

Care Quality Commission

Inspection Evidence Table

Queens Bower Surgery (1-2773012316)

Inspection date: 1 December 2020

Date of data download: 30 November 2020

Overall rating: Inadequate

At our previous comprehensive inspection on 10 December 2019 we rated the practice inadequate overall with ratings of requires improvement for safe services, inadequate for effective and well-led services and good for caring and responsive services.

At this inspection on 1 December 2020, we found the provider had made some improvements and addressed some but not all areas of concern found at previous inspections. Additionally, we found significant failings relating to clinical management of patients.

We have rated the practice inadequate overall with ratings of inadequate for safe, effective, caring, responsive and well-led services.

The issues identified impact on all population groups. Therefore, the practice is rated as inadequate for the population groups of older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

Safe

Rating: Inadequate

At the last inspection in December 2019 we found the practice to be requires improvement in providing safe services because:

- Safeguarding processes required strengthening to ensure arrangements were in place to follow up all non-attendance at children's appointments, and to demonstrate that all adults at risk of significant harm were discussed at meetings with other health and social care professionals.
- Staff files did not always include all the relevant information to support safe recruitment.
- Staff immunisation records were incomplete.
- Fire alarm and emergency lighting systems documentation was not available to evidence records of servicing and maintenance by an external company.
- Appropriate storage was not in place for the effective management of clinical specimens.
- Staffing levels were not always sufficient and documented induction records for temporary staff were not in place.

- Up-to-date risk management plans and risk assessments, and evidence of annual reviews, were not in place for all patients with mental health conditions.
- Robust fail-safe processes for ensuring that two-week referral appointments and cervical screening results were received were not in place at the time of our inspection visit.
- Appropriate action had not been taken in relation to a significant event.

At this inspection, we found some of these areas had been addressed. However, we have rated the practice as inadequate in providing safe services because:

- The systems to identify vulnerable patients were not applied consistently.
- Staff files for agency staff did not always include all the relevant information to support safe recruitment.
- Urgent requests for appointments and medication from patients had not been acted on.
- Some test results had not been communicated to patients.
- The overall processes for managing medicines were not always effective. This included processes for the safe handling of requests for repeat medicines, structured medicines reviews for patients on repeat medicines and monitoring patients' health in relation to the use of medicines including high risk medicines.

Safety systems and processes

The practice did not have fully effective 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
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.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial ¹
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial ²
Explanation of any answers and additional evidence:	
¹ We looked at three records of children on the safeguarding register and found that the use of alerts in the patient records was not consistent. There were no safeguarding alerts in the demographics information, and some had alerts on the main home page whilst others did not. Additionally, patients	

Safeguarding	Y/N/Partial
<p>who had been involved in domestic violence were not always appropriately coded on the clinical system for identification.</p> <p>²At the previous inspection we found safeguarding processes required strengthening to ensure arrangements were in place to follow up all non-attendance at children's appointments, and to demonstrate that all adults at risk of significant harm were discussed at meetings with other health and social care professionals. At this inspection we viewed a record of a child on the safeguarding register and found they had attended secondary care for a head injury, and this was not followed up for several weeks, until they were seen at the practice for a different reason. This meant systems for follow up were still not fully effective.</p> <p>We saw evidence of a meeting between the practice and the health visitor in October 2020. Whilst the practice informed us meetings had not taken place earlier for several months due to the COVID-19 pandemic, they told us they communicated with other health care professionals as and when needed during that period.</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.	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 our previous inspection in December 2019 we found staff files did not always include all the relevant information to support safe recruitment and staff immunization records were incomplete.</p> <p>At this inspection, we checked six recruitment files and found five of these contained all relevant information. There was no evidence of recruitment checks done, including immunization records, for one locum GP at the time of inspection; the practice stated that the appropriate checks had been done through the agency providing the doctor and they would obtain a record of this after the inspection.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 14/02/2020</p>	Y
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: 15/02/2020</p>	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y ¹
There was a fire procedure.	Y
<p>There was a record of fire extinguisher checks.</p> <p>Date of last check: 02/01/2020</p>	Y
There was a log of fire drills.	Y

