

Care Quality Commission

Inspection Evidence Table

Carnarvon Medical Centre (1-5584372381)

Inspection date: 12 November 2020, 13 November 2020 and 19 November 2020

Date of data download: 7 October 2020

Overall rating: Inadequate

We previously inspected the practice in November 2018 and rated it as requires improvement overall and requires improvement for providing safe and effective services.

We inspected in October 2019 to follow this up and we found that not all the concerns had been addressed from the previous inspection and in addition, new breaches of regulations were found. When we inspected this practice in October 2019, we rated the practice as requires improvement overall. We rated the key questions as follows: safe as inadequate, effective as requires improvement, caring as good, responsive as good and well-led as requires improvement. The practice was issued a warning notice.

At this inspection (November 2020), we have rated the provider as inadequate overall. We found that there were concerns related to the safe and effective care of patients and that there was a lack of awareness of this from leaders. We also found that some of the improvements required at the last inspection had not improved sufficiently.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Inadequate

At our **previous inspection**, we rated this practice as inadequate for providing safe care. This was because not all staff had received a disclosure and barring system (DBS) check, including some staff who had completed chaperone training. This was a repeat issue from the previous inspection. There was no child or adult safeguarding policy in place which was specific to the practice. There was no recruitment policy and procedure in place and staff files were inconsistent. Staff vaccination was not maintained in line with current Public Health England (PHE) guidance. Health and safety checks of the premises were unclear, and records were incomplete. Reviews following a complaint or significant event did not ensure that measures were put in place to reduce the likelihood of recurrence. There was no formal induction for new staff. Not all staff had received training on infection prevention and control.

At **this inspection**, although we found that most of these concerns had been adequately addressed, we found that there were new concerns, so we again rated the practice as inadequate for providing safe care. We found that:

- There were no regular multi-disciplinary meetings held with other health professionals. This had not changed since the previous inspection.
- Although we saw posters on display which described the signs and symptoms of sepsis, clinical staff and reception / administration staff we spoke to could not clearly describe the signs and symptoms.
- There was no evidence of patient care plans on the system.
- There was a process in place to monitor the health of patients in relation to their use of high-risk medicines, however this was not effective.
- On the day of inspection, we found that prescription stationery was not kept securely, and its use was not monitored in line with national guidance. Vaccines were not appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.
- There was not an effective system for recording and acting on safety alerts.
- Where reviews of high-risk medicines had been undertaken, they were not recorded consistently in the patient's record.
- Significant events were not being reviewed effectively to identify learning. This had not improved since the last inspection.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|--|-------------|
| There was a lead member of staff for safeguarding processes and procedures. | Y |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |

| Safeguarding | Y/N/Partial |
|--|-------------|
| Policies took account of patients accessing any online services. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | P |
| The Out of Hours service was informed of relevant safeguarding information. | N |
| There were systems to identify vulnerable patients on record. | Y |
| 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. | N |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found that:</p> <ul style="list-style-type: none"> • There was no evidence of who the named safeguarding lead was for the practice. • There was no safeguarding policy that was specific to the practice. • There was no Disclosure and Barring System (DBS) system in place. • There was no system for oversight of what training staff had attended and when refresher training was due. <p>We found that these concerns had all been adequately addressed. However, during this inspection we identified new concerns:</p> <ul style="list-style-type: none"> • There were no regular multi-disciplinary meetings held with other health professionals. This had not changed since the previous inspection. • Although we saw posters on display which described the signs and symptoms of sepsis, clinical staff and reception / administration staff we spoke to could not clearly describe the signs and symptoms. | |

| 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. | Y |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found that:</p> <p>There was no recruitment policy or procedure in place and staff files were inconsistent.</p> <p>Staff immunisation information was not kept centrally.</p> | |

At this inspection, we found that these concerns had all been adequately addressed.

