

Care Quality Commission

Inspection Evidence Table

Dr Srinivasan Subash Chandran (1-501778195)

Inspection date: 10 December 2019

Date of data download: 06 December 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

The rating for safe has changed from good to inadequate because:

- There was inadequate monitoring of patients on high risk medicines and unsafe medicines management processes. For example, poor repeat prescribing and medicine review practices.
- There were poor safeguarding practices to ensure patient safety.
- Recruitment checks were inadequate.
- Health and safety procedures and processes were inadequate.
- Infection control and fire safety practices were not always implemented effectively.
- There were insufficient failsafe processes for minor surgery.
- Significant event reporting and investigation procedures were insufficient.
- There were inadequate processes for dealing with safety alerts.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	No

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not maintain a safeguarding list. We viewed the records of three patients who did not have an appropriate safeguarding alert/code which meant that staff were not alerted to safeguarding issues when accessing the record.</p> <p>Not all staff had received safeguarding training. Training records were not up to date at the time of inspection and eight of the 11 records we reviewed did not include evidence of safeguarding training.</p> <p>We were told that DBS checks were undertaken for all staff. We saw evidence of this in some staff files, however, not all records of checks were being consistently maintained and we found that there was no record of a DBS check for one nurse working in the practice.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	No
<p>Explanation of any answers and additional evidence:</p> <p>We looked at three recruitment files and found that some recruitment checks were carried out. However, these were not comprehensive or maintained consistently. For example, two staff files did not have evidence of a full employment history and none of the three files had a record of satisfactory evidence of conduct in previous employment.</p> <p>Staff vaccination records were also not consistently maintained in line with PHE guidance as they only covered hepatitis B.</p> <p>At the time of the inspection recruitment records were difficult to locate, with some records not held within staff files, although some of these were provided later in the day or following inspection.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: October 2019</p>	Yes
<p>There was a record of equipment calibration. Date of last calibration: February 2019</p>	Yes
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	No
<p>There was a fire procedure.</p>	Yes
<p>There was a record of fire extinguisher checks. Date of last check: June 2019</p>	Yes
<p>There was a log of fire drills. Date of last drill:</p>	No
<p>There was a record of fire alarm checks. Date of last check:</p>	No
<p>There was a record of fire training for staff. Date of last training: April 2019</p>	Partial
<p>There were fire marshals.</p>	No
<p>A fire risk assessment had been completed. Date of completion: May 2019</p>	Yes
<p>Actions from fire risk assessment were identified and completed.</p>	No
<p>Explanation of any answers and additional evidence:</p> <p>The provider could not demonstrate that they had risk assessments for the storage of hazardous substances.</p> <p>We were told that fire safety was managed centrally for the building. One member of staff could recall attending a fire drill but others could not. The provider could not demonstrate that they had records of fire drills, alarm and extinguisher checks.</p> <p>We reviewed training records and saw that only three of 11 staff had a record of completing fire safety training in the last year.</p> <p>A fire risk assessment had been completed. However, there were action points that had not been addressed. These included the development of a disabled evacuation strategy, allocating and training designated fire wardens, undertaking an in-house fire inspection and monthly checks of firefighting equipment.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	No
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	No
Explanation of any answers and additional evidence: The provider could not demonstrate that they had premises, security or health and safety risk assessments carried out within the practice.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	No
The practice had acted on any issues identified in infection prevention and control audits.	No
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: There was no identified lead within the practice for infection control and there was no evidence of audits or risk assessments having been carried out. There were fabric chairs in use within clinical areas but no evidence of this having been identified as a potential risk or plans to address it. The infection control policy had been due a review in 2017 which had not been completed. There was no identified lead within the practice for infection control and the provider could not demonstrate that audits or risk assessments had been carried out. The providers records for staff training could not demonstrate that all staff had received infection control training.	

