

# Care Quality Commission

## Inspection Evidence Table

### Blake House Surgery (1-1848256408)

Inspection date: 09 February 2022 (remote GP searches) 14 February 2022 (site visit)

Date of data download: 28 January 2022

## Overall rating: Requires Improvement

At the last inspection in November 2017, we rated the practice as Good overall.

At this inspection in February 2022, we rated the practice as Requires Improvement overall because:

- Effective systems and processes to ensure good governance in accordance with the fundamental standards of care had not been fully established. This included: safe management of medicines, infection prevention and control, the management of risk such as fire safety, and ensuring staff recruitment records and training were up to date.
- The practice did not have fully embedded systems and processes in place to keep patients safe: recording and learning from significant events and acting on complaints were not always sufficiently thorough and did not include any learning from the events.
- The practice did not have clear and effective governance processes and systems in place. Staffing at Blake House Surgery was vulnerable due to the staff shortages and recruitment difficulties.
- There was no documented development or succession plan for the practice.

## Safe Rating: Requires Improvement

At the last inspection in November 2017, we rated the practice as Good for Safe.

At this inspection in February 2022, we rated the practice as requires improvement for safe because:

- Some staff recruitment records were incomplete, and some pre-employment checks had not been undertaken.
- The provider did not have clear safeguarding systems in place to keep patients safe. Not all staff were up to date with the appropriate level of safeguarding training for their role.

- Systems and processes to support fire safety had not been implemented effectively as the provider had not carried out regular fire alarm testing.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a safeguarding lead and a deputy for adults and children however, the practices' child safeguarding policy was last reviewed in 2019. This meant there was a risk staff were not aware of current guidance in relation to safeguarding.</p> <p>The staff demonstrated they understood how to report any safeguarding concerns and where to access policies and procedures.</p> <p>The training matrix provided by the practice showed that two out of five GPs had not received adult and child safeguarding training to level three as recommended by the intercollegiate guidance for child safeguarding published in 2019.</p> <p>We reviewed two locum GP files (a locum is a person who temporarily fulfils the duties of another) which were incomplete, as there was no proof disclosure and barring checks (DBS) had been carried out. Therefore we could not be assured the correct recruitment procedures or checks had been followed.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	

We reviewed five staff recruitment files and we found that not all of them were complete. For example, three staff recruitment files did not hold any interview summaries and one recruitment file did not have proof that an induction process took place.

At the time of the inspection, there was no system in place to check individual clinician registration records or to ensure they were up to date. The practice immediately set up a process to ensure this was now actioned.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: February 2022 Actions from fire risk assessment were identified and completed. None identified	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Fire Safety:</p> <p>The fire risk assessment was reviewed by the practice in February 2022. However, we found that:</p> <ul style="list-style-type: none"> <li>• There was insufficient information documented to indicate that regular fire alarm testing was being completed.</li> <li>• The fire safety policy was out of date and had not been reviewed since 2020. The policy stated to report concerns to an employee who no longer worked at the practice.</li> <li>• Three out of twelve staff had not completed the fire safety training as per the practice policy.</li> </ul> <p>Control of Substances Hazardous to Health (COSHH):</p> <ul style="list-style-type: none"> <li>• We found chemicals (cleaning products and alcohol gel) inadequately stored in a locked shed. There was no signage stating there were chemicals and flammable products being stored there.</li> </ul> <p>The practice did have:</p> <ul style="list-style-type: none"> <li>• There was an appropriate person trained as a fire warden however not all staff were aware of who this was.</li> <li>• Staff were able to describe the fire procedures, for example, where the fire assembly point was and what assistance they would give to anyone with a disability or reduced mobility.</li> <li>• Fire drills had been completed regularly and the most recent one took place in February 2022.</li> <li>• Documentation demonstrated actions taken to reduce the risk of Legionella (Legionella is a bacteria that can cause a serious type of pneumonia (lung infection) called Legionnaires disease). We saw evidence that water temperature checks had been carried out on a regular basis.</li> </ul>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 20 October 2021 Clinical waste full audit: February 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice's infection prevention and control (IPC) policy stated all staff would receive training on an annual basis. Records sent to us prior to the inspection showed four GPs out of five were not up to date with IPC training and some clinical staff had not completed any update training since 2017. This meant we could not be assured the practice staff had up to date knowledge on how to manage risks around infection control.</p> <p>Clinical audits had been carried out and findings acted upon however the feedback from these audits were not formally documented or discussed at the monthly staff minutes.</p> <p>The practice's IPC policy made no reference to COVID-19 or the current guidelines with regards to the use of personal protective equipment (PPE). There were no specific risk assessments in place for managing the pandemic however:</p> <p>Senior management told us how they kept up to date with the daily guidance from the Department of Health and the local Clinical Commissioning Group (CCG), and this information was disseminated to all staff.</p> <p>We observed the following measures in place to reduce the risk of COVID-19 infection:</p> <ul style="list-style-type: none"><li>• We observed staff wearing PPE and the premises were visibly clean and tidy on the day of the inspection.</li><li>• Staff told us extra time was built into the appointment system enabling them to clean all surfaces between patients.</li><li>• Alcohol gel was located at the entrance and throughout the building. There was signage prompting people to use it.</li><li>• The practice employed their own cleaner and we saw cleaning schedules in place.</li><li>• National guidance was followed to reduce the footfall during the COVID-19 pandemic. Patients were able to use online services, email and telephone consultations.</li></ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff had access to information about the signs and symptoms of sepsis and the deteriorating patient, and they were aware of what actions to take. All clinical staff had undertaken sepsis awareness training, although non-clinical staff had not been offered this training.</p> <p>The practice had a period of instability during the COVID-19 pandemic due to staff illness and isolation. Senior management told us that they were struggling to recruit for clinical and non-clinical staff due to the rural location of the practice.</p> <p>Three staff responded to the Care Quality Commission (CQC) survey ahead of the inspection. Their responses highlighted themes:</p> <ul style="list-style-type: none"><li>• Staff told us that they cover each other during annual leave and sickness due to the lack of staffing arrangements however, this can lead to a buildup of work as some specific roles have no staffing cover in place such as the nursing role.</li><li>• Some staff highlighted that there is an increase in patient demand but not enough GPs: therefore, locums were being used.</li><li>• Staff told us they are aware of the recruitment challenges.</li></ul>	

