same day appointments and longer appointments were offered when required.
- Staff explained patients with a learning disability were offered an annual health check. However; when requested, clinicians were unable to provide evidence of care plans and were unable to recall completing care plans for a considerable amount of time.
- End of life care was mainly being delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. For example, staff attended multidisciplinary meetings; however, clinicians were not developing plans and records we viewed showed patients did not have a care plan in place.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Inadequate.**  
This is because involvement in care planning were not clear and the practice were unable to explain reasons for high exception reporting rates.

**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 and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend medicine reviews. However, the system was not effective as patients diagnosed with a long-term condition were not routinely coded on the clinical system. As a result, patients were not being identified to enable effective monitoring of their condition.
- During day one of our inspection, clinicians were unable to provide evidence of care plans or describe reasons for high exception reporting rates. During day two of our inspection, the management team provided a list of patients who had care plans in place which we saw were carried out by the nursing team.
- The 2018/19 QOF data published following our inspection showed mental health indicators for patients on one of the providers patient lists had slightly declined but remained comparable to local and national averages. Indicators for patients registered on the second patient list had also declined, except for patients diagnosed with dementia which had improved.
- 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Clinical system one Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.7%	90.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	11.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption	100.0%	93.0%	90.0%	Tending towards variation (positive)

has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0.0% (0 )	9.5%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months(01/04/2017 to 31/03/2018) (QOF)	80.0%	83.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0 )	6.5%	6.6%	N/A
<b>Clinical system one Mental Health Indicators 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	83.3%	87.2%	89.4%	No statistical variation
Exception rate (number of exceptions).	50.0% (6 )	11.6%	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)	83.3%	88.9%	90.2%	No statistical variation
Exception rate (number of exceptions).	50.0% (6 )	9.4%	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)	100.0%	82.7%	83.6%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0 )	6.6%	6.7%	N/A

<b>Clinical system two Mental Health Indicators</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	90.0%	89.5%	Tending towards variation (positive)
Exception rate (number of exceptions).	30.8% (4)	11.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.0%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	30.8% (4)	9.5%	10.5%	N/A
The percentage of patients diagnosed with	76.9%	83.8%	83.0%	No statistical variation

dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	13.3% (2)	6.5%	6.6%	N/A
<b>Clinical system two Mental Health Indicators 2018/19 Published data</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	40.0%	87.2%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	9.1% (1)	11.6%	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)	44.4%	88.9%	90.2%	Variation (negative)
Exception rate (number of exceptions).	18.2% (2)	9.4%	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)	100.0%	82.7%	83.6%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	6.6%	6.7%	N/A

#### Any additional evidence or comments

The clinical and non-clinical management team were unable to provide a coherent explanation regarding who took responsibility for exception reporting. For example, clinicians explained they were not involved in exception reporting and had not exception reported any patients; however, non-clinical staff explained clinicians were responsible for exception reporting. The 2018/19 QOF data published following our inspection, showed mental health indicators exception reporting for patients on the providers first patient list had increased; however, the second patient list exception reporting had declined.

#### Monitoring care and treatment

The practice operated a programme of quality improvement activity and mainly reviewed the effectiveness and appropriateness of the care provided. There was limited monitoring of the outcomes of care and treatment.

Clinical system one Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	Data Unavailable	Data Unavailable	537.5
Overall QOF score (as a percentage of maximum)	Data Unavailable	Data Unavailable	96.2%
Overall QOF exception reporting	Data Unavailable	Data Unavailable	5.8%

Clinical system two Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	478.4	526.8	537.5
Overall QOF score (as a percentage of maximum)	85.6%	94.2%	96.2%
Overall QOF exception reporting (all domains)	8.6%	5.8%	5.8%

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

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

During our inspection, the practice provided evidence of audits which had been repeated to assess whether quality improvements had been achieved. For example, the practice carried out an audit to assess the monitoring of patients diagnosed with Coeliac disease (an autoimmune condition affecting the small intestine). The first audit identified patients who did not routinely have their bloods reviewed regularly. The practice acted to improve screening of patients and clinicians' awareness was raised during clinical meetings regarding the implementation of national guidance. The practice repeated the audit which showed improvements in the clinical management of patients diagnosed with Coeliac disease.

The inspection team viewed two audits looking at the use of antibiotics and dipsticks in urine infection. Both audits had set targets for improvement and demonstrated improvement in the second cycle of the audit regarding appropriate use of dipstick but no change in appropriate use of antibiotics. The use of antibiotic prescribing to treat sore throats and recording of fever pain score showed a slight increase to 20% when the practice revisited the audit and prescribing of antibiotics at the correct dose had also improved.