| 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: 26 February 2020 | Y |
| There was a record of equipment calibration. Date of last calibration: 26 February 2020 | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| There was a record of fire extinguisher checks. Date of last check: October 2020 | Y |
| There was a log of fire drills. Date of last drill: January 2020 | Y |
| There was a record of fire alarm checks. Date of last check: Each Friday | Y |
| There was a record of fire training for staff. Date of last training: Ongoing, renewed annually. | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed. Date of completion: April 2018 | Y |
| Actions from fire risk assessment were identified and completed. | N/A |
| Explanation of any answers and additional evidence: At the previous inspection we found that: <ul style="list-style-type: none"> • The practice was unable to confirm when checks had taken place. • There were no risk assessments for storage of hazardous substances. • We were not satisfied that the practice complied with the relevant health and safety regulations. At this inspection, we found that these concerns had all been adequately addressed. | |

| Health and safety | Y/N/Partial |
|--|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: June 2020 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2020 | Y |
| Explanation of any answers and additional evidence: | |

At the **previous** inspection, the practice was unable to confirm if or when the above assessments had been carried out.

At this inspection, the practice provided evidence to show that the assessments had been carried out and that any required actions had been completed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|--|-------------|
| There was an infection risk assessment and policy. | Y |
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: N/A | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| There was a system to notify Public Health England of suspected notifiable diseases. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection evidence showed that not all staff had received training on infection prevention and control.</p> <p>At this inspection, we found that all staff had attended the appropriate training.</p> <ul style="list-style-type: none"> Evidence was seen that potential infection control risks related to the COVID-19 pandemic had been considered and mitigated, although a formal documented risk assessment was not present. Infection control and prevention updates relating to COVID-19 had been disseminated to staff as they were received by the practice and staff were aware of their responsibilities. | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Y |
| There was an effective induction system for temporary staff tailored to their role. | Y |
| Comprehensive risk assessments were carried out for patients. | Y |
| Risk management plans for patients were developed in line with national guidance. | Y |
| The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | N |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | N |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | P |
| There was a process in the practice for urgent clinical review of such patients. | Y |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Y |
| Explanation of any answers and additional evidence: | |

- Although we saw posters on display which described the signs and symptoms of sepsis, clinical staff and reception / administration staff we spoke to could not clearly describe the signs and symptoms.
- Reception staff told us that in the event of a patient deteriorating in the surgery, they would call a clinician straight away. They told us they had not been given any guidance on this, although they had attended first aid training.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

| | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | N |
| Referral letters contained specific information to allow appropriate and timely referrals. | Y |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results, and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |
| The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff did not take part in multi-disciplinary team, (MDT) meetings, but were considering the possibility of joining a virtual team meeting in the near future. This was a repeat issue from the previous inspection. • We found no evidence of patient care plans. Staff we spoke to told us that the patient kept a hard copy of their individual care plan and the practice also kept a hard copy. We were not shown any evidence of the plans. <ul style="list-style-type: none"> ➤ Additional evidence following the inspection was sent to us and this showed that a system and process to include computerised care plans had been developed. | |

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization.

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA) | 0.81 | 0.92 | 0.85 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA) | 17.5% | 12.1% | 8.6% | Significant Variation (negative) |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2020 to 30/06/2020) (NHSBSA) | 6.11 | 6.27 | 5.35 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA) | 0.93 | 1.02 | 1.92 | Tending towards variation (positive) |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | N |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Y |

| Medicines management | Y/N/Partial |
|---|-------------|
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | 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. | N |
| 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. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | P |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | N |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Although the number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) was comparable to local and national guidelines, the number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set), (01/07/2019 to 30/06/2020) was significantly higher than local and national averages and had risen from 14.2% at the previous inspection to 17.5% at this inspection. There was no clear action plan for improvement. On the day of inspection, we found that prescription stationery was not kept securely, and its use was not monitored in line with national guidance, specifically, no records had been kept of blank prescriptions issued, meaning that a high number were unaccounted for. Additional evidence provided following the inspection showed that a system to ensure the safe storage of prescription stationery, had been implemented. Although the practice had a defibrillator on site, there were no paediatric pads available. Following the inspection, staff told us that paediatric pads had been ordered. On the day of the on-site inspection, we saw that the daily log for recording the temperature of the fridge in which vaccines were stored, was not complete; some weeks saw two or three days on which the temperature had not been recorded. <p>Additional evidence provided following the inspection showed that there was a digital system of recording the fridge temperatures. However, there was no evidence that the written log or the data from the SD card were being monitored.</p> | |

| Medicines management | Y/N/Partial |
|----------------------|-------------|
| | |

