

Care Quality Commission

Inspection Evidence Table

Dr Paramjit Wasu (1-526774472)

Inspection date: 10 February 2020

Date of data download: 27 February 2020

Overall rating: Not rated

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

Safe

Rating: Not Rated

Safety systems and processes

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.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence:	
At the previous inspection we found there were inadequate processes in place to safeguard children or vulnerable adults from the risk of abuse. We continued to identify issues at this inspection.	

Safeguarding	Y/N/Partial
- Safeguarding policies were not accessible to all staff. One new clinician told us that they did not have access to the policies. - There was no evidence provided to show policies took account of patients accessing online services. - There was no evidence provided that the out of hours service was informed of relevant safeguarding processes. - At the previous inspection we found there was no vulnerable adults or children at risk register. At this inspection, we found the practice had created both registers; however, they were not effectively implemented or monitored. The practice created a child risk register in November 2019 and 11 patients were listed on this register. However, we found one patient did not have a reason for being placed on the register and we found two of the patients listed on the children at risk register were over 18 years of age. The practice told us they did not maintain contact with these patients. - We also found an adult safeguarding register was now in place. The practice told us this was reviewed weekly; however, it was not always updated with the most recent GP consultation. For example, one entry reported last GP consultation was in October 2019 but when we looked at the clinical record, we saw the last GP consultation was in December 2019. - At the previous inspection, we found gaps in safeguarding training. At this inspection, we continued to find gaps. For example, there was no evidence of safeguarding adults training for two clinicians. - There were no regular discussions between the practice and school nurses and community midwives. However, referrals were made to external clinics where required and there was evidence of discussions with health visitors and social services.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N

Explanation of any answers and additional evidence:

- At the previous inspection, we found there were no effective recruitment and selection processes, such as obtaining CVs, full employment history and references. At this inspection, we found there were still some gaps. For example, we looked at recruitment records for two new staff and found one new salaried GP did not have references in place and had no signed contract.
- At the previous inspection, there was no system in place to monitor that staff immunity was checked according to PHE recommendations. At this inspection, we continued to find immunisation gaps which included varicella, typhoid, diphtheria and chicken pox, including for new staff.
- At the previous inspection, there was no evidence to show how the registration of nursing staff was continuously monitored. At this inspection, the system in place was still not effective as there were no revalidation information for the practice nurse kept on file. The practice manager was not aware of this.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not 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: 19 February 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	N

Explanation of any answers and additional evidence:

- Since the previous inspection, the practice had assigned one of the GP locums as the infection control lead. However, this designation had occurred a week before the inspection and therefore any improvements to infection control systems within the practice had not been embedded at the time of the inspection.
- We found some improvements whereby the practice had acted on actions identified during the last infection control audit. Actions included replacing examination light in nurses' room and adding sharps injury posters in treatment rooms.
- There were no purple lidded sharp bins available in the first-floor treatment room used for the disposal of hormone-containing medicines; for example, contraceptive medicines.
- At the previous inspection, we found there was no cleaning schedule for the spirometer or nebulizer. The cleaning schedule in place was only for the ear irrigator. At this inspection, we found the documentation for monitoring the cleaning process consisted of a tick box under the list of equipment. The document did not specify what cleaning procedures were required.
- Furthermore, the ear irrigator was not cleaned according to the manufacturer's instructions. The external surface of the ear irrigator was cleaned with an antibacterial wipe. However, the manufacturer states that safe decontamination of the internal components is necessary using a specific strength of cleaning solution.

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.	Partial
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N

The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N

Explanation of any answers and additional evidence:

- The nurse who started employment had completed an induction programme. However, they stated they were shown a folder of policies when they first joined but did not know where they were kept or what was contained within them. The induction did not cover their clinical tasks or roles.
- Risk management plans were not developed in line with national guidance. At the previous inspection, we found the practice was registered as a Yellow Fever Centre with the National Travel Health Network and Centre (NaTHNaC) and there was no evidence of risk assessments carried out for patients receiving this vaccine. At this inspection we continued to find risk assessments were not taking place for patients receiving this vaccine.
- At the previous inspection, we found gaps in sepsis training. At this inspection, we found this had improved. We saw evidence of one of the locum GPs delivering this training for staff. The reception team were able to demonstrate they understood what to do should a patient's health deteriorated within the practice.
- We were not assured the practice monitored the impact on safety when there were changes to staff. This was in relation to ensuring staff were adequately trained for the roles they were undertaking.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarizing of new patient notes.	Not inspected
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
Referral letters contained specific information to allow appropriate and timely referrals.	N
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