**Any additional evidence or comments**

We viewed other audits which the practice provided ahead of our inspection, which were carried out for both the providers patient lists. For example, two clinical audits; one assessing whether patients diagnosed with Rheumatoid arthritis were being prescribed Methotrexate safely in accordance with national guidelines and the second audit looked at whether controlled drugs such as Hypnotics were being prescribed in accordance to national guidelines. Both audits were initially carried out in October 2019; as the audits were first cycle the practice was unable to demonstrate quality improvement. The practice was unable to demonstrate that they used information about care and treatment to make improvements. For example, issues picked up by the inspection team in areas such as medicine management as well as the management of long-term conditions had not been identified by the practice prior to our inspection. There was evidence which showed diagnoses were being missed and information on the clinical systems were not always a true reflection of patients' conditions which impacted on the practice ability to effectively monitor patients care and treatment.

## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles in most areas.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Non-clinical staff were carrying out additional roles such as overseeing the monitoring and tracking of patients' blood monitoring due dates. However, the practice was unable to demonstrate that staff received training or clinical support to carry out this role effectively and the practice did not operate a system to assess levels of competency. Clinicians who carried out childhood immunisations were unable to evidence that they had attended or completed training updates to enable them to carry out this role effectively.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or	Y

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence:	



## Helping patients to live healthier lives

**Staff were mainly 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.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Clinical records showed patients at risk of developing a long-term condition such as diabetes were not routinely being referred to a diabetes prevention education programme.</p> <p>Staff actively signposted patients to social prescribing schemes. For example, staff explained patients were signposted to the local care navigation service who looked at patients' needs such as social aspects, access to social services and befriending services.</p> <p>Some staff were multilingual, and leaflets were available in up to five different languages.</p>	

Clinical system one Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months(01/04/2017 to 31/03/2018) (QOF)	95.5%	96.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4 % (1 )	0.9%	0.8%	N/A

Clinical system two 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,	95.6%	96.7%	95.1%	No statistical variation



schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.0% (0)	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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence:	

## Caring

**Rating: Good**

**Kindness, respect and compassion**

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

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

CQC comments cards	
Total comments cards received.	67
Number of CQC comments received which were positive about the service.	65
Number of comments cards received which were mixed about the service.	Two
Number of CQC comments received which were negative about the service.	Nil

Source	Feedback
CQC comment cards	The 67 completed comment cards received represented a mixture of patient comments across both of the provider's patient lists. Patients described staff as being understanding, professional and patients felt they were treated with respect and dignity. Patients felt staff listened, made them feel at ease, reassured and met their needs. Staff were described as friendly, helpful, welcoming and willing to go above and beyond.
Patient interviews	We spoke with patients across both of the provider's patient lists. Patients we spoke with during our inspection felt their needs were being met and staff were understanding.
NHS Choices	Comments placed on NHS Choices showed patients felt staff were not routinely friendly, helpful and felt staff were dismissive of patients requests of needs.
Practice 2019 internal survey	The practice internal survey showed patients felt health care practitioners understood their illness and were interested in them as a person and not just their illness.

## National GP Survey results

Patient list one population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1,489	363	92	25	Not available

Patient list two population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1518.0	424.0	76.0	17.9%	5.01%

Patient list one - 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) <small>(GPPS)</small>	86.2%	84.7%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern(01/01/2019 to 31/03/2019) <small>(GPPS)</small>	86.6%	82.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019) <small>(GPPS)</small>	94.2%	91.6%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice(01/01/2019 to 31/03/2019) <small>(GPPS)</small>	71.0%	75.0%	82.9%	No statistical variation

Patient list two - 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	85.8%	84.7%	88.9%	No statistical variation

Patient list two - Indicator	Practice	CCG average	England average	England comparison
31/03/2019)				
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)	83.7%	82.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	94.6%	91.6%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	77.5%	75.0%	82.9%	No statistical variation

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

Any additional evidence
The practice carried out internal surveys and unpublished data provided by the practice showed patients were satisfied with the care they received. For example; unverified data showed the practice handed out 20 survey forms between May and July 2019; 19 completed forms were returned. The practice analysed the data which showed patients were satisfied with their visit to the practice. The practice repeated the survey during July 2019 where 20 surveys were handed out and all 20 was returned. Data showed patients remained satisfied with the practice and the treatment they had received.

