

Care Quality Commission

Inspection Evidence Table

Orchard Surgery - St Ives (1-560546305)

Inspection date: 4 February 2020

Date of data download: 22 January 2020

Overall rating: Requires Improvement

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

Safe

Rating: Inadequate

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

- We found not all staff had received the appropriate level of safeguarding training to their role or completed basic life support training.
- The practice did not evidence that recruitment checks such as; the verification of identify documents, Disclosure and Barring Service (DBS) checks and references were always obtained prior to employment. In addition to this, the practice was unable to evidence that dispensary staff were appropriately trained.
- The practice did not provide evidence of any risk assessments being in place for oxygen and other flammable gasses or control of substances hazardous to health (COSHH).
- We found the practice did not have oversight of the progress of actions arising from a fire risk assessment and infection prevention and control audit. Following the inspection, the practice provided a copy of their fire risk assessment action plan for all three sites, which evidenced oversight of the required actions.
- We found the monitoring of patients in waiting areas was not effective. The practice did not provide any evidence that the risks to patients had been assessed or mitigated.
- We found the monitoring of prescription stationery was not always effective.
- The system and process to ensure all appropriate emergency medicines were available needed to be improved as we found a missing item (Dexamethasone) at two of the sites (Orchard & Fenstanton). This was previously raised as a concern at our March 2019 inspection.

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 ¹
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
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.	Y
Partners and staff were trained to appropriate levels for their role.	N ¹
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N ²
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found not all clinical staff had received the appropriate level of safeguarding training for their role. For example:</p> <ul style="list-style-type: none"> • One GP, and the safeguarding lead in the practice, had not undertaken Adult Level 3 Safeguarding training since 23 February 2016. • One GP had not undertaken Child Level 3 Safeguarding training since 23 February 2016. • One GP had not undertaken Adult Level 3 Safeguarding training since 2 March 2016. <p>The practice told us these clinicians were due to complete the safeguarding training on the day of the inspection. At the time our inspection concluded, the clinicians had not completed the training.</p> <p>2 – We reviewed five staff personnel files and found that four of the five files did not contain evidence that a DBS check had been completed. We asked the practice about this and the practice told us they were unable to find DBS records for any of the nursing or health care assistant team.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We reviewed five staff personnel files and found records did not contain adequate information:</p> <ul style="list-style-type: none"> • We found a lack of evidence that identity documentation had been verified for two out of five members of staff reviewed. • We found no references on file for three out of five members of staff reviewed. <p>The practice told us they were in the process of updating their recruitment processes following the resignation of the previous practice manager.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: Orchard site: 14 October 2019 Fenstanton site: 1 March 2019 Parkhall site: 1 October 2019</p>	Y
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: Orchard site: 14 October 2019 Fenstanton site: 24 July 2019 Parkhall site: 1 October 2019</p>	Y
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	N ¹
<p>There was a fire procedure.</p>	Y
<p>There was a record of fire extinguisher checks.</p> <p>Date of last check: August 2019</p>	Y
<p>There was a log of fire drills.</p> <p>Date of last drill: Orchard site: 31 January 2020 Fenstanton site: No date recorded Parkhall site: 13 December 2019</p>	P ³
<p>There was a record of fire alarm checks.</p> <p>Date of last check:</p>	Y
<p>There was a record of fire training for staff.</p> <p>Date of last training: Ongoing training as per individual staff requirements.</p>	Y
<p>There were fire marshals.</p>	Y
<p>A fire risk assessment had been completed.</p> <p>Date of completion: 23 January 2020 – all sites</p>	Y ²
<p>Actions from fire risk assessment were identified and completed.</p>	Y ²
<p>Explanation of any answers and additional evidence:</p> <p>1 – We asked to review the practice’s risk assessments. The practice did not provide evidence of any risk assessments being in place for oxygen and other flammable gasses held at the practice. In addition to this, the practice did not provide evidence of any risk assessments being in place for control of substances hazardous to health (COSHH).</p> <p>2 – We reviewed the practice’s fire risk assessment for all three sites dated 23 January 2020. We found that actions were requiring completion, such as; obtaining a gas safety certificate, additional emergency lighting, upgrading fire alarm systems and the relocation of combustible materials stored in outside bins.</p>	

However, at the time of the inspection these actions were outstanding. In addition to this, the practice was unable to evidence oversight of the actions or inform us of the progress of these actions. Following the inspection, the practice provided a copy of their fire risk assessment action plan for all three sites, which evidenced oversight of the required actions.