- At the previous inspection, we found staff did not always have the information they required to provide safe care and treatment. We continued to find significant gaps at this inspection.
- We found gaps in some of the patient records we reviewed. For example, a patient had received an immunisation from the practice nurse in a consultation that lasted over 30 minutes. However, there was no record of this consultation or the immunisation administered in the patient record.
- We also found evidence in the electronic attendance register of another patient having consulted with the GP; however, there was no corresponding GP clinical record.
- We found a patient with a diagnosis of dementia and another patient diagnosed with a serious condition. Neither condition was recorded on the active problem list or coded on the system. This would make it difficult for other clinicians; for example, locum GPs to know of this diagnosis and provide safe care for the patient.
- At the 25 June 2019 inspection we found concerns relating to two-week wait referrals and this had been resolved by our second site visit in July 2019. However, at this inspection, we identified new issues regarding two-week wait referrals. Although all referrals were documented using a spreadsheet and a clinician maintained oversight over this task, effective monitoring was required. Staff responsible for monitoring the two-week wait referral spreadsheet had not notified the GP a new patient referral was required after the patient had missed their appointment after informing the practice they had not received an appointment letter four days prior.
- All letters had been filed and actioned. All pathology results had been read and actioned. However 25 pathology results had not been matched to the patient. The majority of these results were very recent or from the day of the inspection. Five were marked as urgent. However, some had not been acted on by the practice since 6 December 2019.

- There was also no system to follow up hospital result letters after patients had attended their two-week wait referral appointments. We found one hospital letter had not been received for an appointment in November 2019. The practice had not followed this up.
- At the previous inspection, we found there were no assurance systems in the monitoring of cervical screening. At this inspection, we continued to find concerns. The practice did not have a failsafe to ensure a result was received for every sample sent.
- The practice stated a new system was in place for the receiving laboratory to electronically track cervical screening results; however, we could not see evidence this system worked, or the practice had a system prior to this electronic tracking being introduced. Therefore, the practice could not be assured all results would have been returned and could cause delays in further investigations and treatment of abnormal results for women if their sample was mislaid.
- The practice nurse did not monitor results of samples sent for cervical screening as part of continuous self-evaluation and to ensure abnormal results were followed up.
- We also found the cervical sample takers were using different codes and templates to record samples taken. This would make it difficult for the practice to monitor their own performance. The practice manager was not aware of this.
- A sample check of consultation records identified sample takers did not always document their sample taker number. This had been brought to the attention of the practice by the laboratory who had stated this could result in the rejection of samples. The practice manager was not aware of this.
- On reviewing consultation records for patients who had received cervical screening, we found one example of no evidence of the test being carried out but just a copy of the request form. This would affect the practice's ability to accurately monitor results.
- We saw evidence of a patient being asked to attend an appointment for a diabetes review. During the review it was identified that the patient did not have diabetes. However, this had not been brought to the attention of the GP and the patient remained coded with a condition, which he did not have, which would lead any clinician seeing him to assume he had diabetes.

Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Not inspected
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N
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.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence:	