Date of last drill: 20/09/2020	
There was a record of fire alarm checks. Date of last check: 20/11/2020	Y ²
There was a record of fire training for staff. Date of last training: Various dates.	Y ³
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 23/11/2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: ¹ Following our previous inspection, a risk assessment was now in place for the storage of oxygen. ² At the previous inspection in December 2019 we found there was no documentation to evidence that fire alarms had been serviced by an external company and emergency lighting required updating. At this inspection we found both actions had been completed. ³ Staff were up to date with their fire training.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 23/11/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 23/11/2020	Y
Explanation of any answers and additional evidence:	

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: 16/11/2020	Y ¹
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 ²
Explanation of any answers and additional evidence:	
<p>¹An infection prevention and control audit had been carried out internally by the practice using the same methodology used by external providers who had previously carried out the audits. This included an assessment in response to the COVID-19 pandemic. This incorporated access to personal protective equipment (PPE), systems to ensure social distancing including the use of remote consultations, and the provision of dedicated time for cleaning in-between any face-to-face patient consultations.</p> <p>²Since our previous inspection in December 2019, a cleaner now attended the practice on every working day at the practice was open. A protocol was now in place regarding the handling of clinical specimens when received by patients. This stated that patients could only drop off samples before 11am daily as they had one collection only for pathology samples that required testing off site, and the practice did not have overnight storage for them.</p>	

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.	N ¹
Risk management plans for patients were developed in line with national guidance.	N ²
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	N ³
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	N ³
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N ⁴
Explanation of any answers and additional evidence:	

¹At this inspection, we found numerous urgent requests from patients that had not been acted on. Many of the appointments had not been undertaken and some of them were urgent. These included patients in pain and those who needed urgent medication. Patients had not been contacted, therefore comprehensive risk assessments were not carried out.

²As part of the inspection, we ran a set of standard clinical searches on the practice clinical system. On the day of inspection we re-ran the searches and analysed the results which showed patients were not being monitored in line with national guidance. National guidance had been adjusted to account for the impact of the COVID-19 pandemic by extending some intervals for monitoring, whilst keeping people safe. Whilst some patients had been reviewed in response to our initial searches, there remained a number of patients whose monitoring was outstanding on the day of inspection.

³ There was no clear system for managing the requests to ensure they were all reviewed and acted on. Whilst we found evident that the reception team triaged patients with urgent needs correctly, we could not be assured that urgent requests passed on to the GPs were acted on promptly as required. We saw one record where the receptionist had appropriately advised a patient to call emergency services. However, another patient who had requested an urgent telephone call from a GP in the morning had their request eventually passed on to another GP for action in the evening, after telephoning the practice several times to follow up on their request. Therefore, we could not be assured clinicians knew how to identify and manage patients who could have severe infections including sepsis.

⁴Given the concerns above, we could not be assured that the practice monitored the impact on safety when there were changes to services or staff.

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.	N ¹
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.	Y
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 ²
There was a documented approach to the management of test results and this was managed in a timely manner.	N ³
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N ³
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹During our clinical review, we found some individual care records where consultations were not written as the patient had not been assessed. We saw inadequate history and examination documentation in some records.</p> <p>²At our previous inspection in December 2019, we found there were no effective fail-safe processes for ensuring that two-week referral appointment and cervical screening results were received. At this inspection, we found there was a documented system in place and staff were able to describe how they followed up and audited referrals and cervical screening results.</p> <p>³At this inspection, we found that some test results had not been communicated to patients who were telephoning the practice several times to speak to a doctor about their results. On reviewing some patient records, we found that some medications had been changed with no communication with the patients or apology offered to them. This meant patients were not receiving timely information about their care and treatment and subsequently put at risk of deterioration and poor outcomes.</p>	

Appropriate and safe use of medicines

The practice did not have fully effective 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) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.95	0.82	0.82	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). (01/10/2019 to 30/09/2020) (NHSBSA)	5.5%	8.0%	8.8%	Tending towards variation (positive)
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 (01/04/2020 to 30/09/2020) (NHSBSA)	4.42	4.69	5.34	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	109.7‰	125.3‰	124.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	0.51	0.59	0.68	No statistical variation