### Involvement in decisions about care and treatment

#### Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
The 2019 national GP patient survey	The survey results indicated that patients felt involved as much as they wanted to be in decisions about their care and treatment during their general practice appointment.
Interviews with patients.	Patients we spoke with during our inspection felt involved in decisions about their care and treatment; they also felt nurses clearly explained treatment plans and medicines.

### National GP Survey results

Patient list one - 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	88.4%	90.5%	93.4%	No statistical variation

Patient list one - Indicator	Practice	CCG average	England average	England comparison
to 31/03/2019) (GPPS)				

Patient list two - 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)	87.6%	90.5%	93.4%	No statistical variation



	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: There were staff members who were multi-lingual and able to speak up to five different languages.	

Carers	Narrative
Percentage and number of carers identified.	The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 32 (2%) patients as carers and 52 (5%) had a carer on the practice first patient list and 27 (2%) patients as carers and 38 (2%) had a carer on the second patient list.
How the practice supported carers (including young carers).	The practice had a carers lead who signposted patients to local support services as well as local authority assessments.
How the practice supported recently bereaved patients.	If families had suffered bereavement, their usual GP contacted them, and they were invited in to speak with the GPs or if unable to attend the practice were sent a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice had bereavement packs which included information and details of support services available for the family.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: The management team explained the implementation of pass cards which enabled patients who presented upset, distressed and unable to get their words out to hand a card to receptionists which	

alerted them that the patient wanted to speak in a confidential area. Staff explained this system was introduced following learning from an incident.

## Responsive

**Rating: Good**

### Responding to and meeting people's needs

**The practice organised and delivered services to meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

WC one and WC two Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 7.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 7.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	GPs 9am to 1pm and 2.30pm to 6.30pm Nurse 8.30am to 6pm HCA 8.30am – 1pm
Tuesday	GPs 9am to 1pm and 2.30pm to 6.30pm Nurse 8.30am to 6pm HCA 8.30am – 1pm
Wednesday	GPs 9am to 1pm and 2.30pm to 6.30pm HCA 8.30am – 1pm
Thursday	GPs 9am to 1pm and 2.30pm to 6.30pm HCA 8.30am – 1pm
Friday	GPs 9am to 1pm and 2.30pm to 6.30pm HCA 8.30am – 1pm

## National GP Survey results

Patient list one population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1,489	363	92	25%	6.02%

Patient list two population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1518.0	424.0	76.0	17.9%	5.01%

Patient list one - 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) (GPPS)	94.2%	91.5%	94.5%	No statistical variation

Patient list two - 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)	91.1%	91.5%	94.5%	No statistical variation

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>All patients had a named GP who supported them in whatever setting they lived.</li> <li>The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.</li> <li>In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.</li> <li>Enhanced services for patients at risk of hospital admission and staff explained contact were made if patients were admitted or seen by out of hours (OOH) services.</li> <li>There was a designated phone line provided to care homes and residents at increased risk of hospital admission.</li> </ul>

**Findings**

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice did not operate an effective system to enable staff to routinely identify patients with long-term conditions as well as ensure access to appropriate services and care coordination.
- 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.
- Staff explained care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. However; during day one of our inspection, when requested, clinicians were unable to provide evidence of completed care plans. On day two of our inspection, the management team provided a list of patients who had care plans in place.
- The practice worked with specialist nurses to manage complex patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD), asthma or diabetes to support patients to improve control of their condition.

## Families, children and young people

Population group rating: Good

### Findings

- Nurse appointments were available from 8.30am and until 6pm on a Monday and Tuesdays for school age children so that they did not need to miss school. The practice recognised the need to improve access to nurses and explained they had increased the nurses working days.
- Staff discussed healthy eating with parents or guardians and actively encouraged enrolment onto child obesity programmes.
- Staff explained that to improve the uptake of childhood immunisation they held dedicated immunisation clinics as well as carried out home visits if necessary when parents or guardians found it difficult to present their child for their immunisations.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7.30pm on a Monday and Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice had Hub arrangements in place. Appointments were available Monday to Sunday 8am until 8pm at a neighbouring practice.
- Patients were able to access pre-booked cervical screening appointments 8am to 8pm Monday to Sunday as part of the Hub arrangements. However, staff explained that there was a six week wait for patients who wished to be seen at the practice.
- The practice carried out healthy lifestyle checks for patients over the age of 45 years old and offered advice and support with lifestyle changes.
- The practice provided a range of appointments focused on lifestyle; for example, smoking cessation, weight management and alcohol counselling.
- Meningitis vaccines for 18-year olds and students going to university were available at the practice

