

Care Quality Commission

Inspection Evidence Table

Marybrook Medical Centre (1-6419208852)

Inspection date: 4 February 2020

Date of data download: 27 January 2020

Overall rating: Inadequate

We rated the practice as requires improvement overall because:

- Processes to respond to significant events and identify learning, were not effective.
- Processes to ensure the practice held appropriate emergency medicines were not effective.
- Processes to mitigate risk were not always effective.
- There was not effective oversight of staff training.
- Processes to ensure recruitment checks were consistently conducted including for locum staff, were not effective.
- Achievement for annual health reviews was below local and national averages.
- Processes to ensure privacy and dignity for patients were not embedded.
- Complaints were not consistently responded to in line with policy.
- Policies and procedures were not fully embedded to ensure compliance with the regulations.

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

Safe

Rating: Inadequate

We rated the practice as requires improvement for providing safe services because:

- Processes to respond to significant events and identify learning, were not effective.
- Patient specific directions were not always authorised before the medicine was administered.
- Processes to ensure the practice held appropriate emergency medicines were not effective and the impact had not been monitored.
- Processes to mitigate risk relating to fire, Legionnaire's disease, health and safety and infection prevention and control were not always effective.
- Not all staff had received appropriate training in safeguarding, infection prevention and control, and fire safety.
- Processes to ensure recruitment checks were consistently conducted including for locum

staff, were not effective.

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.	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.	Partial
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	No
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to evidence their process for monitoring patients on their safeguarding registers. They told us that they conducted a monthly review of these registers however, this had not been documented.</p> <p>We saw evidence that safeguarding had been an agenda item for a clinical meeting held in November 2019. This meeting was attended by the lead GP, a salaried nurse and a district nurse. However, the practice told us that no clinical meetings had been held or scheduled following this. The practice could not demonstrate that the information discussed was disseminated to the wider clinical team which was largely run by locum staff.</p> <p>The practice's safeguarding policy did not identify appropriate levels of safeguarding training for staff in line with national guidance. For example, it did not identify that reception staff required level two safeguarding children training. Staff we spoke with were able to demonstrate an understanding of safeguarding concerns, however the practice was unable to demonstrate that all staff including locums had completed or were up to date with their safeguarding training. For example, we identified;</p> <ul style="list-style-type: none"> 10 nurses and healthcare assistants who had not completed or were up to date with safeguarding training in line with guidance. 19 reception and admin staff who had not completed or were up to date with safeguarding training 	

Safeguarding	Y/N/Partial
in line with guidance.	
The practice told us that there were not regular discussions with other health and social care professionals, however they shared information with each other.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The 'partial' above and concerns identified in this section, related to locum staff only.</p> <p>Systems to ensure accurate and relevant information was held for locum clinicians, were not embedded. For example;</p> <ul style="list-style-type: none"> The practice had not consistently conducted a recruitment checklist for each locum in line with policy. We also identified that the checklist which had been used was not the same as the one included in practice policy. The practice could not evidence any recruitment information for locum nurses. The practice told us that the nurses had been recruited through a local agency, however they were unable to demonstrate that assurances had been given by the agency that appropriate checks had been completed. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 18 February 2019	Yes
There was a record of equipment calibration. Date of last calibration: 9 April 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: January 2020	Yes
There was a log of fire drills. Date of last drill: 21 May 2019	Yes
There was a record of fire alarm checks. Date of last check: 30 December 2019	Partial
There was a record of fire training for staff.	Partial

There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 8 February 2019	Yes
Actions from fire risk assessment were identified and completed.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice's fire risk assessment did not accurately reflect areas for improvement. For example, the risk assessment identified the question 'basic security against arson or other persons appears reasonable' as not applicable with no recorded rationale.</p> <p>Processes to mitigate risk in line with the practice's fire risk assessment, were not always embedded. For example;</p> <ul style="list-style-type: none"> • The target date given for a fire drill to be completed was March 2019. This was not done until May 2019. • No target date was given to ensure weekly fire alarm checks were conducted. Our inspection identified that while this had been actioned following the risk assessment, no fire alarm checks had been conducted since 30 December 2019. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 8 February 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 6 November 2019	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Processes to mitigate risk in line with the practice's health and safety risk assessment, were not always embedded. For example, it was identified that the external lighting needed to be reviewed but it was not documented if this had been completed.</p>	