Track record on safety and lessons learned and improvements made

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

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | P |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | P |
| There was evidence of learning and dissemination of information. | N |
| Number of events recorded in last 12 months: | 13 |
| Number of events that required action: | 4 |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We spoke to a member of staff who advised us of a significant event which was not included in the log of significant events provided by the practice. Of the thirteen significant events recorded, six were identified as requiring no action, four were identified as requiring follow up action and three were identified as ongoing. Staff we spoke to on the day of inspection told us that they could not recall any significant events being discussed at a meeting. | |

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

| Event | Specific action taken |
|--|---|
| A referral was not tasked to a staff member to action. | It was agreed that a meeting would be arranged when the clinician returned from holiday. The lead GP was informed. This was discussed at a time to learn meeting. It was not clear what the outcome of this was. |
| A patient was prescribed seven months medication in seven weeks. | It was agreed that audits would be run, and staff were to inform management when errors were noticed. This was discussed at a time to learn meeting. It was not clear what the outcome of this was. |

| 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: <ul style="list-style-type: none"> Staff we spoke to were unclear about how they received information about safety and medicines alerts and how these were acted upon. Evidence received after the inspection reflected that patients an effective system was in place. | |

Effective

Rating: Inadequate

At our **previous inspection** we rated the practice as Requires Improvement for providing effective care, including all population groups. This was because:

Training records were incomplete and there was no oversight or monitoring. The performance indicators for patients with diabetes showed negative performance over time, with no plan in place for improvement. The data for two of the childhood immunisation indicators were below target for the year 2018/2019 and were also below target for the previous year 2017/2018, with no plan in place for improvement. The performance data for cancer indicators was below national averages for all five indicators and was below both local and national averages for four out of the five indicators. The data for cervical screening was also below local and national averages for 2018/19 and for the previous year, 2017/2018.

During **this inspection** we found that improvements in some areas had been made. However:

- Childhood immunisation uptake continued to be below the national minimum targets.
- Performance for some of the cancer performance indicators continued to be below local and national averages.
- There was no programme of quality improvement and information wasn't always used to make improvements about care and treatment.

Therefore, we have rated the population groups families, children and young people, and working age people as inadequate. The remaining population groups have been rated as requires improvement.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

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

| Prescribing | Practice performance | CCG average | England average | England comparison |
|--|----------------------|-------------|-----------------|--------------------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHSBSA) | 1.56 | 1.27 | 0.70 | Tending towards variation (negative) |

Older people

Population group rating: Requires Improvement

| Findings |
|--|
| <ul style="list-style-type: none"> 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. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks were offered to patients over 75 years of age. |

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

| 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. (01/04/2019 to 31/03/2020) (QOF) | 78.3% | 73.2% | 76.6% | No statistical variation |
| Exception rate (number of exceptions). | 1.3% (5) | 8.4% | 12.3% | 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 (01/04/2019 to 31/03/2020) (QOF) | 94.0% | 88.8% | 89.4% | No statistical variation |
| Exception rate (number of exceptions). | 7.4% (8) | 10.7% | 12.7% | N/A |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| 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 (01/04/2019 to 31/03/2020) (QOF) | 94.7% | 93.2% | 91.8% | No statistical variation |
| Exception rate (number of exceptions). | 5.0% (3) | 3.0% | 4.9% | N/A |

Any additional evidence or comments

Although improvements had been made since the last inspection, and action plan had not been put in place to achieve this.