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

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N ¹
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N ¹
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.	N ²
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹At the previous inspection in December 2019, we found that medicines reviews of patients with mental health conditions were not fully up to date. At this inspection, we reviewed some records of patients with dementia and found they had the appropriate care plans in place. However, we found several medication reviews had not been to an appropriate standard in some patients:</p> <ul style="list-style-type: none"> • Patients were coded as having had a medication review without reviewing all medications or checking that the quantities were aligned. There was no evidence of communication with patients regarding quantities taken and/or changes to their medications. • Allergies to medicines were not coded appropriately to enable easy identification. • There was no evidence of changes to medicines dosage as requested by consultants in one patient. • Contradictory dosages in one patient's records had not been amended during a medication review which had taken place and the use of off license medicine had not been discussed or reviewed with the patient. • There was no clinical oversight of medication reviews undertaken by locum doctors. <p>²The process for monitoring patients' health in relation to the use of medicines including high risk medicines was not effective. The provider had reviewed some records of patients on high risk medicines following our initial clinical searches prior to the inspection, but others remained outstanding on the day of inspection.</p>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none">• We identified three patients who were prescribed lithium (a high-risk medicine used to treat patients with bipolar disorder), and all three were still overdue their monitoring despite the monitoring intervals being extended from six months to nine months during the COVID-19 pandemic.• Four patients who were on medicines used to thin blood had not received regular monitoring of their kidney function, putting them at increased risk of side effects.	

Track record on safety and lessons learned and improvements made

The practice did not always learn and make improvements in relation to safety alerts.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	2
Number of events that required action:	1
Explanation of any answers and additional evidence: The practice had recorded two significant events, one relating to a patient with pressure sores and another relating to a potential missed diagnosis of diabetes in a child. The practice reviewed their involvement in the care of the patient with pressure sores and found there had been no missed opportunities on their part, therefore no actions were required, and no learning identified. Learning was identified following the potential missed diagnosis incident and this was shared with all staff to increase awareness and prevent recurrence in future. Therefore, appropriate actions had been taken in respect of the significant events.	

Example of significant event recorded and actions by the practice.

Event	Specific action taken
During consultation with a GP, a mother reported their young child was drinking more and passing more urine. Sugars were not tested. The child was admitted to hospital the following day and diagnosed with diabetic ketoacidosis. They were discharged with no long-term complications from the hospital.	Learning was shared with other members of clinical team (locum GPs including the doctor involved), and the reception team. A poster was made for all treatment rooms encouraging clinicians to be vigilant for diabetic ketoacidosis in undiagnosed diabetic patients, in particular children, and the checking of blood sugars if in any doubt regarding this.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: Whilst there was a system in place for receiving safety alerts, we found that alerts were not acted on effectively. We found several patient records where medicines were not reviewed in line with Medicines and Healthcare Products Regulatory Agency (MHRA) drug safety updates which indicated they could cause potential harm. An alert relating to patients receiving Citalopram (an antidepressant medicine)	

had been acted on just before our inspection took place, following the clinical searches we ran prior to the inspection.

Other alerts issued by the MHRA which had not been acted on in some patients included:

- Patients taking medicines to thin blood, especially those at increased risk, for example the elderly and those with renal impairment;
- Patients on Amlodipine (a medicine used to treat high blood pressure) which should not be prescribed together with more than 20mg of Simvastatin (a cholesterol lowering medicine) a day;
- Patient on omeprazole (a medicine used to reduce stomach acid) who should not be prescribed in combination with Clopidogrel (a blood thinning medicine), due to Omeprazole reducing the effectiveness of Clopidogrel as an antiplatelet agent, potentially increasing the risk of stroke in patients already at increased risk of stroke as it is prescribed to patients who have previously had a transient ischaemic attack or stroke.

Effective

Rating: Inadequate

At the last inspection in December 2019 we found the practice to be inadequate in providing effective services because:

- The practice had some policies and procedures, but clinical protocols required further development to support non-medical staff when carrying out some clinical tasks.
- The practice's performance in several clinical areas was below local and national averages, including mental healthcare and childhood immunisation uptake rates.
- Only two of 21 patients with a learning disability had received an annual health check.
- A documented induction process was not in place for employed staff.
- Documented clinical supervision arrangements were not in place for temporary staff.