Infection prevention and control

Processes to ensure appropriate standards of cleanliness and hygiene were met, we not effective.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
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: 2019	Partial
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:

The practice was unable to demonstrate that all staff including locums had completed or were up to date with infection prevention and control (IPC) training. For example, records we reviewed identified that a clinical member of staff who started work at the practice in November 2019 had not completed this training.

Not all areas identified as requiring improvement on the IPC audit had been completed. For example:

- It was identified that an audit should be conducted to monitor the cleaning company employed by the practice. The review date for this was identified as February 2019. The practice could not evidence if this had been completed.
- It was identified that seating in the waiting room needed to be reupholstered. This was recognised as a conclusion from the risk assessment but not included as a required action. We were told that because the practice was under a temporary contract with their provider, a lot of areas requiring improvement were waiting until the new provider came in. We saw that tape had been applied to the seating in the waiting room for the interim period, however this was no longer effective.

Processes to mitigate risk relating to Legionella, were not effective. A risk assessment had been completed but there was no date to determine when it had been carried out. Information on the risk assessment was not always comprehensive. For example:

- No answer was given next to four questions, including 'does the cold-water tank have a cover?'
- The risk assessment identified that the supply temperature was not a minimum of 50 degrees. No additional comments or information were recorded.
- We saw that two water temperatures were recorded on 29 August 2019 and one was recorded out of range. No additional comments or actions were documented and the practice was unable to evidence that further water temperature checks had been conducted.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety but these were not always effective.

	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.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
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

Explanation of any answers and additional evidence:

Records we reviewed identified that there was not a consistent induction system for temporary staff. For example, we identified a health and safety induction checklist had been introduced for locum staff but this had not been consistently conducted. For example, the practice was unable to demonstrate that this had been completed for all locum staff.

Reception staff told us that they had not received training to help them identify patients who were deteriorating or were acutely unwell. However, we saw posters in the reception area displaying the symptoms for sepsis and staff we spoke with were able to demonstrate an understanding of what symptoms would require an urgent review by a clinician.

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.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	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.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that historical note keeping and accurate coding on patient records by a previous provider was not always adequate. The practice told us that some work had been done to review patient records to ensure they were receiving effective care and treatment. However, they told us that under the temporary contract they did not have the resources to dedicate to a full review. Following inspection, we received assurances from the clinical commissioning group that a full review of patient records would be commenced and continued by the new provider.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however these were not fully embedded.

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)	0.89	0.83	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)	6.8%	8.9%	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)	5.11	5.55	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)	2.00	1.93	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.	No
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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	Yes

Medicines management	Y/N/Partial
appropriate monitoring and clinical review prior to prescribing.	
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
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	No
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Processes to monitor stock levels of medicines were not embedded. The practice told us that if clinicians required medicines from the store cupboard, they would be signed out to evidence an audit trail. However, we identified, and staff confirmed that not all locum clinicians followed this process.</p> <p>Emergency medicines were not held in a secure location. They were held in a store cupboard which was not locked and was accessible to patients. The practice was unable to demonstrate that this had been risk assessed.</p> <p>The practice did not always hold appropriate emergency medicines and the impact of this had not been monitored. For example, we identified that the practice did not have medicines used to manage severe pain and were unable to evidence that the impact had been risk assessed.</p> <p>Processes to ensure patient specific directions (PSD) were signed and authorised before the medicine was administered, were not embedded. For example, we identified one PSD signed by the healthcare assistant on 2 December 2019 but it had been authorised by an appropriate person on 3 December 2019 which was after the medicine had been administered.</p> <p>The practice did not employ any non-medical prescribers.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have an effective 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	No

There was a system for recording and acting on significant events.	No
Staff understood how to raise concerns and report incidents both internally and externally.	No
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	8
Number of events that required action:	8
Explanation of any answers and additional evidence: Processes to identify and act on significant events were not effective. We identified; <ul style="list-style-type: none"> • Not all staff were aware of what would constitute a significant event. • Significant event forms were not always completed or comprehensive to demonstrate outcome of review. • Systems to identify and implement learning to reduce likelihood of reoccurrence, were not embedded. • It was not always recorded if duty of candour had been followed for patients affected. 	