- At the previous inspection, we found Patient Group Directions (PGDs) were not being signed by the GP and at times by both nurses at the practice. At this inspection, we continued to find concerns. For example, we found the practice nurse had signed the PGDs in January 2020 when they commenced employment; however, these PGDs had ~~had~~ been signed by the authorising manager in June 2019. The PGD for administering Hepatitis A vaccine expired in October 2019. This demonstrated a lack of oversight of the system to ensure the correct legal authorisation was in place for the nurse to administer Prescription Only Medicines, such as vaccines.
- We found concerns in relation to prescribing medicines. For example, there was no record of any indication, or history of examination to justify why one patient had been prescribed ophthalmic steroid medicine. There was a risk of harm to the patient if incorrectly prescribed.
- There was evidence of inappropriate medicines reviews in some cases. For example, we saw evidence one medicine review had taken place without the patient being present and reset to the following year. However, there was no recorded evidence to show the patient would receive their long-term condition review of asthma and diabetes which were due in the meantime.
- At the previous inspection on 23 July 2019, we found concerns regarding high-risk medicines identified at the 25 June 2019 inspection had been resolved. However, at this inspection, not all high-risk medicines were being monitored appropriately. We found concerns regarding some of the high-risk medicines. We found one patient prescribed lithium (mood stabilizer) was overdue a blood test by one month since October 2019 and had been prescribed this medicine in February 2020 without any action being taken. We also found the patient's condition was not reflected in the patient summary and the patient was not did not receive regular reviews.
- When we reviewed eight records for patients prescribed warfarin (anticoagulant), we found three of these patients had been issued prescriptions without any evidence recorded of the latest blood test result or the appropriate dosing advice having been reviewed. There was no system in place to monitor this.
- When we reviewed 23 patients prescribed DOACs, we found one patient did not have clear monitoring in place. There was a mismatch between the medicine review date and the blood test review date. The patient was due a blood test in February 2020 but it was not clear whether this need for a blood test would be identified by the practice.
- When we reviewed seven records for patients prescribed methotrexate (immunosuppressant). Although this medicine was generally prescribed safely, we identified minor concerns.
- At the previous inspection, we found inadequate systems to ensure the oxygen and defibrillator were regularly checked and fit for use. We found improvements had been made at this inspection. For example, we saw evidence the practice routinely checked the defibrillator and oxygen and accessory equipment such as spare pads, razor and scissors were available. Staff we spoke to on the day of inspection understood their responsibilities in the event of an emergency.
- At the previous inspection, we found the practice kept a range of emergency medicines in a locked cupboard in the ground floor clinical room. At this inspection, we found emergency medicines were organized based on the clinical need and now included atropine (for slow heart rate) and benzylpenicillin (for meningitis) which was not stocked during the last inspection. However, the packs did not include the appropriate medicine for the conditions. For example, GTN spray was stored in the asthma pack, buscopan was stored in the seizure pack, prednisolone was stored in the cardiac pack and adrenaline was stored in the diabetes pack instead of the anaphylaxis pack for which it is the first line treatment.
- The location of the adrenaline, GTN spray and prednisolone was inappropriate and could lead to delay in administration in the event of an anaphylactic reaction and treatment of acute asthma and cardiac pain. Adrenaline was not kept in the treatment where vaccines are administered.

Medicines management	Y/N/Partial
• At the previous inspection, we found inadequate processes to ensure vaccines were continuously stored at an appropriate temperature. At this inspection, we found this had improved. Staff had received training, although we found that until September 2019, vaccines fridge temperatures were below the recommended levels and no action had been taken. • Cold chain monitoring records from September 2019 showed temperature ranges were checked and were within the appropriate range for both upstairs and downstairs vaccines fridges. We found the downstairs fridge was empty and the practice told us this fridge would be used for high demands for vaccines during vaccines campaigns. • The practice manager now had overall responsibility for cold chain monitoring and reception staff were responsible for checking the fridge temperatures. • The practice did not always take steps to ensure appropriate antimicrobial use to reduce the risk of adverse events. For example, one patient was coded as being allergic to a certain antibiotic on their record; however, despite this, they were prescribed from this group of medicines, placing the patient at risk of a serious allergic reaction. We also found this patient had been prescribed another medicine but despite an alert of contraindications on their record. This also placed the patient at risk of an adverse reaction.	

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.	
Staff knew how to identify and report concerns, safety incidents and near misses.	N
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	N
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	6
Number of events that required action:	n/a
Explanation of any answers and additional evidence: - We identified two new significant events since the previous inspection. We saw evidence they had been discussed at practice meetings. The practice told us copied of the meeting minutes were sent to staff who could not attend. However, the new practice nurse had not attended these meetings and told us copies of meeting minutes were not disseminated to them. There was no system in place to monitor if staff had read meeting minutes. - The new practice nurse was not aware of the significant events policy and did not know where to record an event, or aware of any previous events at the practice. They were unaware of how significant events were managed in the practice and did not know where they were discussed to ensure staff learned from them.	