At this inspection we found some of these areas had been addressed. However, we have rated the practice as inadequate in providing effective services because:

- Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice did not have a fully comprehensive programme of quality improvement activity which routinely reviewed the effectiveness and appropriateness of the care provided.
- Staff were not always consistent and proactive in helping patients to live healthier lives.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N ²
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N ²
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N ³
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.	Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
Explanation of any answers and additional evidence:	

¹There was no clinical oversight of temporary staff to ensure they were working in line with best practice. We saw evidence of poor medication reviews undertaken by temporary clinical staff, including long term locum GPs.

²A clinician failed to consult with patients who had been made appointments (via telephone), including those with urgent needs, in order to be able to assess their conditions, address their concerns and respond to their requests. We saw appointment slots for patients who had requested for a call back from the GP in order to be assessed to determine if they needed to be seen face to face, patients calling to request medicines and patients following up on blood tests had not received a call back from the clinician on the day, nor followed up afterwards at a later date by the clinician.

³Patients with long term conditions and those taking high risk medicines were not managed and reviewed within recommended timescales, and clinicians did not always take appropriate action to update records following correspondence from other professionals.

Some of our findings in respect of responding to immediate and ongoing clinical needs, coding, medicine management, medicine reviews and potential missed diagnoses impacted on all population groups and therefore, all groups have been rated as inadequate.

Older people

Population group rating: Inadequate

Findings

- 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.
- We found clinicians did not always respond to patients' immediate and ongoing needs. Therefore, we could not be assured that the practice followed up on all older patients discharged from hospital to ensure that their care plans and prescriptions were updated to reflect any extra or changed needs.
- We saw evidence indicating medication reviews for older patients were not always carried out in a structured and appropriate manner.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings

- Patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. At this inspection, we found medication reviews were not completed effectively. Some patients had changes made to their medicines without discussion with them to check compliance, side effects or effectiveness of the medicines.
- The practice could not demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes. A search identified six patients with a potential missed diagnoses of diabetes, who had raised blood glucose levels on two separate occasions in the presence of symptoms suggestive of diabetes such as thirst, weight loss or excessive urination. Therefore, these patients had not been included in the practice recall programme for regular monitoring of their diabetes to ensure their conditions were under control and did not deteriorate.
- Patients with asthma were not appropriately managed. At this inspection, we found 15 patients who had been prescribed 12 or more inhalers in the last 12 months, which suggested their asthma was poorly controlled and preventative treatment may need to be increased.
- We found clinicians did not always respond to patients' immediate and ongoing needs. Therefore, we could not be assured that the GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

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)	82.2%	79.0%	76.6%	No statistical variation
PCA* rate (number of PCAs).	2.1% (5)	10.6%	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)	90.0%	89.2%	89.4%	No statistical variation
PCA rate (number of PCAs).	5.3% (5)	11.6%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	74.5%	81.6%	82.0%	No statistical variation
PCA rate (number of PCAs).	1.0% (1.0)	4.7%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	52.6%	64.9%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.1% (5.0)	14.6%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	68.9%	72.6%	72.4%	No statistical variation
PCA rate (number of PCAs).	1.7% (7.0)	6.4%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	87.0%	94.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	1.8% (1)	5.7%	4.9%	N/A

Any additional evidence or comments

At the previous inspection in December 2019, the practice told us they were recruiting a permanent practice nurse to help with performance in the care of people with long term conditions. At our inspection we found the practice had not managed to recruit a permanent practice nurse and were supported by two part-time long-term locum nurses. However, the nurses were not directly responsible for or involved in chronic disease management.

Findings

- The practice has not met the minimum 90% for all 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 all four childhood immunisation uptake indicators. There was a nominated member of the administration team who worked with the practice nurses to contact parents or guardians who had declined immunisations to encourage uptake and liaise with health visitors when necessary.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- At the previous inspection in December 2019 we found the practice did not have clear arrangements for following up failed attendance of children's appointments following an appointment in secondary care. At this inspection we found the arrangements had not improved. We viewed a record of a child on the safeguarding register and found they had attended secondary care for a head injury, and this was not followed up for several weeks, until they were seen at the practice for a different reason.
- 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)	30	36	83.3%	Below 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)	38	46	82.6%	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)	38	46	82.6%	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)	38	46	82.6%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2018 to 31/03/2019) (NHS England)	42	52	80.8%	Below 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 verified figures for childhood immunisations in the table above have not been updated since March 2019, and therefore these are the same as they were at the previous inspection and as such do not reflect the performance in the last 18 months. Despite the COVID pandemic, the practice informed us that this was an area they were working hard to address. Unverified data provided by the practice appeared to indicate that there was an improving trend and quarterly targets were being met.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. However, we found clinicians did not always respond to patients' immediate and ongoing needs. Therefore, we could not be assured that there was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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: 30/06/2020) (Public Health England)	76.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	68.3%	74.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	52.4%	59.3%	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 (01/04/2019 to 31/03/2020) (QoF)	72.7%	90.9%	92.7%	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)	52.9%	54.5%	53.8%	No statistical variation