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

Event	Specific action taken
A significant event was raised in June 2019 following missed diagnosis of cauda equina by a locum clinician.	This was discussed at a clinical meeting held in August 2019 with the locum clinician. A significant event form had been started but not completed. Meeting minutes we reviewed identified areas of learning for the clinician, but the practice had not identified how they intended to monitor this. No wider learning for the practice was identified.
A significant event was raised in November 2019 following a delay in diabetes review by locum clinicians.	This was discussed in a meeting held in November 2019. Learning identified included that a report would be conducted to identify any other patients affected. No further information was available to determine if this had been carried out. There was no evidence to demonstrate learning identified for the locum clinician.

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
Explanation of any answers and additional evidence: The practice was unable to demonstrate what action had been taken for alerts received after December 2019. The practice told us that when an alert was received it was passed to the clinical pharmacist who would then conduct the relevant searches. Records we reviewed identified that alerts issued had been recorded on the practice's system but there was no record of action taken.	

Effective

Rating: Requires Improvement

We rated the practice as requires improvement for providing effective services because:

- Not all staff had completed mandatory training in line with practice policy.
- The practice was unable to demonstrate that they held appropriate records for clinical staff demonstrating their qualifications.
- Achievement in patient health reviews was below local and national averages.
- Coding was not consistent to ensure patients received appropriate care and treatment.

Effective needs assessment, care and treatment

Patients' needs 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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: The practice was unable to demonstrate how they kept clinicians including locums up to date with current evidence-based practice. The practice advised that this would be discussed in clinical meetings however, no meeting had taken place or had been scheduled since November 2019. Furthermore, records of meetings we did review did not include locum staff. Since the provider took over the practice in October 2018, they placed a lot of focus on ensuring patients received necessary care and treatment. The practice provided us with unverified Quality and Outcomes Framework (QOF) data which showed improvements had been made. However, on inspection we identified that codes on patient records were not always consistently applied. For example, we identified patients who had received a review but had not been appropriately coded.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.47	0.81	0.74	No statistical variation

Older people

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to achievement for annual health reviews and staff training which affected all population groups. However, there were areas of good practice.

- 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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to achievement for annual health reviews and staff training which affected all population groups. However, there were areas of good practice.

- Improvements had been made to ensure 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.
- 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>	65.0%	82.5%	79.3%	Variation (negative)
Exception rate (number of exceptions).	7.4% (23)	16.6%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	64.4%	78.8%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.5% (17)	13.0%	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) <small>(QOF)</small>	71.0%	81.8%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	15.2% (47)	17.2%	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>	40.9%	76.2%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	0.8% (3)	8.3%	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>	52.5%	91.4%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	5.7% (6)	12.8%	11.2%	N/A

Indicator	Practice	CCG	England	England
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		average	average	comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	66.5%	84.1%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	5.3% (42)	4.9%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	90.8%	92.8%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.0% (3)	5.7%	5.9%	N/A

Any additional evidence or comments

QOF indicators from 1 April 2019 were updated and some of the indicators shown above have been retired. Therefore, we are unable to provide a comparison using unverified data for the diabetes indicators shown above.

However, the unverified data we reviewed for the 2019/2020 QOF year indicated improvements in uptake for health reviews. For example:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 was 93.7%.
- 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 was 100.0%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less was 78.8%.

The practice had achieved improvements by actively recalling patients for a review which previously had not been systematic.

Families, children and young people

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to achievement for annual health reviews and staff training which affected all population groups. However, there were areas of good practice.