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	No

Comprehensive risk assessments were carried out for patients.	No
Risk management plans for patients were developed in line with national guidance.	No
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	No
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There were limited induction plans for either permanent or temporary staff.</p> <p>The provider could not demonstrate that risk assessments were routinely carried out for patients and management plans were being developed in line with national guidance. For example, the standard algorithm for predicting cardiovascular risk (QRISK) was not in use. Ambulatory blood pressure monitoring was not offered, and patients were not referred to a neighbouring practice that did offer this service.</p> <p>There was no evidence of frailty assessment for older patients.</p> <p>We did see an area expected practice, n that the sepsis assessment had been completed in line with national guidance</p> <p>The provider could not demonstrate that GPs and locum staff had received basic life support training in the last year nor that reception staff had received training on action to take, if encountering an acutely unwell patient.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial

The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	No
<p>Explanation of any answers and additional evidence:</p> <p>Patient records were not always consistently maintained. For example, we viewed the records of one patient who had received a home visit but this was not appropriately recorded in the patient record. In addition, patient records did not consistently include safeguarding information where relevant.</p> <p>The provider could not demonstrate that they operated a failsafe log for minor surgery histology results. We reviewed a spreadsheet for minor surgery and saw there was no histology results recorded on excised lesions from 23 September 2019. This had not been followed up despite results having been received for those done after this date.</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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.92	0.94	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). (01/10/2018 to 30/09/2019) (NHSBSA)	16.3%	9.1%	8.5%	Significant Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	6.60	6.01	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	5.19	2.31	2.08	Variation (negative)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	No
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The use of broad-spectrum antibiotics (used when the type of bacteria is unknown rather than targeted to specific types of bacteria) was higher than local and national averages. There was limited appreciation of this within the practice. Historical data showed an increase in prescribing of these types of antibiotics in the last year.</p> <p>Blank prescriptions were not always stored securely. We found blank prescriptions in printers in an unlocked room used for training. We were told that the prescriptions were from one of the other practices in the building, however, there was no clear audit trail for this.</p> <p>We were told that PGDs were in use within the practice but staff were unable to locate these during inspection. Following the inspection the practice provided evidence of PGDs that had been appropriately authorised and signed by nursing staff in the days following inspection.</p> <p>Medicines used during minor surgery were recorded on a log but not in the individual patient records. There was limited evidence of structured medicines reviews. Some medicines that would normally be prescribed as a repeat were prescribed as an acute prescription, this made monitoring of repeat</p>	

Medicines management	Y/N/Partial
<p>prescribing difficult. Other repeat prescriptions were issued over the authorised number of repeats which meant they were issued without the proper authority of the GP. Patients on repeat prescriptions requiring regular medicines reviews were not always appropriately coded.</p> <p>The practice did not always maintain an appropriate audit trail or take action when medicines were changed by other services. For example, we saw evidence of one patient who had a dose of a high-risk medicine reduced by secondary care in November 2019. However this had not been actioned on their repeat prescriptions.</p> <p>Medicines optimisation advice from the CCG pharmacist was not always been acted on in a timely way. This included advice to review prescribing practice that presented potential risks to patients.</p> <p>Patients on high risk medicines were not consistently monitored appropriately. We reviewed the records of 13 patients on a high risk 'anti-rheumatic' medicine and found that 11 of the 13 patients had not received appropriate monitoring. In addition, we saw evidence of other high-risk medicines where monitoring advice had been given by secondary care that had not been acted on.</p> <p>We reviewed the monitoring of patients on thyroxine (to treat thyroid hormone deficiency) and found that 30% of patients had not received appropriate monitoring or review in the last year.</p> <p>Emergency medicines stored within the practice did not include treatment for seizures, heart failure, croup in children or suspected bacterial meningitis and there was no risk assessment to support the decision making in relation to this.</p> <p>Vaccines were stored in a medicines fridge and regularly monitoring of temperatures had been recorded. However, there had been a consistent period at the beginning of December 2019 where the temperature was recorded as outside of the required range and had not been acted on.</p>	

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.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a significant event policy, however, not all incidents were recorded or reported. For example, a complaint from a patient that included information about an incident during an appointment, had not been recorded as a significant event and had not been fully investigated. A further incident where a patient had been threatening to a member of staff had not been recorded as a significant event as it occurred outside of the practice. Not all incidents had been appropriately acted on and there was limited evidence of learning used to make improvements.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	No
<p>Explanation of any answers and additional evidence:</p> <p>We found that alerts were received at the practice but there was no clear audit trail to show that these were being actioned appropriately. A September 2018 alert relating to a medicine with the potential to cause birth defects had not been appropriately acted upon. A review of patients who were prescribed these medicines had not been carried out since 2017. We reviewed the records of five women of potential childbearing age on this treatment and found that there was no record of action in line with the recommendations from the alert in three out of the five.</p>	

Effective

Rating: Inadequate

The rating for effective changed from good to inadequate because:

- There was a lack of evidence-based practice.
- There were insufficient patient assessments and a lack of clinical review.
- The provider could not demonstrate evidence of appropriate staff training updates.
- There were poor patient outcomes in some areas and high exception reporting.
- Poor childhood vaccination performance, and below target cervical screening;
- There were limited quality improvement activities.
- Not all clinical staff demonstrated an understanding of the requirements of legislation and guidance when considering consent and decision making .