Any additional evidence or comments

The verified figures for cancer screening in the table above have not been updated since March 2019, and therefore these are the same as they were at the previous inspection and as such do not reflect the performance in the last 18 months. Despite the COVID-19 pandemic, the practice informed us that this was an area they were working hard to address.

At the previous inspection in December 2019, the practice told us they were recruiting a permanent practice nurse to help with performance in this area. At our inspection we found the practice had not managed to recruit a permanent practice nurse and were supported by two part-time long-term locum nurses.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- Same day appointments and longer appointments were offered when required. However, we found clinicians did not always respond to patients' immediate and ongoing needs. Therefore, we could not be assured there were effective systems to keep people in this population group safe.
- At the previous inspection in December 2019 we found only two of 21 patients with a learning disability had received an annual health check. At this inspection, the practice had completed 10 annual health checks out of 14 patients identified on the register.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

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, cancer and access to 'stop smoking' services. However, we found clinicians did not always respond to patients' immediate and ongoing needs. Therefore, we could not be assured there were effective systems to keep people in this population group safe.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.9%	81.0%	85.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	20.6%	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) <small>(QOF)</small>	33.3%	82.4%	81.4%	Significant Variation (negative)
PCA rate (number of PCAs).	6.3% (1)	8.5%	8.0%	N/A

Any additional evidence or comments

The practice told us the COVID-19 pandemic had impacted their performance as it had not been possible to recall all patients who required a review of their condition prior to the end of March 2020. During the pandemic, they had prioritised patients who had poor control of their conditions and those who required flu vaccinations.

Monitoring care and treatment

The practice did not have a fully comprehensive programme of quality improvement activity which routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	468.96	Not Available	533.9
Overall QOF score (as a percentage of maximum)	83.9%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	2.5%	Not Available	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.	N
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

An audit had been completed on monitoring of prescribing of nitrofurantoin in patients with impaired renal function. Nitrofurantoin is an oral antibiotic for the treatment and prevention of urinary tract infections. In patients with renal impairment, the use of the antibiotic may reduce the antibacterial efficacy, increase the risk of side effects (e.g. nausea, vomiting, loss of appetite), and may result in treatment failures. The practice ran three cycles of the audit since 2017 and found patients who had been prescribed the antibiotic had been managed appropriately.

Any additional evidence or comments

At the previous inspection in December 2019 we found the practice's quality improvement programme was not fully comprehensive as it did not target all the areas of concern identified at previous inspections. At this inspection, the practice provided seven audits and reviews, most of which had been undertaken in November 2020 after we had announced our inspection. They told us the COVID pandemic had impacted on audit activity as they had to prioritise patient needs during this time. However, the continuing concerns found at this inspection demonstrated that quality improvement was not effective.

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.	N ¹
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial ²
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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 ³
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹The significant failings we found during the inspection related to care and treatment of patients did not assure us that all staff had the skills and knowledge to deliver effective care, support and treatment.</p> <p>²At the previous inspection in December 2019 we found staff did not have the opportunity to network and learn with staff from neighbouring practices. At this inspection, the practice told us the COVID-19 pandemic had impacted on additional training planned for staff.</p> <p>³Since our last inspection, the administrative manager had left the practice. Permanent staff told us they could access support from practice managers at other practices and we saw evidence of recent staff appraisals that had been undertaken with one such practice manager. A locum nurse told us she had appraisals, mentorship and support provided through her recruiting agency and had recently been revalidated.</p>	

Coordinating care and treatment

Staff worked 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 ¹

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centered 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.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>¹We found clinicians did not always respond to patients' immediate and ongoing needs, therefore failed to assess, plan and deliver care and treatment.</p>	

Helping patients to live healthier lives

Staff were not always 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.	N
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N
Patients had access to appropriate health assessments and checks.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	N
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: At this inspection we found clinicians did not always respond to patients' immediate and ongoing needs. We found medication reviews were not completely appropriately and some changes were made to treatment without consulting the patients. Therefore, we could not be assured the practice was proactive in helping patients to live healthier lives.	

