

Care Quality Commission

Inspection Evidence Table

Elmdene Surgery (1-7207643145)

Inspection date: 19 and 20 November 2019

Date of data download: 12 November 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

The practice was inspected in July 2018 under the previous partnership of which the current provider was a member. The Safe domain was rated Inadequate. At this inspection the Safe domain has again been rated Inadequate.

We rated the practice inadequate for providing safe services because:

- The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Risks to patients were not appropriately assessed and any actions required to address or minimise risk, had not been completed.
- Staff did not always have the information they needed to deliver safe care and treatment.
- The practice did not have appropriate systems for the safe management of medicines including the dispensaries.
- The practice did not have an effective system to learn and make improvements when things went wrong.

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	P
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	P

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	P
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	N
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.	P
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>There was a child safeguarding policy dated 15 September 2018 but with no review date.</p> <p>There was a vulnerable adult policy, but it was not signed or dated.</p> <p>There was a system that allowed vulnerable adults to be flagged up in the medical records and identified as vulnerable when the record was opened. However, children on the 'at risk' register and members of their household were not flagged in their medical records so that a clinician that accessed the record would not immediately be aware that an 'at risk' child was living in that household. We were told after the inspection that a record of children on the 'at risk' register was maintained, although they hadn't been flagged on the system. This was of particular concern because of the practices' reliance on locum clinicians. This was a systemic issue across all the registered locations.</p> <p>The current training record showed that two clinical staff were only trained to a Basic Safeguarding Adults level.</p> <p>We were told that there were no regular safeguarding meetings although we were also told that there were multi-disciplinary team meetings carried out on a monthly basis and health visitors would be contacted where appropriate.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>Of the five staff files we looked at four had appropriate checks carried out, however there were no interview records for one newly appointed staff member.</p> <p>We asked for proof of registration for one locum clinical member of staff. This was not available, and we</p>	

did not receive the information as requested after the inspection.

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: June 2018	Y
There was a record of equipment calibration. Date of last calibration: Elmdene Surgery 10/01/2019 Bennett Way Surgery 20/08/2018	P
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	P
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: July 2019	Y
There was a log of fire drills. Date of last drill: 28/02/2019	Y
There was a record of fire alarm checks. Date of last check: 18/11/2019	Y
There was a record of fire training for staff. Date of last training: Individual online training dated from April 2018 to 19 February 2019	P
There were fire marshals.	P
Fire risk assessments had been completed. Date of completion: Elmdene Surgery 02/10/2018 The last three reports weren't available to CQC or the practice on the day of the inspection but were sent to us after the inspection. Elmdene Surgery 30/10/2019 Bennetts Way Surgery 13/11/2019 Bean Surgery 13/11/2019	Y
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>Medical equipment should be calibrated annually. Equipment at Elmdene Surgery had been calibrated within the previous 12 months, however it was 15 months since the equipment at Bennett Way Surgery had been calibrated. We were not shown the calibration records for Bean Surgery at the inspection and asked for but did not receive a copy after the inspection.</p> <p>At the inspection of 27 November 2018 we saw that substances identified as Control of Substances Hazardous to Health (COSHH) products at Elmdene Surgery had been moved to a steel cupboard. At this inspection we found that COSHH products at Elmdene Surgery were being stored in a cupboard that contained the boiler and were not stored in line with COSHH legislation. This was a systemic issue</p>	

across all the registered locations. The provider told us that they were going to order protective cabinets for the practices and sent us evidence that they had ordered a hazardous storage COSHH cabinet. However, the order that we saw appeared to only be for one cabinet.

The fire risk assessment at Elmdene Surgery of 2 October 2018 had several actions recommended. One of these was to carry out routine in-house fire safety inspections. The practice could produce no records of these having taken place. The practice did however carry out monthly fire and smoke alarm tests.

We did not see evidence that three of the clinicians had received fire safety awareness training.

We saw that two members of staff had received fire warden (fire marshal) training across the three sites, but one of those was not currently working at the practice. There were no deputies appointed should the fire warden be unavailable.

The three fire risk assessments that had recently been carried out and were forwarded on to CQC after the inspection once available. All had recommendations that required action.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 30/10/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30/10/2019	N
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>A health and safety risk assessment was carried out on 20 September 2018 by an external agency. In our report of Elmdene Surgery published 7 January 2019 it was noted that risks identified had been actioned. For example, lone working was highlighted as an area of risk, and as a result, the practice ensured that two members of staff worked together. However, when we inspected on 19 November 2019 we found that a member of staff was working alone from 7.20am to 8am two days a week and that the front door was left open to allow patients access which was contrary to the lone working policy.</p> <p>There were Legionella risk assessments dated 9 July 2018 for each of Elmdene, Bean and Bennetts Way surgeries. Not all of the recommendations made in these reports had been carried out. For example, each report recommended that they carry out monthly temperature testing for all domestic water services in the building to ensure that cold water temperatures at all outlets were operating below 20°C and all hot water outlets were running at 50°C to 60°C. The practice could not provide records of any recording of water temperatures across any of the three sites Elmdene and the two branches. This was also a systemic issue across all the provider's registered locations.</p> <p>We also saw that there was a shower in Bennett Way Surgery that was not being used or regularly flushed through with water.</p> <p>The practice could not produce gas safety certificates for any of the three sites. After being informed they booked gas safety inspections for three days after the inspection.</p>	

The health and safety risk assessment of 20 October 2019 was received by the practice after the inspection and forwarded to CQC. There were actions which the practice told us they were going to address.

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.	P
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Elmdene Surgery 14 November 2018 Bennetts Way Surgery 18 December 2018 Bean Surgery 17 December 2018 (The document did not have the site details on it, but we were made aware it related to Bean Surgery.)	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 current training record showed that two members of clinical staff had not received infection prevention and control training. We could not find a cleaning schedule at Elmdene or Bennett Way Surgery. The same company worked to a clear cleaning schedule at Bean Surgery. The practice assured us that they would apply the same cleaning schedules at Elmdene and Bennett Way Surgeries.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	P
There was an effective induction system for temporary staff tailored to their role.	P
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	P
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.	N
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.