Families, children and young people

Population group rating: Inadequate

Findings

- The practice had not met the minimum 90% for two of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- 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 immunization.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England) | 50 | 54 | 92.6% | 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) | 45 | 52 | 86.5% | Below 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England) | 46 | 52 | 88.5% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | 47 | 52 | 90.4% | Met 90% minimum |

Any additional evidence or comments

- The practice was aware of the performance data relating to childhood immunisations.
- The data for the two indicators which were below target (see above) had also been below target for the previous year.
- The practice told us that they took appropriate follow-up action for those children who had not received their vaccinations.

Working age people (including those recently retired and students)

Population group rating: **Inadequate**

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England) | 63.9% | N/A | 80% Target | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE) | 62.9% | 63.8% | 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) | 45.1% | 50.3% | 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. (to) (PHE) | | - | | 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) | 69.6% | 55.5% | 53.8% | No statistical variation |

Any additional evidence or comments

- The performance data for three cancer indicators was below national averages and was below both local and national averages for two of the indicators and had been for the previous year also.
- At the **previous inspection** in October 2019, the practice had told us that a new member of staff had recently been appointed and we were told that one of their priorities was to improve this data.
- At the **previous inspection** on October 2019, the practice told us that there were plans to visit a local mosque with the aim of educating community leaders of the importance of cervical screening.
- At **this inspection**, staff told us that they had delivered some information leaflets to a local mosque with the aim of promoting uptake, but on the day of inspection, this had not resulted in an increased uptake. We found no evidence of any action plan to improve uptake.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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

- 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, and cancer.
- Same day and longer appointments were offered when required.
- 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.
- Not all staff had received dementia training in the last 12 months.
- 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 | 65.6% | 76.9% | 85.4% | No statistical variation |

| | | | | |
|---|-----------|-------|-------|--------------------------|
| the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | | | | |
| Exception rate (number of exceptions). | 1.5% (1) | 20.4% | 16.6% | 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 (01/04/2019 to 31/03/2020) (QOF) | 81.3% | 84.2% | 81.4% | No statistical variation |
| Exception rate (number of exceptions). | 15.8% (3) | 6.1% | 8.0% | N/A |

Any additional evidence or comments

- The exception reporting rate for the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) was higher than local and national averages, although the total number of patients this related too was low (three).
- Evidence provided to us showed that only three staff had received dementia training.

Monitoring care and treatment

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

| Indicator | Practice | CCG average | England average |
|--|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 516.0 | 528.4 | 539.2 |
| Overall QOF score (as a percentage of maximum) | 92.3% | 94.5% | 96.7% |
| Overall QOF exception reporting (all domains) | 3.5% | 4.8% | 5.9% |

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

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

- There was minimal quality improvement work carried out.
- There was no evidence of a planned programme of audit and there was limited other quality improvement activity. For example, themes and trends were not looked at within complaints and

significant events analysis and there was limited evidence of action plans following identification of these.

- The practice provided evidence of audits which they had completed. However, there were no two-cycle audits indicating any evidence of improvement.

For example:

1. The practice had undertaken an audit of patients with a specific condition who were not prescribed a particular medicine. The result was that it was planned to offer five patients medication reviews and for those with no other contraindications, that particular medicine would be offered. It was not clear what the outcome was for these patients.
2. The practice had undertaken an audit of the prescribing of antibiotics according to NICE guidelines for patients with a specific condition. The audit found that of 811 patients with a record of that particular condition, 681 had been prescribed antibiotics in line with NICE guidelines. The conclusion was that clinicians would be reminded unless there is a reason not to do so, they should prescribe the first-choice antibiotic recommended by NICE. It was not clear what the outcome of this audit was.

Any additional evidence or comments

Effective staffing

The practice was able 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. | Y |
| The learning and development needs of staff were assessed. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Y |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| Explanation of any answers and additional evidence: | |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|--|-------------|
| 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. | N |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | N |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us that they had not attended any multi-disciplinary team (MDT) meetings, but consideration was currently being given to attending online MDT meetings in the future. | |