Consent to care and treatment

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

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

Caring

Rating: Requires Improvement

At the last inspection in December 2019 we found the practice to be good in providing caring services because staff treated patients with kindness and respect and involved them in decisions about their care.

At this inspection we found the practice to be requires improvement in providing caring services because:

- Clinicians did not always respond to patients' immediate and ongoing needs.
- The practice had not carried out any patient feedback exercises since our last inspection to assure themselves their service was meeting the needs of the patients.
- There had been no improvement in the presentation of information available to patients via the practice website to make it easy for patients to understand. This is an action the provider had agreed to review at the previous inspection.

Kindness, respect and compassion

Staff did not always treat patients with kindness, respect and compassion. However, feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: At this inspection we found clinicians did not always respond to patients' immediate and ongoing needs. Therefore, we could not be assured that all patients were given timely information.	

Source	Feedback
	We were unable to distribute patient comment cards at this inspection due to the COVID pandemic.
CQC patient feedback	Since the last inspection in December 2019, we received negative feedback from two patients registered at the practice. Some of the comments related to the lack of continuity of care with one clinician due to the employment of many locum clinicians; and potential misdiagnosis of asthma in a child due to the clinician's dismissive attitude.
NHS Choices	There were no new comments submitted since our inspection in December 2019.
Healthwatch	We asked Healthwatch if they had received any feedback about the practice, but no response was received from them.

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)	80.9%	89.2%	88.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	82.0%	88.0%	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)	87.2%	96.0%	95.3%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	71.2%	83.3%	81.8%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> The practice provided comments relating to National GP Survey results prior to the inspection but did not specifically address the results from the indicators above. They told us they had been unable to collect patient feedback through the NHS Friends and Family test since the start of the COVID-19 pandemic, as recommended by NHS England. Since our last inspection, the practice had not carried out any patient feedback exercises to assure themselves their service was meeting the needs of the patients.

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.	Partial

Staff helped patients and their carers find further information and access community and advocacy services.	Y
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Explanation of any answers and additional evidence:
 At the last inspection in December 2019 we found some of the information available to patients via the practice website was not presented in a way that was easy for patients to understand, and the provider agreed to review this. At this inspection we found the website presentation had not been improved and more information had been added to it.

Source	Feedback
Interviews with patients.	We spoke to one patient over the telephone who was also a member of the patient participation group. They told us they had been seen at the practice during the COVID-19 pandemic and found their overall experience of using the service as good.

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)	86.4%	93.9%	93.0%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 70 carers from their list size of 4,000, which equates to 1.75%. This was an improvement from the previous inspection where the practice had identified 0.95% as carers.
How the practice supported carers (including young carers).	A carers champion was in place and a carers information board was displayed in the patient waiting area. Carers were offered the flu vaccine.
How the practice supported recently bereaved patients.	The practice sent bereavement cards to recently bereaved patients.

Privacy and dignity

The practice respected 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:	

Responsive

Rating: Inadequate

At the last inspection in December 2019 we found the practice to be good in providing responsive services because:

- The practice organised services to meet patients' needs. Patients could access care and treatment in a timely way.

At this inspection we found the practice to be inadequate in providing responsive services because:

- Clinicians did not always respond to patients' immediate and ongoing needs. We found that some changes to medication were made without communication with the patients, thereby not giving them any flexibility or choice in their care.
- At the previous inspection in December 2019, the provider agreed to review information available to patients on the waiting room information screen, the practice website and the practice telephone message as it was overly detailed and difficult to understand. At this inspection we found that minimal changes had been made in this respect.
- Patients could not access care and treatment in a timely way. We found that for a significant period, patients who had requested to see or speak to a GP for urgent and ongoing needs had not been responded to or followed up.