The practice had a rota for clinical and non-clinical staff however it is not clear how well staff absences were managed. CQC had received a complaint from a patient about Elmdene Surgery in which it was alleged that following a long wait on the phone a patient was told that all the GPs had called in sick.

We saw that there was a locum pack available for locum staff, but it was not clear whether locums were given a personalised induction on commencing work.

We did see that on occasions the nurse would be administering childhood immunisations with an advanced nurse practitioner, but no GP on site. The current practice training record did not have a record of the nurse having received anaphylaxis training. Additionally, the practice was unable to demonstrate how they had assured themselves, that the advanced nurse practitioner (ANP) was suitably registered, qualified and had the appropriate competencies to provide the supervision of immunisations. This was a systemic issue across all the registered locations.

There were no adult or child pulse oximeters at any of the three surgeries or risk assessment as to why they were not available. We were sent evidence that these were purchased immediately after the inspection. This was a systemic issue across all the registered locations.

We could see no record that any of the non-clinical staff had received specific training in how to identify and manage patients with sepsis. There was no flow chart guidance on the signs and symptoms of potential serious illness including sepsis available at the reception desks at any of the three surgeries. We saw minutes from an administration/reception meeting in October 2019 that suggested staff tell patients who ring in with chest pain or breathing difficulties to go to A & E. This could lead to delay in urgent treatment. The same meeting minutes suggested that if there were no appointments available then reception staff should tell patients to ring the 111 service for advice.

Staff were all trained in basic life support.

The current training record showed no record of three clinical staff members having received training in the management of anaphylaxis including one GP.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	P
There was a system for processing information relating to new patients including the summarising of new patient notes.	P
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
Referral letters contained specific information to allow appropriate and timely referrals.	P
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	P
There was a documented approach to the management of test results and this was managed in a timely manner.	P
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	P
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	P
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>Medical records and care data were saved securely on the practice server. However, it could not be guaranteed that all the data that a clinician required to manage a patient was immediately available to them:</p> <p>We were told that one of the administrative staff liaised with the council, fostering organisations and hospitals where appropriate. The practice held monthly multi-disciplinary team meetings.</p> <p>We found that 531 documents had been scanned in to the system since 2 September 2019, but were waiting for their contents to be reviewed, actioned and filed. We looked at nine documents and found that of these, one was a duplicate of a previous letter and had been actioned and one urgent request was made by the palliative care team and not fulfilled for four weeks. The other seven had not been reviewed or actioned. Examples of requests that had not been actioned were: a request from a consultant for a patient who had had previous episodes of pneumonia to be immunised against it and another urgent request from the palliative care team. This was a systemic issue across all the registered locations.</p> <p>Care plans for patients at nursing homes were kept at the nursing homes, but copies were not stored at the practice.</p> <p>We were told that there was no system in place for sharing information with out of hours or ambulance services.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.94	0.99	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	7.0%	9.7%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	6.66	5.68	5.63	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	2.79	2.22	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.	P
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	P
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
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.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	P
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.	P
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	P
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	P
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>Medicines (including controlled drugs), were usually stored safely and securely. However, at Bennetts Way Surgery the access to medicines was not restricted to authorised staff as the door between the waiting area and dispensary was not always closed and locked. Medicines were stored appropriately at the Bean Surgery dispensary.</p> <p>The controlled drugs cabinet at Bennetts Way did not meet requirements. Controlled drugs were therefore not stored in line with legislation. The controlled drugs cabinet was appropriate at the Bean Surgery dispensary.</p> <p>There were written standard operating procedures in place for the management of controlled drugs. However, these were not always followed. For example, a balance check of the controlled drugs at Bennett Way dispensary had not been completed since July 2019.</p> <p>Prescription stationery was not always stored securely in line with national guidance at Bennett Way Surgery although it was at Elmdene and Bean surgeries. Prescription stationery was logged on receipt into the practice and tracked through the surgeries.</p>	

Medicines management	Y/N/Partial
<p>Patient Group Directions (PGDs) (a written instruction for the administration of medicines to groups of patients not previously prescribed for) were present for all the vaccines offered by the provider. However, some of the PGDs were out of date, but the practice did have new ones signed by the nursing staff and awaiting a GP signature. These had been signed by a GP before the inspection was completed.</p> <p>We were told by non-medical prescribers and GPs that they had access to GPs for advice and discussion. The lead GP said that they monitored prescribing by non-medical prescribers, however there was no documentary evidence of this. This was a systemic issue across all the registered locations.</p> <p>We did not see evidence of a process for prescribers to routinely review patients' repeat prescription medicines. Staff told us there was no clear system to refer patients to their GP for medication review.</p> <p>We were told by staff that the process of making changes to people's medicines (including changes made by other health care professionals) was not always processed in a timely manner. There was no audit trail for the management of this information. Staff told us patients often would have to tell dispensary staff about changes to their medicines when they came to collect them. Staff would then have to search for evidence of this change in the patient's records before correcting the medicine.</p> <p>The practice was not effectively managing high risk medicines to ensure patients remained safe. Staff told us that patients had sometimes received medicines without the necessary monitoring and when monitoring would have required a change in treatment.</p> <p>There was a system in place to monitor the safe prescribing of high-risk medicines which included calling patients for blood tests if they missed appointments, but it was not effective. We examined the records for 16 patients who were prescribed medicines that required regular blood monitoring. We found that five patients were not being monitored in line with national guidance to ensure it remained safe to provide this treatment. Similar issues had been identified at our inspection of July 2018 and systems had initially been put in place to resolve the issues and ensure patient safety. However, the systems were not being fully adhered to and the management of patients on high risk medicines was no longer safe.</p> <p>Vaccines were stored and monitored appropriately, however there were also several food items being kept in the vaccine fridge at Bennett Way Surgery. Public Health England guidance states that food must not be stored in the same fridge as vaccines or medicines.</p> <p>We also saw that when giving joint injections the GP was not recording the batch numbers or dates of the injection.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	N
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	N
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	P
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	P
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	N
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	N
<p>Explanation of any answers and other comments on dispensary services:</p> <p>There was a GP responsible for the leadership in both dispensaries, however, this role had been conducted remotely for several months prior to the inspection and dispensing staff were not able to access advice in a timely way. The practice rota showed that there were times during the week when the dispensaries were open, but with no GP on site particularly during the provider's absence. For example, on a Tuesday all day at Bennett Way Surgery and on Monday and Wednesday morning, and all day on Friday at Bean Surgery.</p> <p>Standard Operating Procedures were in place but there was no process to monitor compliance with these.</p> <p>All dispensary staff underwent mandatory training on joining the practice. However, there were no records of competency checks taking place, or a review of knowledge and skills through appraisals. Staff at one of the dispensaries on the day of the inspection asked a lot of questions of the medicines inspector around what they were and were not able to do for patients. It appeared they were not confident in what medicines they were able to provide to the patients in various situations.</p> <p>Prescriptions were signed prior to being dispensed and handed to patients. However, at Bennett Way Surgery the dispensary would sometimes operate without a prescriber being accessible on site to help dispensary staff with prescription problems. Staff were not clear on when they could give medicines for</p>	