- The practice had met the minimum 90% target for one of four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators. (please add additional comment for any childhood immunisations indicators below 90%).
- 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.
- 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)	44	48	91.7%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	52	52	100.0%	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)	52	52	100.0%	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)	52	52	100.0%	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

We rated this population group as requires improvement due to concerns identified relating to achievement for annual health reviews and staff training which affected all population groups. However, there were areas of good practice.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could 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
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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)	81.7%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	70.7%	73.2%	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)	60.3%	61.9%	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)	23.1%	68.7%	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%	58.5%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to achievement for annual health reviews and staff training which affected all population groups. However, there were areas of good practice.

- Same day appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to achievement for annual health reviews and staff training which affected all population groups. However, there were 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 appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	5.6%	90.9%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	16.3%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	22.2%	91.9%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	14.5%	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)	69.2%	86.8%	83.6%	No statistical variation
Exception rate (number of exceptions).	15.2% (7)	7.3%	6.7%	N/A

Any additional evidence or comments

The practice told us that they were actively recalling patients for reviews of their conditions which previously had not been systematic. We reviewed unverified data for the 2019/2020 QOF year which indicated improvements in uptake for health reviews. For example:

- 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 was 100.0%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 93.3%.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	428.8	550.1	539.2
Overall QOF score (as a percentage of maximum)	76.7%	98.4%	96.7%
Overall QOF exception reporting (all domains)	6.3%	6.3%	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.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed an audit programme which was conducted by the clinical pharmacist who worked from the practice two days a week. These included audits on prescribing practices. The practice told us that they had not prioritised practice led quality improvement audits as there were other areas which required more immediate attention. For example, ensuring patients received effective care and treatment by recalling them for a review of their condition.</p> <p>We identified that not all unplanned admissions or readmissions were reviewed. The practice told us that they would review patients who had been admitted to hospital following a fall to determine if their medicines required adjustment.</p>	

Effective staffing

The practice was unable to demonstrate that all 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.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of	Partial

professional revalidation.	
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	n/a
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to demonstrate that all staff including locums had completed or were up to date with mandatory training in line with policy and national guidance. For example, records we reviewed showed that:</p> <ul style="list-style-type: none"> • 18 members of staff including locums had not completed adult basic life support. • 13 members of staff including locums had not completed General Data Protection Regulation (GDPR) training and 18 members of staff were not up to date. <p>The practice was unable to demonstrate that one member of their clinical team was appropriately qualified. The member of staff advised that the practice held a copy of their certificates demonstrating their qualifications, however the practice was unable to evidence this.</p> <p>The practice was unable to demonstrate that all staff had received an appraisal in line with practice policy. For example, we reviewed staff files and found that there was no evidence that a healthcare assistant had received an appraisal.</p> <p>The practice was unable to demonstrate that they had an appropriate approach to support and manage staff when their performance was variable. Two significant events had previously been raised which related to the performance of locum clinicians. The practice was unable to demonstrate that they had put measures in place to monitor this going forward.</p>	

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.	Yes
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

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

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>	91.4%	94.9%	95.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.4% (60)	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 but it was not monitored

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	No
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: The practice did not have a system to monitor the process for seeking consent.	

Caring

Rating: Requires improvement

We rated the practice as requires improvement for providing caring services because:

- The practice had not identified actions to improve survey results which were below local and national averages.
- Privacy and dignity were not always respected.

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.	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.	16
Number of CQC comments received which were positive about the service.	14
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards	Feedback included that patients felt cared for and listened to.

National GP Survey results

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)	79.6%	90.7%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the	78.5%	90.1%	87.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)				
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)	86.8%	96.5%	95.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	67.3%	86.6%	82.9%	Tending towards variation (negative)

Any additional evidence or comments
The practice had not identified actions to improve positive outcomes from the GP patient survey. However, they told us that as a temporary provider, they had focused on trying to ensure patients received effective care and treatment.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

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

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	84.4%	95.4%	93.4%	Tending towards variation (negative)

	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.	156 – representing approximately 3% of the patient population.
How the practice supported carers (including young carers).	The practice health checks and flu immunisations to all carers.
How the practice supported recently bereaved patients.	Recently bereaved patients would receive a phone call from the GP.