## 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:  The practice had a written protocol setting out the management of blood tests and results. This also included guidance on what to do with test results should the named clinician be on annual leave.  Clinical records demonstrated patients had been referred to secondary health services in a correct and timely manner.	

## Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However processes did not always align with best practice ensuring patients would be safe.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.78	0.71	0.71	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2020 to 30/09/2021) (NHSBSA)	12.5%	9.9%	9.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2021 to 30/09/2021) (NHSBSA)	7.25	5.77	5.32	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	205.5‰	143.1‰	128.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.69	0.77	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	4.9‰	7.5‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance	Yes

Medicines management	Y/N/Partial
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	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>On the day of inspection, we were advised that the controlled drugs (CDs) cupboard keys were all kept together in the safe on the same key ring. This meant there was a risk of not being able access the CD medicines if the keys went missing.</p> <p>Patient Group Directives (PGDs) were up to date with a system for monitoring expiry dates and updating as required. However, the PGDs were adopted for use within the practice by the practice manager with no clear documentation of authority to do this within their job description.</p> <p>Emergency medicine was stored securely on both clinical floors of the building, however, there was no risk assessment in place to determine the range of medicines held.</p>	



Medicines management	Y/N/Partial
<p>The practice had a cold chain policy which was reviewed in February 2022, however, one of the named responsible persons was no longer employed at the practice. On the day of the inspection there was no cold chain records for vaccines delivered to the practice as per the policy.</p> <p>As part of our remote clinical searches, we reviewed patient records to ascertain the appropriate monitoring and clinical reviews were being carried out. We found 148 medication reviews had been carried out within the last three months and these were well structured.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Partial
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Partial
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Partial
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The practice's Standard Operating Procedures (SOPs) had not been reviewed since 2017, and a previous GP that is no longer employed by the practice was still named on these. There was no evidence of any regular auditing of these SOPs.</p> <p>We spoke with dispensary staff who explained the training they had undertaken however, it was unclear who was responsible for their competency checks and how often these were carried out.</p>	

Medicines requiring refrigeration must be stored at temperatures ranging between +2 to +8C. The purpose of monitoring is to ensure that the medicines are fit for purpose at the time they are needed. Therefore, monitoring should be continuous, with the temperatures being recorded each day the practice is open.

We reviewed records of the fridge temperatures within the dispensary for the previous month (January 2022) and found there were 12 gaps within the recording. This meant there were no robust systems in place to ensure medicines requiring refrigeration were stored safely.

The practice's dispensary provided a delivery service to enable medicines to be taken to designated collection points, however, on the day of the inspection staff were unable to locate the risk assessment or SOP that was in place to ensure the process was being correctly followed. The practice immediately sent us the required process following the inspection.

## Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong however this process was not yet embedded.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	13
Number of events that required action:	9
Explanation of any answers and additional evidence:	
<p>We received three staff responses to a CQC survey where staff advised us:</p> <ul style="list-style-type: none"> <li>They were aware of how to raise a significant event and these were then discussed at the monthly practice meetings.</li> </ul> <p>Senior staff advised us they recently started adding significant events to a new system called PITCH. PITCH is a computer designed system to log themes and trends for good practice and was introduced by the Devon Clinical Commissioning Group (CCG). However, this system and process was not yet fully understood by the staff and they needed further training which had been organised.</p> <p>On the day of the inspection, we saw a number of incomplete significant event recordings, for example, no actions had been identified within the individual significant event and other events were brief in description and it was unclear who was responsible for investigating the event. Following the inspection, the practice had introduced a standardised recording process to ensure learning and actions could be shared better with the team.</p> <p>We saw minutes from the monthly practice meetings and significant events were a standing agenda item and discussed amongst the team. The practice had a significant event policy in place however, it was last reviewed in 2020.</p>	

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

Event	Specific action taken
A message was left with a patient's family member regarding their COVID-19 clinic appointment.	Staff were reminded that personal information was not to be discussed with family members or information to be left on an answer phone unless the practice had the correct authorisation in place to do so.

Ascorbic Acid (a natural water-soluble Vitamin C) 50mg was dispensed instead of 500mg as part of the patient's monthly repeat prescription.	This was a repeat prescription, so the patient was not left without any medicine. The dispensary ordered the correct strength and apologised to the patient.
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Safety alerts		Y/N/Partial
There was a system for recording and acting on safety alerts.		Yes
Staff understood how to deal with alerts.		Yes
<p>Explanation of any answers and additional evidence:</p> <p>We carried out remote clinical searches and reviewed five patient records to ensure safety alerts were acted upon, we saw examples of recent actions taken:</p> <ul style="list-style-type: none"> <li>Three out of the five patients reviewed were taking a combination of Simvastatin and Amlodipine together (Simvastatin is a medicine to treat high cholesterol and Amlodipine is a medicine to treat high blood pressure). A medicines alert advised reducing the dosage of Simvastatin to 20mg if used in combination with Amlodipine or changing to a different medicine combination.</li> </ul> <p>The practice had a system and policy in place for receiving and managing safety alerts including medicine alerts from Medicines and Healthcare products Regulatory Agency (MHRA). The lead GP partner had oversight for the quality assurance of actions taken. However, when asked, some staff were unsure of the process they should follow.</p>		

## Effective

## Rating: Good

At the last inspection in November 2017, we rated the practice Good for providing effective services.

At this inspection in February 2022 we have rated the practice as Good for providing effective services.

*QOF requirements were modified by NHS England for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</li><li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li><li>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li></ul>

- 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. We were advised that any concerns or queries could be raised on the day to the GPs.
- All patients with a learning disability were offered an annual health check.
- GPs at the practice carried out weekly visits to two local care homes and reviewed the needs of patients on a regular basis.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

We carried out remote clinical searches and sampled patient records to establish that management of their conditions was effective. We found:

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

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) (01/04/2019 to 31/03/2020) (NHS England)	16	17	94.1%	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) (01/04/2019 to 31/03/2020) (NHS England)	26	26	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	26	26	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	26	26	100.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	22	24	91.7%	Met 90% minimum

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

#### Any additional evidence or comments

The practice was proactive in contacting parents to set up appointments for children who were due immunisations and were flexible with regards to appointment times.

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: 30/06/2021) (Public Health England)	71.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) ( to ) (PHE)		-		N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) ( to ) (PHE)		-		N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	38.5%	56.6%	55.4%	No statistical variation

#### Any additional evidence or comments

We asked the provider about the low uptake rates for cervical screening. We were advised that patients were being contacted via text messages and offered flexible appointments' practice offered cervical screening appointments predominately on a Tuesday afternoon however any patients unable to attend this clinic could make appointments at other times.

The practice only had one trained nurse employed to carry out cervical screening appointments. We were advised that the practice had been trying to recruit for further nurses without success. This meant there were challenges in covering clinic appointments sickness or annual leave. We were told nurse cover was available from the Primary Care Network (PCN), however, sometimes clinic appointments were cancelled due to the shortage of nursing staff.



## Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice had identified that they had a high level of antibiotic prescribing and actioned an ongoing audit in regard to the prescribing of antibiotics to treat Urinary Tract Infections (UTIs). This was part of an antibiotic stewardship programme promoting the appropriate use of antibiotics to improve patient outcomes. The practice reviewed all patients on long term antibiotic treatment and recalled these patients for further assessment and changes to treatment were made where clinically appropriate.

## Effective staffing

**The practice were able to demonstrate that staff had the skills, knowledge and experience to carry out their roles however there was no programme of learning and development and appraisals were delayed due to Covid-19.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:  The practice was unable to evidence a structured programme of learning and development for staff. However, we saw evidence of online learning and staff we spoke with told us that the practice was encouraging and supportive when approached about further training to enhance their roles.  The practice told us that some staff annual appraisals had been delayed due to the COVID-19 pandemic, staff we spoke with on the day of the inspection advised us that there were plans in place for these to be completed.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence:  The practice signposted patients to relevant services to support smoking cessation and for tackling obesity.  As part of a PCN the practice was able to provide an in-house physiotherapist, a social prescriber and a counsellor who all visited the practice once a week. GPs were able to refer patients directly into these services.	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence:  We saw evidence that staff asked for verbal consent prior to carrying out injections and cervical screening, this was recorded in the relevant templates.	