These areas impacted all population groups and so we have rated all population groups as inadequate'

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	No
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence:	
There were limited systems and processes to keep clinicians up to date with current evidence-based practice. There was no process for reviewing or discussing relevant guidance with clinical staff and there was evidence that not all relevant guidance was followed. For example, in relation to the assessment of cardiovascular risk, ambulatory blood pressure monitoring and frailty assessments.	
Patients did not consistently have their needs fully assessed. We reviewed the care records of a patient where pharmacy advice had been given to the GP regarding a review of the patient. A home visit was	

undertaken but there were limited records and no evidence of an assessment of the patient's chronic obstructive pulmonary disease and poor monitoring of their diabetes. We could not be assured that clear and contemporaneous notes for each patient were being maintained.

Patients presenting with symptoms which could indicate serious illness were not always followed up in a timely way. We reviewed the records of a patient where pharmacy advice had been given to the GP about possible side effects of medicines they were prescribed. Action was not taken to address this for two weeks when the patient was admitted to hospital unwell.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	3.32	0.63	0.74	Significant Variation (negative)

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice did not use a clinical tool to identify older patients who were living with moderate or severe frailty. It was not clear that patients living with frailty were identified or that they received a full assessment of their physical, mental and social needs. We were told that the practice followed up on older patients discharged from hospital. However, care plans were not routinely used within the practice, so it was unclear how the practice responded to extra or changed needs. The practice did not evidence that they carried out structured annual medication reviews for older patients. <p>However, there were areas of good practice:</p> <ul style="list-style-type: none"> Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks were offered to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> Patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. Staff who were responsible for reviews of patients with long-term conditions had received specific training. However, they were not using up to date guidance in specific clinical areas such as assessing cardiovascular risk and using ambulatory blood pressure monitoring. The practice were unable to evidence up to date training for all nurses working in the practice.

- QOF performance for patients with diabetes showed positive variation. However, exception reporting was high which meant that in some areas the proportion of patients receiving the intervention was below average. For example, in relation to cholesterol monitoring and control, and overall diabetes control.

However, there were areas of good practice:

- QOF performance for patients with respiratory conditions showed positive variation.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD) and atrial fibrillation..
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were not offered ambulatory blood pressure monitoring.
- 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)	97.7%	78.8%	79.3%	Significant Variation (positive)
Exception rate (number of exceptions).	46.1% (113)	13.9%	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)	96.4%	77.5%	78.1%	Significant Variation (positive)
Exception rate (number of exceptions).	32.7% (80)	12.0%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) ^(QOF)	88.6%	79.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	49.8% (122)	14.6%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on	96.9%	77.2%	75.9%	Significant Variation

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>				(positive)
Exception rate (number of exceptions).	3.9% (12)	9.2%	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>	99.0%	89.5%	89.6%	Variation (positive)
Exception rate (number of exceptions).	5.9% (6)	9.8%	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) <small>(QOF)</small>	80.4%	83.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.3% (25)	4.5%	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) <small>(QOF)</small>	82.4%	89.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	8.1% (3)	4.2%	5.9%	N/A

Any additional evidence or comments

Hypnotic prescribing was significantly higher than local and national averages. There was little appreciation of this within the practice and no evidence of action to address high prescribing rates. Historical data shows that there had been significant negative variation since 2015 with no evidence of improvement or plans to improve.

There were high QOF exception rates (for example, where patients don't attend for review appointments) in relation to diabetes care. Recall processes for patients who did not attend for review were limited. When taking account of the high exception rates, performance in relation to the actual proportion of patients receiving the intervention meant that performance in some areas fell below average.

Families, children and young people

Population group rating: Inadequate

Findings

- The practice has not met the minimum 90% target for any of the four childhood immunisation uptake indicators. This included three of the four that were significantly below the minimum.
- The practice did not routinely contact the parents or guardians of children due to have childhood

immunisations and there were limited nursing appointments available which may have impacted uptake.