3 – We found that fire drills has been completed at Orchard and Parkhall sites in the months leading to the inspection. However, the practice did not provide evidence that fire drills had been completed regularly before the most recent one undertaken.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Various dates between October 2019 and January 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates between October 2019 and January 2020	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	P ¹
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: 1 – We reviewed the practice's infection prevention and control audit for all three sites, dated January 2020. We found the audit had identified a number of areas which required attention but there was no accompanying action plan to the audit. In addition, some areas were unclear whether an action was required, or had already been completed.	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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.	N ¹
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.	P ¹
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
<p>Explanation of any answers and additional evidence:</p> <p>1 – On the day of the inspection the practice did not provide evidence that all staff had completed basic life support training. Following the inspection, evidence was provided that a majority of staff had completed the training. However, six non-clinical members of staff had not completed, or were overdue, basic life support training.</p> <p>In addition to this, the system and process to ensure all appropriate emergency medicines were available needed to be improved as we found a missing item (Dexamethasone) at two of the sites (Orchard & Fenstanton). The practice did not have their own list of medicines and practice staff did not know the location of where some of the items were kept. This was previously raised as a concern at our March 2019 inspection. We found the Parkhall site did have Prednisalone, an alternative to Dexamethasone for treating croup in children.</p> <p>We found the monitoring of patients in waiting areas was not effective. We found that waiting areas at Parkhall and Orchard sites were a considerable distance from the reception area and the practice staff did not routinely monitor patients in the waiting area. There was no system in place to ensure monitoring of these areas in the event of an emergency. The practice did not provide any evidence that the risks to patients had been risk assessed or mitigated.</p>	

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	P ¹
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice’s approach to care planning was inconsistent. We found and the practice told us that nurses completed care plans on templates within patient records, but GPs completed care plans verbally and input data directly into each consultation record and did not document formal care plans. Therefore, patients did not always have documented care plans which were easily accessible by the patients and other services, such as out of hours services or care homes.</p>	

Appropriate and safe use of medicines

The practice did not always 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)	0.95	0.92	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)	10.5%	10.3%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	5.65	5.75	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)	2.41	2.11	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	P ¹
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	P ²
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	N ³
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found the monitoring of prescription stationery was not always effective. At the Parkhall site, prescription paper was not logged after arriving at the practice. However, it was logged into the individual rooms. This meant that in the event of prescription paper potentially being stolen or misplaced during transit to or following arrival at the practice, this would not be recorded and the practice would not be able to easily identify missing prescription stationery.</p> <p>2 – At the time of the inspection the practice had recently implemented a process for supervising and reviewing the competence of non-medical prescribers. This process was informal at the time of the inspection and therefore there was no documented evidence. However, the practice told us this would be formalised following the inspection.</p> <p>3 – The system and process to ensure all appropriate emergency medicines were available, needed to be improved as we found a missing item (Dexamethasone) at two of the sites (Orchard & Fenstanton). The practice did not have their own list of medicines and practice staff did not know the location of where some of the items were kept. This was previously raised as a concern at our March 2019 inspection. We found the Parkhall site did have Prednisalone, an alternative to Dexamethasone for treating croup in children.</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.	Y
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.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N ¹
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.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
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.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
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.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>1 – We reviewed staff personnel files for the dispensary team and could not find evidence of any training or qualification records. We asked the practice about this who told us they were unable to find NVQ qualification records for any of the dispensary team.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	11
Number of events that required action:	11

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A patient fell at one of the sites.	The practice partners discussed the incident during a partners meeting, a risk assessment was completed and as a result a trip hazard sign was put up. Receptionists were informed to ensure the lights were always illuminated.
A patient's medication was not updated as per a hospital discharge letter.	The practice clinical team discussed the incident during a clinical meeting, the patient's medical notes were correctly updated and the patient was contacted by a GP to discuss the incident further.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y ¹
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: 1 – We found the practice's system for recording and acting on safety alerts was comprehensive and well managed. We reviewed three recent safety alerts and found the practice had taken the appropriate action in all three cases.	