## Caring

## Rating: Good

Blake House was rated Good for the provision of caring services at the previous inspection in November 2017. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key question have been carried through to contribute to the overall rating for the practice.

## Responsive

## Rating: Good

Blake House was rated Good for the provision of responsive services at the previous inspection in November 2017. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key question have been carried through to contribute to the overall rating for the practice.

### Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: The practice carried out regular welfare telephone calls to the elderly and vulnerable patients and if required appointments were made. The staff we spoke with explained that they knew their patients well and would ensure they had longer appointment times if needed.	

## Well-led Improvement

Rating:

Requires

At the last inspection in November 2017, we rated the practice Good for providing Well-led services.

At this inspection in February 2022, we rated the practice as Requires Improvement for providing Well-led services because:

- The practice did not have clear and effective governance processes and systems in place.
- Staffing at Blake House Surgery was vulnerable due to the staff shortages and recruitment difficulties.
- There was no documented development or succession plan for the practice.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.
- There was no process in place to measure the delivery of the practice strategy.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence:  There were regular monthly team meetings to discuss all aspects of the practice. All meetings had an agenda and minutes were recorded.  The GP partnership consisted of a sole GP and a non-clinical supporting partner. The partners told us they were aware of the challenges they faced such as a growing patient list and difficulty in recruiting clinical staff due to the rural area.  At the time of the inspection there was no development or business plan in place to address any actions necessary to mitigate these challenges. However following the inspection we were advised that a development programme and minutes from business meetings had been introduced.	

## 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 vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: The practice had a documented mission statement on its website; however, staff were unaware of the vision and there was no documented evidence to demonstrate what progress was being made against the strategy and how this was being monitored.	

## 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: Staff told us they felt confident to raise any concerns and felt the appropriate actions would be taken.  Staff we spoke with were not aware of how to access a Freedom to Speak up Guardian and there was no allocated individual. The practice's policy stated a Freedom to Speak up Guardian would be introduced in 2017, however, this has not been actioned.	

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

Source	Feedback
CQC staff survey and staff interviews.	Staff who responded to a CQC survey and those who we spoke with told us that all the management team cared about their patients and went the extra mile for them. The practice offered so much to the local community and the patients appreciated this. All the staff highlighted what a great team they worked with.

## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<p>The practice did not have an overarching governance framework in place this included:</p> <ul style="list-style-type: none"> <li>• Staff recruitment records did not provide assurance of safe staff appointments being made.</li> <li>• Systems and processes were not fully embedded for effective oversight of significant events and complaints.</li> <li>• We found health and safety requirements were not fully in place with fire safety checks not being regularly carried out.</li> </ul>	



## 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.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have fully embedded systems and processes in place to manage risk such as:</p> <ul style="list-style-type: none"> <li>• Staff recruitment records were not complete or up to date.</li> <li>• There were gaps in the identification of potential fire safety risks.</li> <li>• Long term challenges of recruitment and reduced staffing had the potential to affect the resilience of the team.</li> </ul> <p>The practice could not demonstrate it had an effective programme of quality improvement in place to improve care and treatment.</p>	

**The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes

There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Face to face appointments took place during the pandemic with social distancing and the use of personal protective equipment as per national guidelines.</p>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial
Explanation of any answers and additional evidence:  Statutory notifications to the CQC had not always been submitted as required. For example, one of the partners had been off for a period of time and we had not been informed of this. There was no system in place to enable the practice to identify when a notification had been missed.	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

## Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:  Three staff responded to a CQC survey ahead of the inspection and advised us that they were able to put forward any ideas or suggestions for improving the service on a regular basis.	

Feedback from Patient Participation Group.

Feedback
<p>The practice had an active PPG group that had been operating for several years. The group had approximately seven members and met every three months. The group had been involved in several projects such as:</p> <ul style="list-style-type: none"><li>• Fundraising for new couches and blood pressure machines for the consultation rooms and pulse oximeters to enable patients to monitor oxygen levels at home during the pandemic.</li><li>• Raising funds for a new lift.</li></ul>

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:  The practice provided placements for registrars training to be qualified GPs. At the time of the inspection, there was one trainer providing support and tuition for one registrar.  The practice had yet to embed systems and processes to ensure evidence of learning and improvement was shared from significant events and complaints.	

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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- 
- $\text{‰}$  = per thousand.