acute prescriptions without a signed prescription.

Medicines waste was not always handled appropriately. The dispensary at Bennetts Way had access to appropriate medicines waste bins. During the inspection we saw unidentifiable medicines in the dispensary both on top of the bin and on the counter which the inspector was told were for destruction. Medicines waste was handled appropriately at the Bean Surgery dispensary.

The practice offered a home delivery service for medicines, which at the time was fulfilled by a service external to the practice. Staff were not able to show that a risk assessment had been completed for this service to deliver medicines on their behalf, or steps taken to ensure people were getting their medicines appropriately.

Staff at Bennett Way Surgery were unable to provide any records of medicines incidents or near misses (dispensing errors made that do not reach the patient). There was no review of dispensing errors conducted regularly to help improve practice. Near misses were recorded at Bean Surgery dispensary.

There was no facility for dispensary staff at Bennetts Way Surgery to talk to patients confidentially.

Several of these issues had been previously highlighted at the inspection of 12 July 2018. Improvements were made and noted at the inspection of 27 November 2018 but had not been embedded.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	N
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	N
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months: (on the final record sent to CQC)	11
Number of events that required action:	11
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a consistent system for recording significant events.</p> <p>When we looked at the register of significant events on the day of the inspection, we saw that issues had been recorded up until March 2019 and since then none had been recorded. However, when we looked at the meeting minutes of a staff meeting on 25 April 2019 we saw that a significant event had been on the agenda where a patient's address was inappropriately shared. The minutes did not record the discussion, its outcome, actions, who was to lead on the issue or a date that it should be resolved by. There was no record of dissemination of learning and it was not recorded on the significant events register.</p> <p>The significant event register was designed to record what action was taken at the time, a review of the action and learning taken at the next meeting and whether there had been a reoccurrence.</p> <p>There appeared to be more than one version of the register. When the lead GP was questioned about significant events, we were shown a record of five significant events, the last one was February 2019.</p> <p>When we were sent a copy of the record after the inspection, the last was recorded as 30 October 2019 and the record contained 11 significant events. Neither of the versions included the example quoted above.</p> <p>We were told that significant events were discussed at weekly meetings although we saw no record of minutes for weekly meetings. We did however see the minutes of monthly staff meetings. In August we saw that the importance of raising significant events was reinforced to staff.</p> <p>Similar issues had been previously highlighted at the inspection of 12 July 2018. Improvements were made and noted at the inspection of 27 November 2018 but had not been embedded.</p>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
There was a power cut at one of the branch surgeries. No patient lists were printed the previous night and so when the power went out, they did not know which patients were coming in for an	Staff were reminded of the importance of printing patient lists for the next day.

appointment.	
A fridge temperature was increasing unexpectedly and inexplicably and not reducing as expected.	As soon as the temperature started increasing and not reducing the stock was taken out of the fridge and put in to the vaccines' fridge. A further note stated that daily temperature monitoring was carried out and there was no further action reported. We did not see any meeting minutes where the event was discussed, or learning disseminated.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a system for recording external safety alerts through the practice, but it did not have a complete audit trail. The alerts were received and recorded by the practice manager and then passed on to the lead GP. The practice could not provide us with records of any actions taken after this point or any dissemination of learning from each alert.</p> <p>However, we looked at three female patients of child bearing age that were prescribed sodium valproate (one of the alerts raised in the last two years) and saw that alerts had been placed on the notes, so in this case some action had been taken.</p> <p>The safety alerts that were received at the Bean dispensary were received, recorded and actioned by the dispenser. They had not yet written the last two recent alerts up but were aware of them and said that they were not relevant to the dispensary, they were however going to write them up. The system provided a clear audit trail for the alerts through the dispensary. A similar system was in place at the Bennett Way dispensary, the last alert recorded was a month previously.</p>	

Effective

Rating: Inadequate

The practice was inspected in July 2018 under the previous partnership of which the current provider was a member. The effective domain was rated Inadequate. At this inspection the effective domain has again been rated Inadequate.

The practice was rated inadequate for providing effective services because:

- Care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- There was limited monitoring of the outcomes of care and treatment.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- Staff did not always work together and with other organisations to deliver effective care and treatment.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	P
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	P
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	P
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: Although we saw examples of patients that had been followed up appropriately, we could not be certain that patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. This was because there was a backlog of 531 scanned documents on the computer system dating back to 2 September 2019, which had not been reviewed and actioned. As specified earlier in the safe section of the evidence table when we reviewed a small sample of these we identified several that needed urgent attention and had not been followed up. There was a system in place to monitor the safe prescribing of high-risk medicines which included calling patients for blood tests if they missed appointments. However, it was not effective as high-risk	

medicines were being prescribed without sight of appropriate test results and patients were therefore being put at risk.

Guidelines such as NICE guidelines were available via the internet and shared computer drive.

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) <small>(NHSBSA)</small>	1.12	0.89	0.75	No statistical variation

Older people

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

- Due to the backlog of scanned documents, the practice was unable to demonstrate that GPs always followed up patients who had received treatment in hospital or through out of hours services for their long-term condition.
- The practice looked after patients in four care homes and care plans were stored at the homes, however, copies were not available at the practice.