Effective

Rating: Requires Improvement

At this inspection, the practice was rated as requires improvement for providing effective services because:

- We found the practice did not have complete oversight of training records of staff. We saw some staff were overdue training that the practice had deemed mandatory and the practice did not have oversight of the qualifications of staff. This was raised as a concern during our March 2019 inspection and a requirement notice was issued identifying that improvements were required to the training.
- We reviewed five staff personnel files and found that four of the five files did not contain evidence that members of staff had completed an induction program. The practice did not demonstrate completion of the Care Certificate for Health Care Assistants employed since April 2015.
- The practice's approach to care planning was inconsistent. Therefore, patients did not always have documented care plans which were easily accessible by the patients and other services, such as out of hours services or care homes.
- We found the number of patients receiving a learning disability health check and 40-74 health check were considerably lower than the number of patients eligible and health checks offered.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance 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.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

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>	0.46	0.80	0.74	No statistical variation

Older people

Population group rating: Requires Improvement

Findings
<p>The issues identified in effective affected this population group, however, there were some areas of good practice:</p> <ul style="list-style-type: none"> • 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. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • The practice carried out structured annual medication reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

The issues identified in effective affected this population group, however, there were some areas of good practice:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	67.3%	79.3%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	6.6% (36)	14.5%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	69.8%	72.4%	78.1%	No statistical variation
Exception rate (number of exceptions).	8.9% (49)	11.5%	9.4%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.0%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	8.7% (48)	13.2%	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>	81.3%	75.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	5.6% (48)	8.4%	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>	87.3%	88.3%	89.6%	No statistical variation
Exception rate (number of exceptions).	8.0% (15)	12.9%	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>	79.3%	82.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.6% (45)	4.7%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.9%	92.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.4% (8)	6.7%	5.9%	N/A

Findings

The issues identified in effective affected this population group, however, there were some areas of good practice:

- The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the four childhood immunisation uptake indicators with a range of 95.9% to 97.6%.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	70	73	95.9%	Met 95% WHO based target
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)	81	84	96.4%	Met 95% WHO based target
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)	81	84	96.4%	Met 95% WHO based target
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)	82	84	97.6%	Met 95% WHO based target

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: Requires Improvement

Findings

The issues identified in effective affected this population group, however, there were some 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. In the previous 12 months, 1,120 patients were offered a health check and 23% of those were completed.
- 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). (31/03/2019 to 30/06/2019) (Public Health England)	79.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	74.8%	71.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	61.7%	58.0%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	51.9%	60.0%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	55.3%	58.9%	53.8%	No statistical variation

Any additional evidence or comments

- The practice was aware their cervical screening uptake was slightly below the 80% PHE target rate at 79.5%. The practice had a recall system in place and regularly contact patients to encourage attendance at screening appointments.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

The issues identified in effective affected this population group, however, there were some areas of good practice:

- Same day appointments and longer appointments were offered when required.
- Patients with a learning disability were offered an annual health check. In the previous 12 months, 37 health checks were offered to 53 eligible patients, 29 (55%) were completed.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

The issues identified in effective affected this population group, however, there were some areas of good practice:

- 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>	90.5%	87.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	17.6% (9)	14.5%	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>	92.9%	86.8%	90.2%	No statistical variation
Exception rate (number of exceptions).	17.6% (9)	12.2%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.5%	83.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	9.5% (6)	7.9%	6.7%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	531.9	542.8	539.2
Overall QOF score (as a percentage of maximum)	95.2%	97.1%	96.7%
Overall QOF exception reporting (all domains)	3.6%	6.7%	5.9%

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

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

- Following a significant event where a prescription for a controlled drug was lost, the practice introduced a tracking form for controlled drug prescriptions across all three sites. The form was attached to controlled drug prescription forms and recorded the patient information, medicine and collect details.
- An audit was completed to ensure all prescriptions issued for controlled drugs contained a tracker form attached to it which had been completed in its entirety.
- On the first cycle of the audit, the results showed:
 - Number of CD tracker forms completed – 69
 - Number of CD tracker forms completed in full – 34 (49%)
 - Number of CD tracker forms with omissions – 35 (51%)
- The results were reported to the dispensary lead GP and dispensary team. A discussion amongst the team took place and a management plan was agreed. The form was redesigned based upon staff engagement.
- On the second cycle of the audit, the results showed:
 - Number of CD tracker forms completed – 66
 - Number of CD tracker forms completed in full – 46 (70%)
 - Number of CD tracker forms with omissions – 20 (30%)
- The second cycle evidenced a 21% improvement in the CD tracker forms being completed correctly, following the changes made. The practice noted the audit would be completed again and re-audited on a three monthly basis until 100% compliance was achieved.