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

Event	Specific action taken
Patient given incorrect medicines by the pharmacy	Locum GP contacted the pharmacy and event was reported to the national incident reporting service.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence: - When we spoke to once clinician about how they were made aware of alerts and new clinical information coming into the practice, they showed how these were forwarded by email by the practice manager. We viewed a recent alert on yellow fever vaccination. - The practice manager told us alerts were sent by email to the relevant staff but staff we spoke to were not asked to confirm they had read the alert or had taken relevant action.	

Effective

Rating: Not rated

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	N
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	n/a

Explanation of any answers and additional evidence:

- At the previous inspection, the practice did not maintain complete and contemporaneous records in respect of each patient, including an adequate record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. At this inspection, we continued to find significant gaps in record keeping in the 30 patient records we reviewed. This included inadequate history taking, lack of adequate investigations, no diagnosis in some of these notes and no clear indications for commencing some treatments.
- For example, we found some asthma reviews did not include measurement of the peak flow, a standard examination for patients with asthma and where a peak flow had taken place, there was no evidence of what action to take if the measurements were below the expected level. We also found there was a lack of discussion of symptoms and their effect on activities of daily living. There was no asthma management plan for one patient we reviewed including the action to take if their condition deteriorated. There was no record of patient attendance to the emergency department in one of these cases.
- We also found some patients seen by the GP with abnormal test results had not been provided with the appropriate treatment and there was no clear coding system to ensure they were followed up.
- We found inadequate history taking, no examination in relation to symptoms and indications for treatment for a patient presenting with ear wax.
- We found significant concerns in relation to the care of one elderly patient. For example, there was no record of one visit, unclear duration of abnormal symptoms, no record of decision making not to investigate these symptoms which could have indicated cancer further despite age of

patient, no action taken on abnormal blood test levels. This patient was also not treated as two-week wait patient despite abnormal symptoms,

- At the previous inspection, we saw evidence that patients immediate and ongoing needs were not always fully assessed. At this inspection, we found there were still concerns. For example, the patient records for one patient diagnosed with anxiety had multiple omissions from the history and records in general. In particular, there was no previous medical history in the patient records, there was inadequate information to justify the diagnosis and treatment, an inadequate referral letter and no advice regarding self-care and follow up was provided to the patient.
- The practice did not have a protocol for the healthcare assistant (HCA) to follow to refer patients to a GP or return for repeat measurements if they had blood pressure above a certain range. This meant decisions around management of patients' blood pressure was left to the discretion of the HCA. Patients were not always told when they needed to seek further help and what to do if their condition deteriorated. For example, one elderly patient diagnosed with asthma was not provided with advice on the steps to take if their condition deteriorated. Their care plan contained out of date information and was not completed.

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.	N
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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.	N
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
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N

Explanation of any answers and additional evidence:

- At the previous inspection, there was limited oversight or ongoing supervision of nursing staff and their clinical record keeping. At this inspection, we continued to find concerns as the practice did not maintain adequate oversight of staff competence and performance. There was no system in place to ensure they regularly checked and recorded competencies of clinical staff relevant to their role. Nurse appraisals were not undertaken by the GP. As a result, they

were unable to demonstrate all staff had received mandatory training and nurses were appropriately trained for the range of tasks they were undertaking in the practice.