Helping patients to live healthier lives

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

| | Y/N/Partial |
|---|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Y |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Y |
| Patients had access to appropriate health assessments and checks. | Y |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Y |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us that there was nobody in the practice trained to offer stop smoking advice. Training had been postponed due to COVID-19. Staff told us that this would be followed-up. Staff referred patients to the social prescriber for further advice and guidance where appropriate. | |

| Smoking Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of patients with any or any combination of the following conditions: | 95.8% | 95.3% | 94.5% | No statistical variation |

| | | | | |
|---|----------|------|------|-----|
| 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 (01/04/2019 to 31/03/2020) <small>(QOF)</small> | | | | |
| Exception rate (number of exceptions). | 0.6% (8) | 0.7% | 0.8% | N/A |

Any additional evidence or comments

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

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

Caring

Rating: Good

Kindness, respect and compassion

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

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

- The practice told us that they had employed a member of reception staff who was Bengali which would assist with communication with Bengali patients. This member of staff was also chaperone trained.

CQC comments cards

| | |
|---|-----|
| Total comments cards received. | N/A |
| Number of CQC comments received which were positive about the service. | N/A |
| Number of comments cards received which were mixed about the service. | N/A |
| Number of CQC comments received which were negative about the service. | N/A |
| <ul style="list-style-type: none"> • We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when carrying out this inspection. We therefore undertook some of the inspection processes remotely and spent less time on site. In order to reduce the risk of infection, we did not ask patients to complete comment cards. | |

| Source | Feedback |
|-------------|--|
| NHS Choices | No feedback in the previous twelve months |
| Healthwatch | No feedback provided |
| Google | No feedback provided in the previous twelve months |

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 (01/01/2020 to 31/03/2020) | 74.7% | 85.6% | 88.5% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020) | 77.8% | 84.1% | 87.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020) | 90.4% | 94.7% | 95.3% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020) | 76.2% | 79.1% | 81.8% | No statistical variation |

| Any additional evidence or comments |
|---|
| <ul style="list-style-type: none"> Although there was only one indicator which showed a statistically negative variation when compared to local and national data, the remaining indicators were also lower in comparison. The practice told us that there may have been language or understanding issues when reading and responding to the survey, as they had a high number of patients on the patient list whose first language was not English. |

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

| Any additional evidence |
|--|
| <ul style="list-style-type: none"> Staff told us that they hadn't carried out any patient feedback exercises in the previous two years and that this was something that was due to take place. The practice collated data from the friends and family tests and staff told us that feedback was usually good with approximately 80% of people recommending the practice. |

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

| | Y/N/Partial |
|--|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Y |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke to told us that a social prescriber worked at the practice one day a week to enable patients to access community services. Staff we spoke to told us that they kept a list of vulnerable patients, which the social prescriber could access. | |

| Source | Feedback |
|---------------------------|--|
| Interviews with patients. | N/A - In order to reduce the risk of infection due to the COVID-19 pandemic, we did not ask patients to talk to us about their experiences of care on the day. |

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 (01/01/2020 to 31/03/2020) | 91.1% | 92.3% | 93.0% | No statistical variation |

| Any additional evidence or comments |
|-------------------------------------|
| |

| | Y/N/Partial |
|--|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | N |
| Information leaflets were available in other languages and in easy read format. | Y |
| Information about support groups was available on the practice website. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Most leaflets had been removed from the waiting area in line with COVID-19 guidance. | |

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | The practice has 50 carers on its register, which is slightly less than 1% of the patient list. |
| How the practice supported carers (including young carers). | The practice has access to a social prescriber. A staff member is the designated carers' champion. Carers are invited to receive the flu vaccination. Adhoc support is offered to carers when they attend the practice. |
| How the practice supported recently bereaved patients. | Staff contact recently bereaved patients to offer support and to signpost to local and national support services. |

Privacy and dignity

The practice respected respect patients' privacy and dignity.

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

If the practice offered online services:

| | Y/N/Partial |
|---|-------------|
| Patients were informed and consent obtained if interactions were recorded. | Y |
| The practice ensured patients were informed how their records were stored and managed. | Y |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | P |
| Online consultations took place in appropriate environments to ensure confidentiality. | Y |
| The practice advised patients on how to protect their online information. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> The data protection information on the website had not been updated to include online consultations, but staff we spoke to told us that video consultations were not kept and that any photographs were stored on the patient record, in line with the guidance. Although there were no formal arrangements to make staff and patients aware of privacy settings for remote consultations, staff we spoke to told us that they were aware. | |

Responsive

Rating: Requires Improvement

We rated this practice as requires improvement for responsive. This was because:

- There was limited learning from complaints.