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 ¹
The learning and development needs of staff were assessed.	P ¹
The practice had a programme of learning and development.	P ¹
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	P ²
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N ²
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 ³
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 ³
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>1 – On the day of the inspection we asked to review the training records of staff. The practice was unable to provide complete training records for all staff. In addition to this, we found:</p> <ul style="list-style-type: none"> • One GP, and the safeguarding lead in the practice, had not undertaken Adult Level 3 Safeguarding training since 23 February 2016. • One GP had not undertaken Child Level 3 Safeguarding training since 23 February 2016. • One GP had not undertaken Adult Level 3 Safeguarding training since 2 March 2016. • On the day of the inspection the practice did not provide evidence that all staff had completed basic life support training. Following the inspection, evidence was provided that a majority of staff had completed the training. However, six non-clinical members of staff had not completed, or were overdue, basic life support training. • We reviewed staff personnel files for the dispensary team and could not find evidence of any training or qualification records. We asked the practice about this who told us they were unable to find NVQ qualification records for any of the dispensary team. <p>Staff training was raised as a concern during our March 2019 inspection and a requirement notice was issued identifying that improvements were required to the training.</p>	

2 – We reviewed five staff personnel files and found that four of the five files did not contain evidence that members of staff had completed an induction program. The practice told us they had recently changed their induction process and the one member of staff with an induction record in their file was the most recently employed member of staff. The practice did not demonstrate completion of the Care Certificate for Health Care Assistants employed since April 2015.

3 – At the time of the inspection the practice had recently implemented a process for supervising and reviewing the competence of staff employed in advanced clinical practice. This process was informal at the time of the inspection and therefore there was no documented evidence. However, the practice told us this would be formalised following the inspection.

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)	Y
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 ¹
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	P ¹
Patients received consistent, coordinated, person-centred care when they moved between services.	P ¹
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice's approach to care planning was inconsistent. We found and the practice told us that nurses completed care plans on templates within patient records, but GPs completed care plans verbally and input data directly into each consultation record and did not document formal care plans. Therefore, patients did not always have documented care plans which were easily accessible by the patients and other services, such as out of hours services or care homes.</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.	Y
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.	P ¹
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: 1 – The practice told us that patients were offered appropriate health assessments and checks. Following the inspection, the practice provided information on the number of health checks offered and completed. We found the number of patients receiving a learning disability health check and 40-74 health check were considerably lower than the number of patients eligible and health checks offered.	

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>	93.1%	95.0%	95.0%	No statistical variation
Exception rate (number of exceptions).	1.0% (28)	1.0%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Caring

Rating: Requires Improvement

At this inspection, the practice was rated as requires improvement for providing caring services because:

- The practice had identified 40 carers, 0.7% of the practice population. The practice told us no specific services were available to carers, other than signposting to relevant support groups and services. The carers register was not fully up to date and accurate at the time of our inspection.
- We found one treatment room at the Parkhall site did not aid patient confidentiality and the practice did not provide any evidence that the risks to patient confidentiality had been assessed or mitigated.

Kindness, respect and compassion

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

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

CQC comments cards

Total comments cards received.	One
Number of CQC comments received which were positive about the service.	One
Number of comments cards received which were mixed about the service.	Zero
Number of CQC comments received which were negative about the service.	Zero

Source	Feedback
Patient consultations	Patients we spoke with on the day of the inspection were wholly positive about the caring nature displayed by staff.
CQC comment cards	The one CQC comment card was positive about the caring nature displayed by staff.
NHS Choices	One review had been posted on NHS Choices in the previous 12 months, a five star rating in relation to positive experiences received at the Parkhall site.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12342.0	289.0	126.0	43.6%	1.02%

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)	95.4%	89.9%	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)	94.2%	87.9%	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)	96.3%	95.7%	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)	81.4%	84.2%	82.9%	No statistical variation

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

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

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)	90.3%	93.8%	93.4%	No statistical variation
				Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.				Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.				Y
Information leaflets were available in other languages and in easy read format.				Y
Information about support groups was available on the practice website.				Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 40 carers, 0.7% of the practice population. The practice told us the carers register was not fully up to date and accurate at the time of our inspection
How the practice supported carers (including young carers).	The practice told us no specific services were available to carers, other than signposting to relevant support groups and services.
How the practice supported recently bereaved patients.	The practice told us GPs contacted recently bereaved patients to ensure they received the support and help they needed.