However, there were areas of good practice:

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- We were told that GPs carried out weekly ward rounds at the four care homes they looked after.
- Flu, shingles and pneumonia vaccinations were offered to eligible patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

- Some patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, The Quality Outcome Framework (QOF) data for long term conditions such as diabetes, COPD and asthma indicated that the percentage completed were significantly below local and national averages (see tables below).
- Due to the backlog of scanned documents, the practice was unable to demonstrate that GPs followed up all patients who had received treatment in hospital or through out of hours services for their long-term condition. However, we did see examples of patients who were followed up following a myocardial infarction (heart attack).
- Some patients with asthma were offered an asthma management plan and those plans that were seen by CQC followed NICE guidelines. However, QOF figures showed that only a small percentage of patients with asthma received an asthma review.

However, there were areas of good practice:

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice did hold monthly multi-disciplinary team meetings.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring, but the practice referred patients to secondary care for this test.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	49.9%	78.1%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	7.1% (33)	15.9%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	38.6%	74.2%	78.1%	Significant Variation (negative)
Exception rate (number of exceptions).	10.3% (48)	12.9%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	43.5%	77.1%	81.3%	Significant Variation (negative)
Exception rate (number of exceptions).	10.0% (47)	14.6%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	22.7%	75.2%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	1.6% (6)	10.7%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	19.3%	85.7%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.1% (5)	13.8%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	54.2%	81.0%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	20.8% (265)	5.5%	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)	82.9%	91.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.5% (3)	3.3%	5.9%	N/A

Any additional evidence or comments

The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.

The data for all the above Quality Outcome Framework (QOF) questions with the exception of the last question, showed significant variation (negative) from Clinical Commissioning Group and England averages. This had been identified as an issue at the inspection in July 2018 when the suggestion was that it was due largely to incorrect coding. The lead GP again suggested that this was the reason for the poor performance.

We looked at examples of the current (unverified) QOF data that the practice held for the period 01/04/2019 until 19/11/2019 (7-8mths). The data shows the QOF achievements so far:

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 was 8%.

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 was 4%.

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less (for the period 01/04/2019 until 19/11/2019 was 27%.

The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 140/90 mmHg was 17%
(The last two questions are not exactly the same as for 2018/2019, but similar.)

Even allowing for the fact that these figures represent progress over a seven to eight months of a 12-month period, the figures are still very low.

This was a systemic issue across all the registered locations.

The practice did say that recalls had not yet gone out. We noted it was recorded in the minutes of an administration/reception team meeting in September 2019 that they will put a robust system in place to

monitor QOF call and recall, but no action plan had been produced.

Families, children and young people

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

- The practice did not have arrangements for following up failed attendance of children's appointments following an appointment in secondary care.
- Children on the at-risk register and members of their household were not flagged as alerts in their medical records.
- The practice had met the minimum 90% target for three of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the four childhood immunisation uptake indicators.

However, there were areas of good practice:

- The practice used a text message reminder service to remind patients about appointments.
- The practice did have a system for following up patients who failed to attend for immunisations.
- Young people could access sexual health advice and some contraceptive services at the practice but were referred to a family planning clinic for more advanced contraceptive services.
- Where required the practice would contact health visitors by phone or email.

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)	117	133	88.0%	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)	141	149	94.6%	Met 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)	140	149	94.0%	Met 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)	140	149	94.0%	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>

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

However, there were areas of good practice:

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could cancel appointments online and order repeat medication without the need to attend the practice. There were also facilities for patients to answer an online survey and update their personal details through the website.
- The practice provided a text messaging reminder service.

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)	73.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	62.4%	71.9%	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)	48.7%	53.7%	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. (01/04/2017 to 31/03/2018) (PHE)	35.7%	69.1%	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)	66.7%	52.3%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

- Patients with a learning disability were not currently offered an annual health check.
- Although the practice liaised with other agencies, there was no evidence that end of life care was always delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Patient records that we looked at did not record carers names or preferred place of care or death.
- The backlog of scanned documents had contained requests for urgent action in respect of two patients receiving end of life care. One had not been actioned and the other only actioned after a significant delay.

However, there were areas of good practice:

- Alerts were placed on the notes of vulnerable patients so that they were immediately identifiable when records were accessed.
- Same day appointments and longer appointments were offered when required.
- The practice demonstrated that they had a system to appropriately refer people who misused substances.

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

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

- There was limited evidence that the practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder as the Quality Outcome Framework (QOF) data for these areas was significantly below the local and England averages (see table below).

However, there were areas of good practice:

- Same day and longer appointments were offered when required.
- There was a system for following up patients who did not collect their prescriptions
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	14.0%	86.6%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	14.1%	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) <small>(QOF)</small>	23.3%	85.7%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	12.7%	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) <small>(QOF)</small>	69.8%	82.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	10.4% (5)	7.0%	6.7%	N/A

Any additional evidence or comments

We looked at examples of the current (unverified) QOF data that the practice held for the period from 1 April 2019 to 19 November 2019.

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record was 0%.

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review was 0%.

The lead GP felt that the low results may be partly due to coding issues. However, this was highlighted as an issue at the inspection in July 2018 and no effective action had been taken to resolve this.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	260.5	No Data	539.2
Overall QOF score (as a percentage of maximum)	46.6%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.8%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N

The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N
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.	N

Any additional evidence or comments

The practice had carried out three single cycle clinical audits:

The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.

One audit of the management of Chronic Obstructive Pulmonary Disease had been carried out on 21 October 2018 with a planned re-audit date in six months, but this had not been started at the time of our inspection.

One audit of the management of Diabetes Mellitus was carried out on 30 October 2018. This was planned to be re-audited in six to eight months but this had not been started at the time of our inspection.

One audit of joint injections, which had not had a second cycle completed.