However, there were areas of good practice:

- The practice had arrangements for following up failed attendance of children’s appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	50	61	82.0%	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)	49	77	63.6%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	46	77	59.7%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	46	77	59.7%	Below 80% uptake

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

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- Cervical cancer screening rates were significantly below target and, below 70% uptake. However, there were areas of good practice;
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example

before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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)	60.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	68.3%	72.5%	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)	46.3%	53.9%	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)	66.7%	78.2%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	9.1%	43.7%	51.9%	Tending towards variation (negative)

Any additional evidence or comments

Cervical screening was significantly below the target. There were limited nursing appointments available at the practice. Overall cancer screening was below the CCG average.

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 this patient population group, so we have rated them it as Inadequate.

-
- Same day appointments and longer appointments were offered when required.

- Patients with a learning disability were not offered a routine annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. However, end of life care plans were not routinely in use by the practice.
- The practice demonstrated that they had a system to identify 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 this patient population group, so we have rated them it as Inadequate.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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>	100.0%	88.6%	89.4%	Variation (positive)
Exception rate (number of exceptions).	5.7% (2)	10.6%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	88.5%	90.2%	Variation (positive)

Exception rate (number of exceptions).	2.9% (1)	9.3%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) ^(QOF)	89.5%	85.4%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.7%	6.7%	N/A

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)	552	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.7%	No Data	96.4%
Overall QOF exception reporting (all domains)	12.3%	5.7%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No
Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	No

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

There were limited quality improvement activities. We saw evidence of some single cycle audits such as breast screening and ADHD treatment. However, it was not clear how these demonstrated improvement in patient outcomes. Clinical audits were not always targeted towards areas where there were concerns. For example, we were shown an audit of nutritional supplements used in end of life care that had been undertaken by an external company.

We were told during the inspection that audits were in the process of being carried out by the medicines management team, relating to the care of patients with asthma and chronic obstructive pulmonary disease (COPD).

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.	Partial
The learning and development needs of staff were assessed.	No
The practice had a programme of learning and development.	No
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	No
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
Explanation of any answers and additional evidence:	
The provider could not demonstrate completed induction plans for new staff. The practice had identified training that was considered mandatory or essential. However, not all staff had completed this. For example, we saw gaps in training for safeguarding, fire safety, infection control. Additionally, information governance training for nine out of the 11 staff training records we reviewed.	
Role specific training for clinical staff was not appropriately monitored by the practice. For example, a member of clinical staff was regularly undertaking ear irrigation, but the practice had no record of appropriate training for the individual staff member. Training records held for nurses working as locums were limited and did not include all areas of clinical activity they were engaged in. In addition, the practice did not hold training records for GPs, including locum GPs working regularly within the practice.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Explanation of any answers and additional evidence:	
Staff worked together to coordinate and deliver care for patients. However, staff shortages, particularly	

in relation to nursing hours negatively impacted time spent reviewing and coordinating patient care in a formal way. Multidisciplinary meetings were held with staff from another practice operating in the same building, this included discussion of patients on the palliative care register.

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: Health care assistants carried out new and NHS patient health checks.	

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>	89.7%	94.7%	95.0%	Variation (negative)
Exception rate (number of exceptions).	0.6% (6)	0.6%	0.8%	N/A

Any additional evidence or comments

There was negative variation in terms of the recording of patients' smoking status within the practice. In addition, there was higher than average smoking prevalence and the practice were below average in relation to the support offered for patients who smoked.

Consent to care and treatment

The practice was unable to demonstrate that it 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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
The practice monitored the process for seeking consent appropriately.	Partial
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: Not all clinical staff demonstrated an understanding of the requirements of legislation and guidance when considering consent and decision making. Some clinical staff had attended training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) but not all staff. However, there were areas of good practice: Written consent was obtained for invasive procedures such as minor surgery.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

CQC comments cards	
Total comments cards received.	19
Number of CQC comments received which were positive about the service.	15
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	2

Source	Feedback
Positive comments	Patients providing positive feedback via the comment cards reported that staff were friendly and helpful, caring and understanding and that they felt listened to.
Mixed comments	Mixed comments showed some issues with accessing appointments in a timely way and one commented that staff did not always demonstrate sufficient patience.
Negative comments	Negative comments included that there were constant difficulties with accessing appointments and that staff came across as being obstructive.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4,736	349	119	34.1%	2.51%

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)	83.6%	85.3%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	83.4%	85.3%	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)	91.4%	94.7%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	77.6%	74.8%	82.9%	No statistical variation

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

Any additional evidence
The practice monitored patient satisfaction using the Friends and Family Test (FFT) survey. They had a box near reception where patients could add a token which indicated if they were or were not satisfied with the service. However, it was not clear how this information was used to make improvements and results were not discussed or reviewed with the patient participation group.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Source	Feedback
Interviews with patients.	We spoke with three patients. Patients had mixed views on the attitude of staff. One patient reported that staff could be abrupt. Another told us they thought that staff would benefit from some customer care training.