- We found one nursing staff member responsible for carrying out health checks was not clear about the guidelines in place. We found referral to the GP for abnormal readings was at their discretion and there was no protocol or guidelines in place that they referred to. There was no system in place to monitor their performance.
- The practice did not maintain adequate oversight of the new practice nurse. For example, the practice nurse told us they had not carried out any spirometry consultations since employment with the practice. However, when we reviewed a patient consultation carried out by the nurse, the records indicated they had carried out a spirometry test. However, on discussion they confirmed this test had not in fact taken place, despite the evidence in the patient record. This demonstrated confusion on the part of the nurse and there was no system in place for this to be identified and addressed by the provider. appointed to carry out asthma reviews independently without adequate knowledge of this task.
- The practice told us training records were kept in staff files. However, we found the they had no systems in place to check clinicians were up to date with their training. We found significant gaps in role-specific training. For example, training records showed one nurse had last received family planning training in 1997, chronic heart disease prevention training in 2004 and travel update training in 2015. There was no up to date training evidence provided by the practice following the inspection.
- Although the practice told us they had a programme of learning and development for all staff, we found this was not implemented effectively. When we reviewed staff training records, we found some staff had completed 12 e-learning modules on the day before the inspection. Staff training records also showed one clinician had completed 20 e-learning modules in one day.
- The practice nurse was not aware of clinical meetings within the practice.
- The practice did not ensure nursing staff had knowledge of the forthcoming changes to the childhood immunisations schedule. We found although one nursing staff knew there was a change to the timing of the pneumococcal vaccination which came into force for babies born from 1 January 2020, they misunderstood the change and incorrectly thought that babies still required two vaccines with their primary immunisations when they would only require one. They stated that they would rely on the parent-held child health record for the correct schedule and would delay immunization if this was not available. There was no system of ensuring new guidance was embedded or opportunity for this misunderstanding to be addressed.

Well-led

Rating: Not rated

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N

Explanation of any answers and additional evidence:

- At this inspection, we found significant evidence of a lack of management insight into safe governance systems. The practice manager did not check staff had received adequate role-specific training for the range of tasks they were undertaking. There was a lack of management oversight in other areas such as cervical screening and the use of correct codes and templates and incorrect documentation of spirometry and diabetes consultations by the practice nurse.
- A lack of management oversight was also identified in staff training. We saw evidence of when staff had carried out 12 e-learning modules and 22 e-learning modules in one day. This was not being monitored to ensure this training was effective.
- The lead GP had acknowledged gaps in their record keeping since the previous inspection and had also undertaken a record keeping course in 2018. However, we continued to find significant concerns in relation to record keeping and the quality of care provided and the practice had not taken effective action to address this. Record keeping audits were not taking place.
- The practice had support from locum GPs, one who had been given lead responsibilities in infection control, triage training, and long-term condition safety netting and sepsis training for staff. However, the locum GP had been allocated these lead roles a week prior to the inspection.
- There was no formal succession plan in place.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: • At the previous inspection, we found the overall governance arrangements were inadequate. We continued to find concerns at this inspection. The practice discontinued the use of their previous GP TeamNet system but we continued to find gaps in relation to new staff accessing practice policies. • Staff were not always clear about their responsibilities. This was in relation to following recommended guidelines when providing care and the changes to the schedule for childhood immunisations. • The practice continued not to maintain oversight over nursing records in particular, continuing professional development training since the previous inspection. Staff were not always clear about their roles and responsibilities ensuring patient consultations were adequate and records were complete. • There was a lack of oversight of the system to ensure the correct legal authorisation was in place for the nurse to administer Prescription Only Medicines such as vaccines using Patient Group Directions (PGDs). • Structures, processes and systems to support good governance were still not adequately embedded at this visit. Although we found some improvements in relation to emergency processes and cold chain monitoring, there were still gaps in governance systems. This was in relation to safeguarding processes, inadequate induction arrangements, significant events, infection control, sharing learning, ensuring that clinical staff were aware of their responsibilities.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Not inspected
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence: - There were no comprehensive assurance systems in place to identify, manage and mitigate risk. This was in relation to recruitment, staff immunisations, yellow fever vaccines and medicines management. - There was also a lack of oversight of systems to prevent cross infection and also the storage arrangements for emergency medicines. - There was risk relating to inadequate nurse induction which meant they were undertaking roles for which they had not assured themselves of competence by recent training and oversight relevant for their role. - There were also no assurance systems in the monitoring of cervical screening and at-risk patients. - Patients were put at significant risk of harm due to incomplete record keeping for care records, clinical findings, decisions made and lack of appropriate examinations in some cases. These failures put patients at risk of not being appropriately treated, followed up and reviewed.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively
The practice did not always act on appropriate and accurate information.

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

Explanation of any answers and additional evidence:

- Our inspection indicated that information was not always reliable and timely. This was in relation to incomplete and unreliable patient care records.
- At the previous inspection, we found the practice did not always make the statutory notifications when required. At this inspection, we found this continued. The practice had not notified the relevant yellow fever external body of their inadequate rating. This was a condition of their registration with this body.

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.