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.	Yes
Consultation and treatment room doors were closed during consultations.	No
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
Explanation of any answers and additional evidence: We identified that two consulting room doors had been left ajar during a consultation and discussions with the patients could be overheard.	

Responsive

Rating: Requires improvement

We rated the practice as requires improvement for providing responsive services because:

- Processes to ensure complaints were responded to in line with practice policy were not embedded.
- There was limited evidence to demonstrate that complaints were used 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.	Partial
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider told us that it had been difficult to recruit new staff as they held a temporary contract to provide services from the practice. As such, they did not have the capacity to provide services to patients outside core hours.</p> <p>The practice's clinical team mostly consisted of locum staff. However, in order to provide continuity of care to patients, the practice told us that they tried to recruit long-term locums.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am to 6.00pm
Tuesday	8.00am to 6.00pm
Wednesday	8.00am to 6.00pm
Thursday	8.00am to 6.00pm
Friday	8.00am to 6.00pm
Appointments available:	
Monday	8.30am to 11.30am and 1.30pm to 5.30pm
Tuesday	8.30am to 11.30am and 1.30pm to 5.30pm
Wednesday	8.30am to 11.30am and 1.30pm to 5.30pm
Thursday	8.30am to 11.30am and 1.30pm to 5.30pm
Friday	8.30am to 11.30am and 1.30pm to 5.30pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	91.8%	95.4%	94.5%	No statistical variation

Older people

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to the complaints process which affected all population groups. However, there were areas of good practice.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to the complaints process which affected all population groups. However, there were areas of good practice.

- 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.
- 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: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to the complaints process which affected all population groups. However, there were areas of good practice.

- 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: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to the complaints process which affected all population groups. However, there were areas of good practice.

- The practice was unable to demonstrate how they responded to the needs of this population group.

The practice was not fully able to offer services which were accessible and flexible for these patients.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to the complaints process which affected all population groups. However, there were areas of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- 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: Requires improvement

Findings

We rated this population group as requires improvement due to concerns identified relating to the complaints process which affected all population groups. However, there were areas of good practice.

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

Timely access to the service

People were 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)	88.8%	N/A	68.3%	Variation (positive)
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)	59.7%	73.2%	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)	54.2%	68.8%	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)	70.5%	78.8%	73.6%	No statistical variation

Source	Feedback
For example, NHS Choices	<ul style="list-style-type: none"> Eight reviews over the last 12 months. Positive comments included that the nursing team provided good care and clinicians explained tests in a way which patients understood. Negative feedback included that there was a lack of continuity of care due to locum GPs.

Listening and learning from concerns and complaints

Complaints were listened and responded to, however there was limited evidence to show they were used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: Processes to ensure complaints were managed consistently and in line with policy, were not	

embedded.

- The practice's complaints leaflet did not correlate to their complaints policy. For example, the leaflet identified that complaints would be responded to in two working days rather than the three working days identified in the policy.
- We saw that patients were referred to the parliamentary and health service ombudsman in the complaint acknowledgement rather than the final response in line with practice policy.

Systems to demonstrate improvement following a complaint were not always effective. For example, a complaint was raised in September 2019 regarding the attitude of locum GP towards a patient with a mental health condition. This was discussed at a clinical meeting in October 2019. The practice's clinical lead agreed to discuss this with the locum GP and suggested that they attend an update on mental health training. The practice confirmed on inspection that these discussions took place but were unable to demonstrate this or evidence that the GP had attended the update.

Well-led

Rating: Inadequate

We have rated the practice as inadequate for providing Well-led services, because:

- Practice systems to support good governance were not always embedded or effectively managed.
- Processes to mitigate risk in the practice were not always embedded.
- Systems to monitor performance were not effective.
- Processes to support the dissemination and sharing of information were no longer in place.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice demonstrated that they were aware of some areas which impacted the quality and sustainability of services, for example, access to clinical staff and continuity of care. However, not all areas for improvement had been identified such as reinstating clinical meetings. To address the concerns identified by the practice, they had tried to source long term locums to improve continuity of care. A new permanent provider was due to take over the practice from 1 April 2020.	