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)	87.3%	91.1%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had worked to increase the identification of carers in the last year, from 36 to 45 in total which was approximately 1% of the practice population.
How the practice supported carers (including young carers).	Support was available from local groups. Leaflets were available in the waiting area and staff supported patients to access services as required.
How the practice supported recently bereaved patients.	The practice had an in-house counsellor and patients could access them as needed.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice advised patients on how to protect their online information.	Yes

Responsive

Rating: Requires Improvement

The practice has changed from good to requires improvement because:

- Complaints were not always used managed effectively and to improve the quality of care.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The practice provided an individual service for patients and provided flexibility and continuity of service in relation to GP appointments. The practice had an understanding of the needs of the local population, however, services were not consistently responsive to those needs. For example, in relation to childhood immunisations, the management of long term conditions, cervical and cancer screening.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am – 6pm
Tuesday	8.30am – 7.45pm
Wednesday	8.30am – 6pm
Thursday	8.30am – 6pm
Friday	8.30am – 6pm
Appointments available:	
Monday	8.30am – 6pm
Tuesday	8.30am – 7.45pm
Wednesday	8.30am – 6pm
Thursday	8.30am – 6pm
Friday	8.30am – 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4,736	349	119	34.1%	2.51%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	90.4%	93.5%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> There were limited nursing appointments available for patients with long term conditions requiring a review. Patients with multiple conditions had their needs reviewed in one appointment. The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this. All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7.45pm on a Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	73.3%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	63.9%	55.1%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	60.1%	54.8%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	79.3%	66.2%	73.6%	No statistical variation

Source	Feedback
NHS Choices	Two reviews dating back to 2018. One positive about the helpfulness of staff, the other negative about poor administration. The practice had not replied to the feedback.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
Explanation of any answers and additional evidence: Complaints were reviewed and we viewed correspondence from the practice and action taken to address the complaints. However, not all aspects of the complaints were addressed satisfactorily. For example, we reviewed a complaint about a GP at the practice. Despite the complaint including that the patient felt they were roughly treated and that they had fallen whilst at the practice, there was no investigation of the incident, no recording as part of the significant event process and limited action taken. The nature of the complaint was described by staff as the patient not getting on with one of the GPs and there was a failure to recognise the potential seriousness of the incident. A second complaint was recorded relating to a large blood pressure cuff not being available. The complaint was not acknowledged in line with the practice policy. It took three weeks for the complaint to be acknowledged by the practice and a month for the complaint to be resolved.	

Well-led

Rating: Inadequate

The rating for well-led changed from good to inadequate because:

- The practice did not have a clear vision, supported by a credible strategy to provide high quality sustainable care.
- The practice culture did not effectively 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.
- There was no systems or 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.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
Explanation of any answers and additional evidence: There was no leadership succession planning, in particular around GP retirement planning which was identified as an issue at the time of the inspection. Leaders did not demonstrate an understanding of the challenges to quality and sustainability as there were a number of areas of poor quality within the practice that had not been addressed. Leaders were visible and approachable, however, there was not a clear plan to address issues of quality and sustainability.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial

Progress against delivery of the strategy was monitored.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a clear vision to provide local, family centred GP services to the community. However, the provider was unable to demonstrate that there was a current strategy; underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery.</p> <p>Staff were clear about their roles and had a focus on patient centred care.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	No
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with demonstrated a commitment to the care of patients within the practice. However, the staffing structure, systems and processes did not effectively support high quality sustainable care.</p> <p>Staff told us they felt able to raise concerns and were aware of how to do this. We saw evidence that the practice communicated with and involved patients when things went wrong. Staff had not undertaken equality and diversity training.</p>	