The practice had not taken action to enhance its programme of quality improvement, particularly for those patients with long term conditions and who were within low QOF target categories. This was a systemic issue across all the registered locations.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	P
The learning and development needs of staff were assessed.	N
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.	P
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	P
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	P
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We looked at five staff files. We reviewed three files where staff members had been working at the practice long enough to have an annual appraisal, two had had appraisals. The third had not in the last two years, but said they were due to have one and there was an undated partially filled in form in their file.</p> <p>Staff had access to online training and there was a programme of training that staff were expected to complete. However, the current training record revealed several areas where training was incomplete. For example, there was no record of sepsis training having taken place for non-clinical staff. Three clinicians had not completed fire safety awareness training, three clinicians had not completed anaphylaxis training and three clinicians, and two non-clinicians had not completed Health and Safety awareness training.</p> <p>We saw that there was a locum pack available for locum staff although it was not clear whether they received a personalised induction.</p> <p>The GP lead told us that they regularly review the notes of advanced nurse practitioners, but there was no recorded evidence of review.</p> <p>There was an induction pack available and an induction checklist, although we saw that a recently employed staff member had not been given an induction pack yet. However, minutes of a staff meeting in June 2019 did comment that if anyone felt that they have not had acceptable training or induction to speak to the lead GP or practice manager to put this in place.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	P
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.	P
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	N
Patients received consistent, coordinated, person-centred care when they moved between services.	N
<p>Explanation of any answers and additional evidence:</p> <p>We were assured that there were monthly MDT meetings, but did not see minutes from the meetings.</p> <p>We were told that there was no system to share records with out of hours and emergency services.</p> <p>The backlog of documents that had not been reviewed contained requests from secondary care and other agencies that hadn't been actioned.</p>	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	P
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.	P
<p>Explanation of any answers and additional evidence:</p> <p>Although we were told that patients were identified and referred for extra support, we were also told that the practice did not refer patients with non-diabetic hyperglycaemia (high blood sugar) to a diabetic prevention programme. Also, although some patients were under the palliative care team, some urgent requests from the team had not been actioned.</p> <p>We were told that patients were referred to a local agency for advice on issues such as smoking cessation and weight control. However, QOF data for the practice shows that the percentage of patients with long term conditions that had their smoking status recorded in the notes was significantly below clinical commissioning group and England averages.</p> <p>The practice did identify patients who may need extra support such as carers.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	62.6%	92.0%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	0.6% (12)	0.8%	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
Explanation of any answers and additional evidence: The GP offered joint injections. Verbal consent was asked for and recorded in the notes.	

Caring

Rating: Requires improvement

The practice was inspected in July 2018 under the previous partnership of which the current provider was a member. The caring domain was rated requires improvement. At this inspection the caring domain has again been rated requires improvement.

The practice was rated as requires improvement for providing caring services because:

- The practice was unable to demonstrate how they made use of feedback from patients.
- National GP patient survey results were generally below local and England averages.
- The practice did not always respect patients' privacy and dignity.

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.	N
Explanation of any answers and additional evidence: Patients were sometimes given appropriate and timely information. However, within the backlog of scanned documents there were two urgent requests for action with respect patients receiving end of life care had not been dealt with in a timely way	

CQC comments cards	
Total comments cards received.	N/A
Number of CQC comments received which were positive about the service.	N/A
Number of comments cards received which were mixed about the service.	N/A
Number of CQC comments received which were negative about the service.	N/A

Source	Feedback
Comment cards	This was an unannounced inspection due to concerns received, so comment cards were not sent out beforehand.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8990.0	362.0	107.0	29.6%	1.19%

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)	78.0%	84.8%	88.9%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	79.0%	82.9%	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)	88.3%	93.6%	95.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	59.9%	77.7%	82.9%	Variation (negative)

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

Any additional evidence
There was a practice online survey which patients can fill in on the website which asks a wide range of questions. The results for 2018 were also on the website although we saw no analysis of actions considered or taken in response to the results.

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

Source	Feedback
Interviews with patients.	We spoke to nine patients about how they were cared for by the practice on the day of the inspection. Patients thought that staff were friendly and helpful They had enough time with the clinicians. Comments about the lead GP and regular clinicians were positive. Comments about locums were less positive.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	84.1%	91.3%	93.4%	Tending towards variation (negative)

Any additional evidence or comments
The practice told us that they tried to provide continuity of care by using the same regular locum GPs and advanced nurse practitioners. They did have to use other occasional locum staff but used the same locum agencies to source them.

	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.	P
Information about support groups was available on the practice website.	N
<p>Explanation of any answers and additional evidence:</p> <p>There was a facility on the website to allow it to be translated to many different languages.</p> <p>Although information about support groups was not available on the website, it was available in the practice waiting room.</p> <p>We were told that leaflets could be printed in larger print if requested.</p>	

Carers	Narrative
Percentage and number of carers identified.	46 carers had been identified. This equates to 0.5% of the practice population.
How the practice supported carers (including young carers).	One of the staff members kept a list of carers. Carers were given a carers' pack and offered an annual influenza vaccination. We were told that letters were sent to carers approximately every three months to ascertain if any help was required.
How the practice supported recently bereaved patients.	The practice phoned the family and sent a card to bereaved patients.

Privacy and dignity

The practice did not always respect 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.	P
There were arrangements to ensure confidentiality at the reception desk.	P
<p>Explanation of any answers and additional evidence:</p> <p>Staff could often, but not always, offer patients a private room, depending on whether the rooms were occupied or not.</p> <p>Elmdene and Bean Surgeries were small and discussions taking place at the reception desk could be overheard in the hallway and the waiting room. There were sliding windows to help prevent discussions in the back office being easily heard, but these usually had to be open. Bennett Way was a larger building and had a larger waiting room. There was a room available where patients could be spoken to</p>	

confidentially if required. The practice was aware of the issues but were limited in their response by the size and layout of the buildings. We were told that they had been trying to access new premises for several years.

The staff meeting record of the June meeting noted that they were expecting Elmdene Surgery to be getting a touch screen check in to relieve the receptionists to take calls. We did not see the screen on the day of the inspection.

Responsive

Rating: Inadequate

The practice was inspected in July 2018 under the previous partnership of which the current provider was a member. The responsive domain was rated requires improvement. At this inspection the responsive domain has again been rated requires improvement.