This issue affected all population groups and therefore all population groups were also rated as requires improvement.

Responding to and meeting people's needs

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

| | Y/N/Partial |
|---|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Y |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Y |
| The practice made reasonable adjustments when patients found it hard to access services. | Y |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Although during the COVID-19 pandemic restrictions were placed on people accompanying patients to their appointments, where there was a clinically assessed need for the patient to have support to enable them to access care, they could be accompanied.• Staff told us that they assessed the communication needs of patients. If a patient had a communication requirement that needed them to be able to visually see the clinician to communicate, they would be offered either a video consultation or a face to face appointment, depending on need. | |

Practice Opening Times

| Day | Time |
|-----|------|
|-----|------|

| | |
|-------------------------|---------------|
| Opening times: | |
| Monday | 8am – 7.40 pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 7.40 pm |
| Friday | 8am – 6.30pm |
| | |
| Appointments available: | |
| Monday | 8am – 7.40 pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 7.40 pm |
| Friday | 8am – 6.30pm |
| | |

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 (01/01/2020 to 31/03/2020) | 94.3% | 93.8% | 94.2% | No statistical variation |

Any additional evidence or comments

| |
|--|
| |
|--|

Older people

Population group rating: Requires Improvement

| Findings |
|---|
| <ul style="list-style-type: none"> • All patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice did not provide effective care coordination to enable older patients to access appropriate services. |

People with long-term conditions

Population group rating: Requires Improvement

| Findings |
|---|
| <ul style="list-style-type: none"> • Patients with multiple conditions had their needs reviewed in one appointment. • The practice did not provide effective care coordination to enable patients with long-term conditions to access appropriate services. • The practice liaised with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. However, there was no formal structure in place. • Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. However, there was no formal structure in place. |

Families, children and young people

Population group rating: Requires Improvement

Findings

- Additional nurse appointments were available for school age children so that they did not need to miss school.
- 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Mother and baby post-natal checks were offered at the same time as the first childhood immunization appointment.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7.40pm on a Monday and Thursday.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

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

- Priority appointments were allocated when necessary to those experiencing poor mental health.

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

Timely access to the service

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

National GP Survey results

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

| 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 (01/01/2020 to 31/03/2020) | 53.3% | N/A | 65.2% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020) | 61.1% | 63.4% | 65.5% | 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 (01/01/2020 to 31/03/2020) | 58.6% | 61.8% | 63.0% | 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 (01/01/2020 to 31/03/2020) | 78.8% | 72.0% | 72.7% | No statistical variation |

Any additional evidence or comments

- The practice had recently installed a new telephone system with an increased number of lines to make it easier for patients to contact the practice.

| Source | Feedback |
|--------------------------|---|
| For example, NHS Choices | There was no feedback on NHS Choices or Google within the previous 12 months. |

Listening and learning from concerns and complaints

Complaints were listened and responded to but there was no evidence that they were used to improve the quality of care.

| Complaints | |
|--|---------------------------------|
| Number of complaints received in the last year. | 8 complaints since January 2020 |
| 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. | Y |
| There was evidence that complaints were used to drive continuous improvement. | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice provided us with a log of eight complaints for the period 1 January 2020 to 10 November 2020. Whilst we found that the practice made appropriate apologies and carried out an analysis of complaints, we saw little evidence of practice wide learning for improvements and to prevent occurrences being repeated. There was no process in place to identify and themes or trends. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|--|---|
| Patient discharged from hospital with no district nurse visits set up. The practice was asked to set up but as the patient was not housebound, they would not visit. | A letter was sent to the patient, offering sympathy and confirming that district nurses only visited housebound patients. |
| A patient was unhappy about the way they were spoken to by a clinician in their appointment. | The clinician wrote up a record of the event and a senior clinician contacted the patient and discussed the situation. The patient was then sent a letter of explanation. The patient was happy with the outcome. |