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- There was limited evidence to demonstrate effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. Staff explained joint visits were carried out when required with other healthcare professionals.
- The practice understood the needs of the patients, such as people who may be approaching the end of their life and people who may have complex needs, such as housebound patients. Staff had received training in Gold Standards Framework (GSF) (an evidence-based guideline to deliver high quality end of life care) and were using GSF to coordinate end of life care with other health care professionals.
- The practice actively engaged and signposted patients to local services who provided support such as the homeless Hub, support for asylum seekers, Lesbian, Gay, Bisexual and Trans (LGBT); we also saw a range of leaflets in patent waiting areas in a range of languages.
- Vulnerable patients were allocated an admin tracker who acted as a single point of contact. Staff explained this enabled admin staff to build a therapeutic relationship; gain a comprehensive understanding of patients' needs which they then discussed with GPs and the nursing team ahead of their appointments. This also enabled staff to carry out well-being calls.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Good**

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Clinicians carried out dementia screening including annual blood tests. There were referral processes in place where identified patients were referred to secondary care memory clinics. Dementia medicine prescribing were taken over from secondary care for patients who were assessed as stable.
- Staff explained there were designated appointment slots kept as well as VIP appointments to ensure were not missed on follow up.
- Staff explained processes in place to for patients to access Improving Access to Physical Therapist



(IAPT services provides evidence-based psychological therapies to people with anxiety disorders and depression) as well as a counselling service was available at the practice. Staff explained the practice had referral processes for patients who required cognitive behavioural therapy (CBT).

## Timely access to the service

### People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: There were Hub arrangements in place which enabled the practice to offer extended access appointments between 8am and 8pm Monday to Sunday at a neighbouring practice.	

Patient list one - 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) (GPPS)	55.7%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment(01/01/2019 to 31/03/2019) (GPPS)	60.6%	58.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times(01/01/2019 to 31/03/2019) (GPPS)	62.6%	60.6%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered(01/01/2019 to 31/03/2019) (GPPS)	62.0%	65.9%	73.6%	No statistical variation

Patient list two - 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)	71.5%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	68.8%	58.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	80.7%	60.6%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	73.7%	65.9%	73.6%	No statistical variation

Source	Feedback
NHS Choices	Comments showed patients were mainly less satisfied with the appointment system. For example, comments included appointment cancellations which patients felt occurred on a regular basis, patients commented on their experience of registering with the practice as less positive. Patients commented on clinicians running late and comments showed patients were not routinely happy with the types of appointments offered.
Patient interviews	Patients we spoke with felt they were able to get an appointment when they needed one, they had not requested a home visit or telephone consultation; however, were aware this was an option if required.
Staff interviews	Non-clinical staff demonstrated clear understanding of the appointment system; as well as systems in place for triaging and prioritising home visits. Staff had completed care navigation training to support them in their role.
Clinical system	A review of the clinical system showed there were occasions where GP cover had not been secured and patients were seen at a neighbouring practice where the provider held the contract to deliver NHS services.

## Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	Three
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Nil

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: There was information in patient waiting areas to support people who wished to make a complaint and patients were encouraged to complete suggestion slips to enable the practice to identify any areas for potential improvement.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Access to national screening such as cervical screening.	Patient contacted and offered an apology. The practice commenced a recruitment campaign to increase the number of practice nurses. Staff were reminded to be more vigilant when monitoring the uptake of cervical screening.
Complainant unhappy with staff attitude and appointment system. and manager rude and ignorant as well as not happy with the appointment system	Discussed during practice meetings and staff reminded about being mindful of their attitude. The practice made it clearer to patients regarding the process for sick notes.