The practice was rated as requires improvement for providing responsive services because:

- The practice did not always organise and deliver services to meet patients' needs.
- People were not always able to access care and treatment in a timely way.
- National GP survey results with respect telephone access, making an appointment and the type of appointments available were below the local and England averages.
- Complaints were not always used to improve the quality of care.

Responding to and meeting people's needs

The practice did not always organise and deliver services that met patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	N
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.	P
The practice made reasonable adjustments when patients found it hard to access services.	P
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:	
The buildings at Elmdene Surgery and Bean Surgery were small. Both had doors and corridors wide enough for wheelchair access, but neither had automatic doors, both had standard doors and handles. Neither had disabled toilet facilities, toilet facilities with wheelchair access or baby changing facilities.	
The building at Bennett Way Surgery had doors and corridors wide enough for wheelchair access. Doors were not automatic and had standard doors and handles. There were disabled toilet facilities and baby changing facilities. Patients could book appointments at Bennet Way, but we did not see signs in the waiting rooms at Elmdene or Bean Surgeries advertising this.	

Practice Opening Times		
Day		Time
Opening times:		
Monday	Elmdene Surgery	8.30am to 18.30pm
	Bean Surgery	9.00am to 13.00pm
	Bennett Way Surgery	9.00am to 13.00pm

Tuesday	Elmdene Surgery	8.30am to 18.30pm
	Bean Surgery	Closed
	Bennett Way Surgery	8.30am to 17.00pm
Wednesday	Elmdene Surgery	8.30am to 18.30pm
	Bean Surgery	9.00am to 13.00pm
	Bennett Way Surgery	8.30am to 18.30pm
Thursday	Elmdene Surgery	8.30am to 17.00pm
	Bean Surgery	Closed
	Bennett Way Surgery	8.30am to 19.30pm
Friday	Elmdene Surgery	8.30am to 18.30pm
	Bean Surgery	9.00am to 13.00pm
	Bennett Way Surgery	8.30am to 18.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8990.0	362.0	107.0	29.6%	1.19%

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)	91.7%	93.3%	94.5%	No statistical variation

Any additional evidence or comments

There were times when non-medical clinicians were the only clinicians on site. For example, a health care assistant on Monday and Tuesday at Elmdene Surgery from 7.20am and Thursday from 9am to 11am at Bennett Way Surgery. A nurse from 8.30am to 10am and 1pm to 2pm on a Friday at Elmdene Surgery and an advanced nurse practitioner from 9am to 12am on a Friday at Bean Surgery.

The next available routine bookable GP appointment was in 17 days. The next available nurse appointment was in 10 days. Patients could make 'on the day' appointments over the phone or by attending the practice. Once appointments had been filled then they would be offered a triage phone call or be directed to a local walk-in centre.

There were some child emergency slots available to book one day ahead.

The lead GP told us that they tried to offer appointments in line with guidance of 72 appointments per 1000 patients per week. We were sent a printout which said that there were 797 appointments between 11 and 16 November. However, there was no detail at all of the type of appointment or who carried it out. We asked for clarification with specific details of appointments for the last month but did not receive a reply.

Older people

Population group rating: Inadequate

Findings

The provider has been rated as inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as inadequate.

- All patients had a named GP who was the lead GP. They had not been available for four months but had delegated the salaried GP to cover in their absence.

However, there were areas of good practice:

- 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.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Inadequate

Findings

The provider has been rated as inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as inadequate.

- Patients with a long-term condition did not consistently receive an annual review to check their health and medicines needs were being appropriately met.
- The practice liaised with other services when managing the care and treatment for people with long-term conditions approaching the end of life. However, urgent requests from other services with respect to patients receiving end of life care were amongst the backlog of scanned documents not actioned for over two months

However, there were areas of good practice:

- 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..

Families, children and young people

Population group rating: Inadequate

Findings

The provider has been rated as inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as inadequate.

- We found no systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had failed appointments to secondary care. Children who were on the at risk register and members of their household did not have alerts flagged on their patient notes.

However, there were areas of good practice:

- GP appointments were available until 7pm on a Thursday evening and advanced nurse practitioner appointments until 7.30pm on a Tuesday for children who could not make appointments during school hours.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The provider has been rated as inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as inadequate.

However, there were areas of good practice:

- 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.
- Elmdene Surgery was open until 7.30pm on a Tuesday and Bennett Way Surgery was open until 7pm on Thursday. Blood tests could be booked from 7.20am on a Monday and Tuesday at Elmdene Surgery. There was also a walk-in service available at a local practice.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The provider has been rated as inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as inadequate.

However, there were areas of good practice:

- The practice had flagged the records of patients whose circumstances made them vulnerable.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability however, they did not offer an annual review to patients with a learning disability.

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

Population group rating: Inadequate

Findings

The provider has been rated as inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as inadequate.

However, there were areas of good practice:

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	P
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 necessary.	Y

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)	30.8%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	33.4%	55.7%	67.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	44.9%	55.5%	64.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	38.4%	64.7%	73.6%	Significant Variation (negative)

Any additional evidence or comments

The CQC inspection team arrived at the practice at 8.45am 15 minutes after it opened. There was a long queue at reception and patients were being told that there were no appointments available. We spoke to five patients and themes from the conversations were that it was hard to get through on the phone and better to come down to the practice although some had been previously and had failed to get an appointment then as well. Patients were being advised to go to the local walk-in centre. Other patients indicated that it was not always as bad as it was on the day of the inspection.

We spoke to four other patients during the inspection. Three told us that it was difficult getting through on the phone the fourth thought that getting an appointment was not too difficult. Patients were unaware of how to complain about the service.