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to

provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	No
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No
<p>Explanation of any answers and additional evidence:</p> <p>The provider had taken over the practice in October 2018 on a temporary contract. They had not established an official set of values or strategy, however they told us that they were patient focused and tried to deliver as high a quality of service as possible. In order to achieve this, the practice had tried to ensure continuity of care and had invested in upskilling the nursing team and had tried to book regular long-term locum staff.</p>	

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.	No
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.	No
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Partial
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.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a formal process to ensure compliance with the duty of candour. We saw evidence that patients had received an apology but this had not been formalised to ensure a consistent approach.</p>	

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

Source	Feedback
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Interviews with staff	Feedback from staff included that since the provider took over, things had improved and that they felt supported.
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Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management, but these were not fully embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Due to recruitment constraints there was not the capacity to fully meet needs of the patient population, for example being unable to facilitate extended access services.</p> <p>Systems to support dignity and respect, were not fully embedded. For example, room doors were not always closed during a consultation.</p> <p>The practice was unable to demonstrate that they had effective governance structures to support safeguarding processes. There were inconsistencies between devised policies and implementation in practice.</p> <p>Oversight of staff training was not embedded. The practice was unable to give assurance that all staff had completed or were up to date with mandatory training.</p> <p>Governance arrangements were not embedded to ensure locum staff had the necessary information and had received the required training for them to effectively carry out their role.</p> <p>The practice did not have sufficient processes in place to ensure ongoing monitoring of quality improvement. Unverified data suggested improvements however, these processes were not fully embedded at the time of inspection.</p> <p>The practice did not have effective systems to recognise and monitor learning identified as a result of complaints and significant events. There was a lack of documented evidence to demonstrate that key discussions had taken place or actions been followed up.</p> <p>Oversight to ensure compliance with practice policy was not always effective. For example; recruitment procedures and responding to complaints.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and	No

improved.	
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	No
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they had not prioritised practice-led audits. However, we saw evidence that some audits had been conducted by the clinical pharmacist on prescribing practices.</p> <p>Processes to mitigate risk in the practice were not always embedded. For example:</p> <ul style="list-style-type: none"> • Items requiring action as identified on practice risk assessments, had not all been completed and no rationale had been recorded. • Processes to ensure appropriate emergency medicines were available, were not embedded and the impact had not been assessed. • The practice could not demonstrate that they had risk assessed the location of the emergency medicines. <p>We saw evidence that there was a major incident plan in place, however it was not fully comprehensive. For example:</p> <ul style="list-style-type: none"> • It identified a possible risk of infection which was to be discussed. There was no evidence to demonstrate that this had taken place or the outcome. • Some detail around what to do in the event of a flood was missing such as the location of the stop valve. <p>Practice systems to monitor performance were not effective. For example:</p> <ul style="list-style-type: none"> • Not all staff had received an appraisal in line with practice policy. • The practice could not demonstrate that locum clinicians had received feedback on their performance following significant events or complaints. The practice also did not monitor consultations conducted by locum clinicians to ensure performance concerns had improved. <p>Processes to ensure staff consistently had the appropriate authorisation to administer medicines, were not embedded.</p>	

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.	Partial
Performance information was used to hold staff and management to account.	No

Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to demonstrate that staff had received feedback about their performance following complaints or significant events.</p> <p>When the provider took over the service in October 2018, they identified concerns relating to historical coding on patient records and that record keeping not always comprehensive. For example, they had identified a patient who had been coded as having rheumatoid arthritis who did not have this condition. At the time of inspection, the provider was unable to give assurance that all coding was accurate as they did not have the resources to conduct a full review of all patient records.</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.

	Y/N/Partial
Patient views were acted on to improve services and culture.	No
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	No
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Following patient survey results, the practice had not identified actions to improve areas where positive outcomes were below local and national averages.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	No
<p>Explanation of any answers and additional evidence:</p> <p>Processes to support the dissemination and sharing of information were no longer in place. The last documented meeting was held in November 2019. The practice was unable to demonstrate that any practice or staff meetings were due to take place in 2020.</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.