## Well-led

## Rating: Inadequate

The practice has been rated requires improvement because:

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

### Leadership capacity and capability

**There was a lack of inclusive and effective leadership at all levels. Leaders demonstrated they had the skills; however, they lacked the capacity to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Westcotes GP surgery was provided by a partnership comprising two GPs who held responsibility for the overarching leadership and management of the practice. Westcotes GP surgery had two separate patient lists and two clinical systems. The management team explained, for business continuity, one GP acted as a silent partner who was not directly involved in the day to day running of the service. However, in the event of the principle GP being unable to work, the silent partner would be appointed as clinical lead. However, there was a lack of coherent planned approach which impacted on the ability to deliver safe, effective, high quality services. For example, we found the partners had limited involvement in the day to day management of the practice which was carried out by non-clinical managers. Decisions about the running of the practice were made by the management team with minimum input from the GP partnership. This resulted in the partnership demonstrating limited knowledge regarding systems and processes to ensure compliance with legal requirements.  Leaders demonstrated they understood the challenges within the local area such as deprivation as well as health inequalities, and actions necessary to address these challenges had been identified. However, leaders were unable to demonstrate how they transferred their knowledge into the day to day delivery of the services provided. For example, oversight of systems and processes was not carried out effectively and despite the practice holding a wide range of internal meetings, we found communication to ensure clarity regarding key responsibilities as well as ensuring partners had access to information to support them in their senior roles was not effective. There was a lack of clarity regarding who held responsibility for areas such as monitoring service delivery and measure key performance indicators. We found some clinical processes were carried out by non-clinical staff with a lack of clinical oversight.  There was a lack of understanding regarding the challenges faced in regard to ensuring adequate staffing levels were maintained to meet the needs of patients as well as cover periods of annual leave.  This all impacted on the providers ability to achieve positive clinical outcomes as well as deliver sustainable safe care and treatment.	

## Vision and strategy

The providers had a vision and credible strategy to provide high quality sustainable care. However, it was not evident that the vision and strategy formed part of a shared approach between the providers and practice management team.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: There was a lack of coherent working within the practice to demonstrate that the vision, values and strategy were developed in collaboration with staff. The vision and strategy did not have a powerful influence on the behaviour of staff at all levels. For example, the approach of partners and non-clinical management to how they worked together was not solely driven by quality and safety; we found partners were not key determinants of whether the vision and values were achieved.	

## Culture

**The practice had a culture; however, it did not routinely drive sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The management team demonstrated a variety of processes to ensure staff were involved and actively engaged in discussions regarding changes within the practice. For example, the practice held a range of meetings such as clinical and admin team huddles. There was opportunity for staff feedback through suggestion boxes and the practice operated an open-door policy. Staff we spoke with explained the management team communicated with them daily exploring ways to support their continued development as well as checking whether they were equipped with the necessary resources to carry out their duties effectively. However, there was limited evidence to demonstrate effective measures to ensure behaviours as well as the practice culture drove or translated into effective sustainable care. The practice did not establish a culture which enabled early recognition when things were wrong such as performance; systems and processes or undertaking the necessary actions to remedy shortfalls within service delivery.</p> <p>There was a lead person responsible for managing and monitoring complaints and significant events. Staff were able to demonstrate systems that were in place to enable the practice to respond to complaints in a timely manner. We saw that incidents were investigated, and meeting minutes we viewed showed learning was being discussed during meetings. However, GPs explained they did not have access to incident logs and were not routinely informed of significant events or involved in investigations as this was managed by the non-clinical management team. Patients who were affected by an incident or were unsatisfied with the service provided received an apology.</p>	



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

Source	Feedback
Staff	Individuals we spoke with explained staff at all levels within the team were supportive and were happy to try new ways of working as well as implement suggestions from the teams to help improve service delivery. Staff explained there was a learning culture and lines of communication. Staff were encouraged to share any ideas as well as discuss any areas of concern.
Management team	Management we spoke with explained they felt supported in their role. However, during our inspection we found management staff who carried out roles to support the clinical team did not receive training to support them in extended roles and there was a lack of clinical oversight to ensure compliance with national guidelines.
Policies	Practice policies were in place which supported leaders to act on behaviour and performance inconsistent with the vision and values of the practice.
Policies and management interviews	The practice had processes which enabled leaders to take action to promote equality and diversity.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Dr Shafiq Shafi and Partners held a two separate GMC contracts which were delivered across the two locations set out in their registration with the Care Quality Commission. Both contracts were operating as one service with an overarching leadership and governance framework. The management team supported service delivery and provided leadership as well as oversight of the governance framework for both contracts. Clinical as well as non-clinical staff also worked across both services when required.</p> <p>The governance framework did not effectively support or ensure the delivery of safe, effective care. For example, oversight of safeguarding arrangements was not carried out effectively, management did not establish an effective approach to managing staffing levels, clinicians explained they were not routinely informed of significant events and staff did not receive support or receive training to support them in additional roles. The practice operated a process for ensuring policies and procedures were reviewed and updated in line with local and national guidance updates. However, clinicians were unable to demonstrate how they accessed some policies and procedures and there were areas where lead roles had not been established or made clear.</p> <p>Clinical governance did not form a systematic approach to maintaining and improving the quality and effectiveness of patient care. For example, information about patients care, treatment and their outcomes such as diagnosis and test results were not routinely collected and monitored. Oversight or medicine management was not carried out effectively and we found non-clinical staff were supporting clinicians in additional roles with a lack of support or training to ensure they were adhering to national</p>	

guidelines. Clinical records we viewed showed the practice was not operating in accordance to legislation which required a qualified prescriber to authorise and prescribe high-risk medicines.