Well-led

Rating: Inadequate

At our **previous inspection** we rated this practice as requires improvement for providing well-led care. This was because: there was a lack of effective systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and there was a lack of effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

At **this inspection** we rated this practice as inadequate for providing well-led care. Some of the issues identified at the previous inspection had not improved sufficiently. We found that leaders could not demonstrate that they had sufficient involvement in the governance or performance of the practice. There was limited evidence of systems to monitor the effectiveness of care and treatment. Systems to identify and manage risks to patients were lacking. There was limited evidence of involvement of patients and third parties to improve the standard of care provided. There was a lack of assurance that decisions were made based on accurate and clear information.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels. However, leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care.

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | N |
| They had identified the actions necessary to address these challenges. | N |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">There was a lack of action plans to address areas where improvement was required. This was evident in the areas of concern identified at this inspection.Since our previous inspection the practice had needed to respond to the COVID-19 pandemic and the rapid changes that this had brought. They had addressed the issues and challenges raised by the pandemic as they occurred, however there was a lack of formal guidance specific to the practice, for staff to refer to on an ongoing basis. The practice cited ever changing guidance for this lack. | |

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. | Y |
| There was a realistic strategy to achieve their priorities. | N |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | N |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | N |
| Progress against delivery of the strategy was monitored. | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw that the practice had identified four points in their future planning, but these were not specific or measurable and were not monitored. • Staff we spoke to were unaware of the future plans for the service. • The plans the practice had made for the future did not include areas where improvement was needed. | |

Culture

The practice had a culture which drove high quality sustainable care.

| | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | P |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | P |
| The practice encouraged candour, openness and honesty. | Y |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| Explanation of any answers and additional evidence: Whilst we found that patients received an apology and informed of action taken, there was a lack of meaningful learning when things went wrong. | |

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

| Source | Feedback |
|------------------|--|
| Staff interviews | <ul style="list-style-type: none"> Staff told us that they felt supported and able to raise concerns. Staff told us that, overall, they enjoyed working at the practice. |

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, these were not always followed or adhered to.

| | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed. | N |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Although there were lines of governance and responsibility, these were not always implemented effectively. There was lack of clarity around the boundaries for responsibility between administrative and clinical leaders. | |

| |
|--|
| |
|--|

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. | N |
| There were effective arrangements for identifying, managing and mitigating risks. | N |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Service changes and developments since our previous inspection had been mainly driven by the COVID-19 pandemic, which continued to be a changing situation. • There was no programme of clinical audits. The audits provided to us by the practice were single cycle audits, with no clear evidence of improvement. | |

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

| | Y/N/Partial |
|--|-------------|
| Staff used data to adjust and improve performance. | N |
| Performance information was used to hold staff and management to account. | N |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | N |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had access to accurate information but did not always act on this to improve performance. • There was very limited audit activity or planning in place and it was not directed at the areas which needed most improvement. | |

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

| | |
|--|---|
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |
| Any unusual access was identified and followed up. | Y |
| Explanation of any answers and additional evidence: | |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|---|-------------|
| Patient views were acted on to improve services and culture. | P |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | P |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The service was last inspected in October 2019 and the majority of the time until this inspection was subject to the COVID-19 pandemic. During this time, changes to delivery of services was dependent on national and local legislation and guidance, so involvement of staff and stakeholders was not always possible. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| <ul style="list-style-type: none"> The new telephone system will help with patients getting through to the practice. They were aware of their roles and responsibilities. It had been difficult to carry on business as usual during the pandemic. |

| Any additional evidence |
|-------------------------|
| |

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | N |
| Learning was shared effectively and used to make improvements. | N |
| Explanation of any answers and additional evidence: | |

- We saw evidence of a range of training courses which staff had completed, however leaders at the practice did not always identify and share the learning from complaints and significant events.

Examples of continuous learning and improvement

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.