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 ¹
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We found one treatment room at the Parkhall site did not aid patient confidentiality. The entire consultation of one patient could be overhead in the reception area by members of the inspection team. The practice did not provide any evidence that the risks to patient confidentiality had been assessed or mitigated.</p>	

Responsive

Rating: Good

Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times: all sites	
Monday	8am to 6pm (Parkhall site 8am – 8pm)
Tuesday	8am to 6pm
Wednesday	8am to 6pm
Thursday	8am to 6pm
Friday	8am to 6pm
Appointments available: all sites	
Monday	8am to 6pm
Tuesday	8am to 6pm
Wednesday	8am to 6pm
Thursday	8am to 6pm
Friday	8am to 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12342.0	289.0	126.0	43.6%	1.02%

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)	95.3%	93.9%	94.5%	No statistical variation

Older people

Population group rating: **Good**

Findings

- 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: **Good**

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- 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

- 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 8pm on a Monday at Parkhall. Pre-bookable appointments were also available in the evening and weekends to all patients at additional locations within the area, as the practice was a member of a GP federation.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice.
- 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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

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)	72.9%	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)	71.1%	72.5%	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)	64.8%	66.8%	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)	72.2%	78.2%	73.6%	No statistical variation

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	27
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Examples of learning from complaints.

Complaint	Specific action taken
Patient complained about a delay in processing a prescription request.	An investigation was completed and the patient received an explanation and apology. The complaint was discussed at a partners meeting and a prescription clerk was recruited.
A patient complained due to a delay in receiving a referral.	An investigation was completed and the patient received an explanation and apology. No changes were made to the process as it was identified to be due to human error.

Well-led

Rating: Requires Improvement

At this inspection, the practice was rated as requires improvement for providing well-led services because:

- We found a lack of leadership capacity to successfully manage challenges and implement and sustain improvements.
- The practice could not evidence that risks, issues and performance were effectively managed to ensure that services were safe.

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.	P ¹
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: 1 – The practice leadership team were aware of a lack of leadership and management capacity due to the resignation and sickness absence of some leaders. At the time of the inspection, one partner was on long-term sickness absence and the practice had been operating with a part-time locum practice manager for five months. The practice partnership team had reduced in size over the previous 12 months and other members of the management team, such as assistant practice managers had also left the practice. This reduced leadership team meant that leaders did not always have the capacity to ensure all challenges to quality and sustainability were addressed. The practice leadership team were aware of these capacity difficulties and had recruited a new practice manager at the time of the inspection, due to start in post in April 2020.	

Vision and strategy

The practice had a clear vision and 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.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

The practice had a culture which drove 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.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff consultations	Members of staff we spoke with told us they were proud to work for the practice. Staff advised they felt well supported by the management and leadership team but were aware of the lack of capacity due to sickness and senior staff leaving the practice.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: 1 – The practice had governance structures and systems in place. However, due to a lack of management capacity these structures and systems were not always implemented. For example, we identified a number of concerns in relation to recruitment and staffing processes. The practice told us this was due to a lack of a full-time permanent practice manager at the practice.	

Managing risks, issues and performance

There were some processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	P ¹
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P ²
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.	Y
Explanation of any answers and additional evidence: 1 – At the time of the inspection the practice had recently implemented a process for supervising and reviewing the competence of staff employed in advanced clinical practice. This process was informal at the time of the inspection and therefore there was no documented evidence. However, the practice told us this would be formalised following the inspection. 2 – We found that the practice had completed risk assessments in relation to issues such as; fire safety and infection control. However, the practice could not demonstrate oversight of the actions required to mitigate the risks identified. In addition to this, the practice had not completed risk assessments in relation to the stock of emergency medicines or the risks to patients in waiting areas.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

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.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

The practice evidenced learning and improvement through the following methods:

- Clinical and non-clinical audit program.
- Reviewing of significant events.
- Reviewing of complaints.
- Reflections and reviews of patient feedback, such as GP National Patient Survey.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example

a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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