The practice had data and information such as QOF to monitor how well the practice was performing, but they were unable to demonstrate how this information was used systematically to identify and improve the quality of care provided. For example, the 2018/19 QOF data showed intended outcomes for patients diagnosed with a long-term condition were not routinely being achieved. During the inspection we identified patients' diagnoses were not being recorded on the clinical system which hindered the ability to operate an effective call and recall system. Exception reporting was above local and national averages with a lack of clarity regarding who held responsibility for monitoring and exception reporting patients.

The governance arrangements did not ensure that responsibilities were clear, and that quality, performance and risks were routinely identified, understood and managed. For example, a holistic and comprehensive understanding of clinical risks which integrated the partners and non-clinical management had not been established. Therefore, issues identified by inspectors had not been picked up prior to our inspection, and staff were unable to demonstrate prior knowledge of clinical shortfalls or measures to reduce risks to patient.

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Clinical records did not provide assurance that accurate and up to date information about clinical effectiveness was being used or understood by staff. Staff were unable to demonstrate that information was routinely used to improve care and treatment as well as patients' outcomes. For example, we saw evidence where clinical audits had been repeated and quality improvement achieved. However; other audits were single cycle and issues picked up by the inspection team in areas such as medicine management as well as the management of long-term conditions had not been identified by the practice prior to our inspection.</p> <p>The management team were unable to demonstrate a systematic approach which enabled the practice to identify where quality and safety were being compromised and to respond appropriately without delay. For example, blood monitoring dates were not routinely added to the practice monthly validation form and blood due dates recorded by non-clinical staff were not in line with national prescribing guidelines. Clinical records showed patients with blood results which should have prompted the practice to review management plans had not been actioned and patients were not contacted. Codes for completed medicine reviews were being added by non-clinical staff with no evidence of a formal medicine review, receptionists were removing medicines without evidence of clinical oversight and INR test clinics were run by staff who was not formally trained to carry out these clinics.</p> <p>In the absence of emergency medicines recommended in national guidance; the practice had carried out a formal risk assessment. However, the risk assessment did not entirely mitigate all potential risks such as detailing the actions to be taken in the event of any emergency service delays.</p> <p>Records we viewed showed arrangements for managing most environmental and clinical risks. For example, the practice carried out fire safety, health and safety, legionella and Control of Substances Hazardous to Health (COSHH) risk assessments. However, the practice was unable to evidence premise's security risk assessment to enable identification and mitigation of potential risks.</p>	

## 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.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:  Information used to enable the practice to effectively manage patients' conditions and ensure positive outcomes were achieved was not routinely accurate, valid or reliable. The management team did not demonstrate a coherent approach to establish who held responsibility for monitoring QOF performance as well overseeing clinical activities within the practice.	

If the practice offered online services:

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

## Engagement with patients, the public, staff and external partners

### The practice involved the public, staff and external partners.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:  The practice had a Patient Participation Group (PPG) which was combined with two neighbouring practices. Members of the management team also attends PPG meetings and outcomes are shared within the practice.	

### Feedback from Patient Participation Group.

Feedback
Patient feedback was mixed. For example, national GP patient survey results as well as internal surveys carried out by the practice showed patients were satisfied with care provided and timely access to treatment. Patients we spoke with during our inspection and completed CQC comment cards demonstrated patients were satisfied with the practice. However, comments placed on NHS Choices showed patients were not routinely satisfied with the service they received.

## Continuous improvement and innovation

### There were some evidence of systems and processes for learning.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:  Oversight of systems for managing significant events showed that these were investigated and responded to in a timely manner. Meeting minutes showed evidence of shared learning. The practice had a system in place for managing complaints in a timely manner. However, the practice did not routinely identify areas of improvement and audits showed limited evidence of quality 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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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 rule 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 considered 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.