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

Source	Feedback
Administrative staff	Reported feeling supported by the GP and practice manager and spoke of an open, supportive team culture.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
<p>Explanation of any answers and additional evidence: We found that there was a significant lack of oversight at the practice.</p> <p>We could not be assured that clear and contemporaneous notes for each patient were being maintained. For example, high-risk medicine monitoring, patient consultations and recording of reviews.</p> <p>We could not be assured that issues and concerns were acted on appropriately and in a way that was timely. For example, in relation to identified concerns about care and treatment, responses to actions required in risk assessments by third parties, complaints and significant events.</p> <p>The providers overarching governance framework therefore did not support the delivery of good quality care.</p>	

Examples of structures, processes and systems.	
Practice specific policies	Staff were able to access practice specific policies and procedures on the practice intranet system and via a paper system. Policies were not consistently reviewed and aligned with practice. For example, a significant event policy was formed from a generic template and had not been personalised to the practice and did not reflect what was happening within the practice.
Clinical Audits	Clinical audits were limited, were not targeted at areas where quality improvement was required and were not part of an overarching audit plan.
Medicines Management	Governance arrangements in relation to medicines management did not include clear action to ensure quality improvement and the safety of patients.
Risk Management	There were insufficient systems and processes to identify and mitigate risks.
Minor surgery	Medicines administered during minor surgery were not sufficiently recorded in patient records. There were insufficient histology failsafe processes.
Clinical records	There were insufficient processes for ensuring clinical records were up to date.
Recruitment	The practice had limited systems in place to ensure that appropriate recruitment checks were carried out prior to employment of new staff. There were gaps in some staff files in relation to evidence of satisfactory conduct in a previous role and employment history. Some recruitment records were difficult to locate on the day of inspection, although some examples were sent to us following inspection. There were limited records kept of staff in locum roles.

Significant Events	There was limited reporting of significant events. Three events had been recorded in the last year, two of which had been reported by external agencies. There was evidence of incidents not being reported as such and limited investigation, learning and quality improvement as a result.
Complaints	Two complaints had been recorded in the last year. There was evidence of action to address the complaints, however, not all aspects of the complaints were sufficiently reviewed with action taken to ensure improvements.
QOF	The practice monitored performance against the Quality Outcomes Framework (QOF) to improve outcomes for patients. However, there was no clear action plan to improve areas where performance was poor.
Staff meetings	Meetings were held within the practice, however not all meetings were minuted with sufficient detail of discussions and action plans. We viewed minutes from clinical meetings that were largely incomplete with limited detail of discussions.
Staff training	There were gaps in staff training and while staff and managers were aware of this, there was limited assurance to address the gaps.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No
<p>Explanation of any answers and additional evidence:</p> <p>We found that risks and issues were not always dealt with appropriately or quickly enough. The risk management approach was not applied consistently and was not linked effectively into planning processes because;</p> <ul style="list-style-type: none"> • Assurance systems within the practice were not regularly reviewed and improved. • There was no comprehensive assurance that processes for managing risks, issues and performance were of a sufficient standard. • Clinical audits were not sufficiently targeted on areas of quality improvement need. • Risk management activities were not comprehensive, including a lack of general health and safety risk assessment processes. Some areas of risk had not been sufficiently acted on to ensure sufficient mitigation. For example, in relation to the monitoring of patients on high risk medicines, repeat prescribing, significant events and fire safety. 	

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.	No
Performance information was used to hold staff and management to account.	No
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence: The information used in reporting and delivering quality care was not always accurate, timely or relevant and we could not be assured that clear and contemporaneous notes for each patient were being maintained. For example, high-risk medicine monitoring, patient consultations, recording of reviews and histology results.</p>	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care, however, feedback processes were not always used to make improvements.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
<p>Explanation of any answers and additional evidence: There was an active patient participation group, however, it was not clear how patient views were acted on to improve services. For example, patient feedback processes were not always reviewed with a view to improving experiences.</p>	

Feedback from Patient Participation Group.

Feedback

Meetings between the practice and the PPG were held regularly. However, processes for seeking and acting on patient views were limited.

Continuous improvement and innovation

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

	Y/N/Partial
--	-------------

There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence:	
<p>We saw that improvements were not always identified, or action taken to ensure continuous improvement. From risk assessments viewed and information from other stakeholders, we found that the practice did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they were either identified or started to be addressed.</p> <p>There were gaps in how the systems and processes for learning and continuous improvement worked. For example, opportunities for learning and improvement were not always recognised. For example, in relation to unreported incidents and complaints from patients that had not been appropriately investigated.</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.