Source	Feedback
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NHS Choices	<p>In the last year there have been three five-star reviews, one four-star review and three one-star reviews on NHS choices. The practice had not responded to the reviews. The positive reviews felt staff were kind, caring and they felt listened to. The GP was supportive and there had fairly recently been a new call waiting system put in which it was felt worked well. The negative reviews mentioned a long queue at the desk and having to go to A&E and a long phone wait eventually having to give up. Patients also mentioned a GP not taking their health seriously and a locum answering a call on their mobile phone during the consultation.</p>
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Listening and learning from concerns and complaints

Complaints were not always used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	18
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	Unknown
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	P
There was evidence that complaints were used to drive continuous improvement.	P
Explanation of any answers and additional evidence: There was a spreadsheet for complaints that showed there were 10 written complaints and three verbal complaints recorded over the last year. Those before April 2019 had an identifier of patients initials but no more. Those from April 2019 had no identifier at all. There were also five complaints dealt with by a member of the administrative staff. These did not appear on the spreadsheet and we could not ascertain what action was taken or whether there was any learning from these complaints. The complaints that were recorded on the spreadsheet did have actions and learning recorded. For example, a verbal complaint recorded on the spreadsheet in September 2019 regarding a patient being held on hold for a long time was discussed at an administrative staff meeting. The minutes recorded the action that staff were to remain at reception at all time, report if they needed to leave and to try to multi-task. CQC had received an enquiry from a patient, who said that they had complained to Elmdene Surgery. The complaint related to issues with hospital letters not being actioned and with difficulty in getting their repeat prescriptions. We could not find a record of the alleged complaint in the complaints spreadsheet or reference to it in staff meeting minutes. There was a complaints policy, but it was undated. The practice advised patients to direct complaints to an email address. This was signposted on the website and the wall in the waiting room. We were given a leaflet on how to complain, but we did not see any in the waiting room. It was not possible to access the letters at the time as they were attached to the patient notes and there were no patient identifiers on the spreadsheet, so it was not possible to assess how well the complaints were dealt with.	

Examples of learning from complaints.

Complaint	Specific action taken
Patient referred to the wrong service as it did not deal with autism.	The note on the spreadsheet showed that the patient was sent to the correct place and the learning was shared with the staff members. We saw that a letter was sent to the patient, but there was no patient identifier, so we didn't know which patient it was and were unable to access the patient's notes or the letter at the time of the inspection. The complaint was raised

	in June 2019, but we could find no record of it in staff meeting minutes from June 2019 to November 2019 where the complaint was discussed, so we could not ascertain what the learning was or how it was disseminated.
Patient was unhappy because they could only see a locum GP.	A letter was sent 26 days after the complaint was received. (The complaints policy specifies an acknowledgement in three working days) Action recorded was that the practice manager wrote a reply letter. The learning recorded on the spreadsheet was to try and accommodate patients as much as they possibly could.

Well-led

Rating: Inadequate

The practice was inspected in July 2018 under the previous partnership of which the current provider was a member. The well-led domain was rated Inadequate. At this inspection the well-led domain has again been rated Inadequate.

The practice was rated inadequate for providing well-led services because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice had a vision, but it was not supported by a credible strategy to provide high quality sustainable care.
- The practice culture did not always support sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks and identified issues.
- The practice did not always act on appropriate and accurate information.
- The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	N
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	
Quality Outcome Framework data had been significantly below local and national averages for the year 01 April 2018 and 31 March 2019. However, there was no clear action plan in place to improve the patient outcomes and unverified data provided by the practice for the period 01 April 2019 until the date of the inspection did not show any improvement. Leaders felt that this was due to the way the data was coded when recorded. However, this issue had been identified at the previous inspection in July 2018 and there had not been any effective action taken to improve outcomes.	
Examples of other issues that had not been addressed were an action required following a fire risk assessment and actions identified following a Legionella risk assessment. Second cycles of clinical audits had also not been completed.	
The GP had been absent from the practice for a period of about four months due to unexpected sick leave and had just returned part time. We were told the practice manager had also intermittently been absent and was now absent for a longer period, their role was currently being covered by a part-time interim practice manager. The practice had a salaried GP who took over the clinical lead role although the lead GP could access practice records remotely. Other clinical cover was provided by a mixture of	

long-term locums, short-term locums and locum advanced nurse practitioners.

There was however still a lack of oversight and clinical governance in particular in the Bennett Way dispensary where staff had only recently been employed. There were also occasions where a nurse and advanced nurse practitioner were working and carrying out childhood immunisations whilst there was no GP on site.

Staff said that when the lead GP had been there, they were helpful and supportive. We were told that the salaried GP was also helpful and supportive. However, one staff member commented that they had only seen the interim practice manager once (they started in September 2019) another had not met them yet at all.

There was currently no succession plan as the lead GP was a single-handed practitioner.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	P
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	P
Staff knew and understood the vision, values and strategy and their role in achieving them.	P
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>The lead GP wanted to move premises as the premises he was in at Elmdene were too small. He said that he had been trying to negotiate that for ten years but had not yet been successful.</p> <p>He wished to merge his Elmdene location with his other location at Joydens Wood so that he wasn't running two businesses.</p> <p>He wished to also improve the health of his patients and their access to services as well as appoint a finance manager.</p> <p>There was not however a detailed strategy to achieve this other than to negotiate with the local Clinical Commissioning Group and Kent County Council with respect to obtaining new premises which had been unsuccessful to date. There were no detailed plans that prioritised quality and sustainability.</p> <p>Staff that we spoke to did understand that the plan was to provide good patient care and eventually move to a new premises.</p>	

Culture

The practice culture did not always support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	P
There were systems to ensure compliance with the requirements of the duty of candour.	P
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	P
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.	N
Staff had undertaken equality and diversity training.	N
<p>Explanation of any answers and additional evidence:</p> <p>Staff safety was not always a high priority. Following the inspection of July 2018, a lone working policy was put in place, it was agreed that there would always be a minimum of two staff working together in the building. We found that on two mornings a week, one staff member worked alone and with the main door open contrary to the lone workers policy. When we asked about this we were told that it would be looked at but that it was not financially viable to have a receptionist on-site at the same time.</p> <p>We did however see that if a patient was visited at home, a record of the visit was retained, and the clinician had to confirm to the practice when they had completed the visit.</p> <p>The current training record showed that although some staff had completed equality and diversity training, three non-clinical and three clinical staff had not.</p>	

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

Source	Feedback
Staff members	<p>Staff feedback was mixed, with a feeling that governance was difficult whilst the lead GP and the practice manager had been absent. One staff member had not yet met the interim practice manager whilst another had only met them once. Whilst some staff expressed the feeling that the staff worked well together and there was a friendly, open door culture, another felt unappreciated. There had also been an expression of concern over the oversight and safety in one area of the service.</p> <p>It was clear (and expressed several times by staff), that they were doing their best to keep the practice running smoothly until the lead GP returned full time.</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	P
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>The governance arrangements were confused and unclear leading to a lack of clinical and administrative oversight that was not always safe and effective. We were initially given a copy of the practice organisational structure that referred to the previous practice manager as a major point of contact. We were later sent a revised version with the interim practice manager on it. The lead GP was on the structure although they had been away from the practice since July 2019 and only just commenced a part-time return to work. They had access remotely to the practice system via a VPN (virtual private network). There was no indication on the structure who to contact when they were unavailable. The practice had sent CQC a statutory notification to say that the salaried GP would cover the lead GP's duties whilst he was on sick leave, but this wasn't recorded on the old or new version of the organisational structure. The structure also indicated that the dispensers should report to the part-time pharmacist who in turn reported to the practice manager, with no direct access to the GP lead or other GPs. It was not clear who they should report to when the pharmacist was not there. We had found evidence of a lack of direct GP oversight in the dispensary particularly at Bennett Way at a time when there were two new members of staff working there.</p> <p>The build-up of scanned documents that had not been reviewed or actioned dating back to 2 September 2019. This indicated a lack of clinical oversight.</p> <p>Staff reported that governance had been difficult in recent months.</p> <p>We saw that governance processes were not working effectively. There were three different versions of the significant event log shown to CQC and we saw that a significant event had been raised in a meeting, but no discussion, outcome or action were recorded. Some more recent staff meeting minutes that we saw were brief and did not always identify who should carry out actions and by when.</p> <p>Policies were not always updated in a timely way, for instance the significant events policy was due for review in August 2019, but had not been, it was also not signed. The complaints policy was undated.</p> <p>Complaints had not been appropriately or consistently recorded. We saw that there was not always a clear audit trail to identify where records of complaints actioned were filed or actions taken to improve services.</p> <p>The provider's overarching governance framework therefore did not support the delivery of good quality care.</p> <p>These were systemic issues across both the registered locations.</p>	

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.	P
There was a systematic programme of clinical and internal audit.	N
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.	N
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>Whilst the practice carried out risk assessments they had not always implemented all the required actions for example those in relation to the fire safety and Legionella risk assessments.</p> <p>Some issues had not been identified by the risk assessments for example the practice could not produce valid gas safe certificates.</p> <p>They had not always carried out risk assessments where indicated. For example, there were no adult or child pulse oximeters (emergency equipment for measuring oxygen levels in the blood) at any of the surgeries. We were told that the GPs carried their own, but there was no risk assessment in place. Such a risk assessment may have identified that there were many times when non-medical or locum staff were working without a GP on site and who did not have access to a pulse oximeter.</p> <p>There had been three audits started but they were only single cycle. The second cycles had not been commenced at the time specified in the first cycle of the audit.</p> <p>Quality Outcome Framework) QOF results were in general significantly lower than clinical commissioning group (CCG) and England averages. Records showed that some of these figures had been poor year on year, but with no clear systematic action plan to address the issues and improve outcomes for patients.</p> <p>These were systemic issues across both the registered locations.</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.	N
Performance information was used to hold staff and management to account.	P

Our inspection indicated that information was accurate, valid, reliable and timely.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>Quality Outcome Framework data was available, but there was no plan in place to improve outcomes and no improvements had been made in response to the generally poor results from 2018 to 2019.</p> <p>We could not be certain that information available to staff was always valid, reliable and timely. For instance, we found that patient records were not always reviewed and updated in a timely manner. We found 531 documents that had been scanned in to the system dating back to 2 September 2019, but were awaiting review, action and filing in the correct records. This meant that anyone accessing the records would not necessarily have a current view of the patient's medical record and that urgent actions may not have been carried out.</p> <p>The system for monitoring high risk medicines was not working effectively and potentially put patients at risk.</p> <p>Some risk assessments such as those for Legionella and fire safety had identified actions required that were not being carried out.</p> <p>These were systemic issues across all the registered locations.</p>	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	P
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	P
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>There was an online survey available and the results for 2018 were published online. The results did include a list of patient suggestions and comments. However, we saw no evidence that the results had been reviewed, and we saw no action plan drawn up in response to the results or indication whether any ideas had been adopted.</p>	

Administrative and reception staff were involved in monthly meetings with the practice manager, however, there were no agenda items in the minutes or recording of discussions that suggested that staff had the opportunity to give feedback or suggest innovations. We did see some examples were patient feedback from complaints

The practice was not working together with other local practices as part of a Primary Care Network and had not fulfilled clinical commissioning group (CCG) action plans.

These were systemic issues across all the registered locations.

Feedback from Patient Participation Group.

Feedback

As this was an unannounced inspection, we were not able to speak to the Patient Participation Group. However, we did note that the group was advertised on the practice website and in the practice and they were actively recruiting members. We were told that a meeting was to be held on 20 November 2019. We did ask for meeting minutes to be forwarded to CQC but did not receive any. A note on the practice website seen after the inspection, showed that the next meeting would be on 5 February 2020 at 7pm at Elmdene Surgery.

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:</p> <p>The registered provider is responsible for the locations of Elmdene Surgery (with branch practices at Bean Surgery and Bennett Way Surgery) and Joydens Wood Medical Centre.</p> <p>From our own observations and from information from other stakeholders, we saw that where issues had been identified by external bodies, for example at our previous inspection, initial improvements were made to systems and processes. However, these improvements were not sustained, or embedded, and similar issues were found at this inspection.</p> <p>There were systems for recording significant events and complaints, but these were inconsistent, and it was not always clear whether learning had been identified, recorded and disseminated in all cases.</p> <p>These were systemic issues across all the registered locations.</p>	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > 1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.