Responding to and meeting people's needs

The practice did not always organise and deliver 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.	N ¹
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.	N ²
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Partial ³
<p>Explanation of any answers and additional evidence:</p> <p>¹Clinicians did not always respond to patients' immediate and ongoing needs. We found that some changes to medication were made without communication with the patients, thereby not giving them any flexibility or choice in their care.</p> <p>²We saw evidence that a clinician had not responded to a request to assess a housebound patient made by their relative. Additionally, patients were having to telephone the practice several times before they were called back by a clinician.</p> <p>³At the previous inspection in December 2019, the provider agreed to review information available to patients on the waiting room information screen, the practice website and the practice telephone message as it was overly detailed and difficult to understand. At this</p>	

inspection we found that the waiting room information screen was not in use, and minimal changes had been made in respect of the website and telephone.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Appointments available:	
Monday	Various times depending on clinician
Tuesday	Various times depending on clinician
Wednesday	Various times depending on clinician
Thursday	Various times depending on clinician
Friday	Various times depending on clinician
Additional routine evening and weekend appointments were available through the Nottingham City GP Alliance GP+ service. Some appointments were also available through at practices in the same primary care network as Queens Bower Surgery. These included appointments with a nurse practitioner and healthcare assistant.	

Some of our findings in respect of responding to immediate and ongoing clinical needs, coding, medicine management, medicine reviews and missed diagnoses impacted on all population groups and therefore, all groups have been rated as inadequate.

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was not always responsive to the needs of older patients and did not always offer home visits and urgent appointments for those with enhanced needs and complex medical issues. We saw evidence of appointment requests that had not been responded to or acted on by the clinician assigned to them. These included requests by older people for urgent medical needs. The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> At this inspection, the practice told us they had to prioritise patients due to the COVID-19 pandemic, therefore several patients had not received reviews for their long-term conditions in a timely manner. Where reviews had taken place, we found some medication reviews were not completed appropriately. Some patients had changes made to their medicines without discussion with them to check compliance, side effects or effectiveness of the medicines.

- The practice did not always respond appropriately to test results for people with long term conditions. A search identified six patients with potential missed diagnoses of diabetes, who had raised blood glucose levels on two separate occasions in the presence of symptoms suggestive of diabetes such as thirst, weight loss or excessive urination. Therefore, these patients had not been included in the practice recall programme for regular monitoring of their diabetes to ensure their conditions were under control and did not deteriorate.
- Additionally, the practice did not respond appropriately to information which indicated some people who had asthma were over-using their inhalers, therefore needed their treatment to be reviewed. We found 15 patients who had been prescribed 12 or more inhalers in the last 12 months, which suggested their asthma was poorly controlled and preventative treatment may need to be increased.
- The practice did not always provide effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Inadequate

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. However, the systems were not always applied consistently. Records we looked at showed that alerts were recorded variably in the patient records.
- At the previous inspection in December 2019 we observed that systems for following up accident and emergency (A&E) attendances needed strengthening. Records we looked at confirmed systems had not been improved. We viewed a record of a child on the safeguarding register and found they had attended secondary care for a head injury, and this was not followed up for several weeks, until they were seen at the practice for a different reason.
- We saw evidence of appointment requests that had not been responded to or acted on by the clinician assigned to them. Therefore, we could not be assured that parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Clinical appointments were available outside school hours for school age children so that they did not need to miss school.

Working age people (including those recently retired and students)

Population group rating: Inadequate

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. However, we found clinicians did not always respond to patients' immediate and ongoing needs.

- The practice was open from 8am to 6.30pm Monday to Friday. Since the previous inspection, the practice now opened on Thursday afternoons. Extended hours appointments were available to patients via the extended access service (GP+) in Nottingham city centre run by Nottingham City GP Alliance. This opens from 4pm to 8pm Monday to Friday, and 9am to 1pm at the weekends.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

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

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- Priority appointments were not always allocated when necessary to those experiencing poor mental health. We saw evidence of appointment requests that had not been responded to or acted on by the clinician assigned to them. These included requests by people experiencing poor mental health for urgent medical needs.
- 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 not 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.	N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	N
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	N
Explanation of any answers and additional evidence:	

- Clinicians did not always respond to patients' immediate and ongoing needs. We found that for a significant period, patients who had requested to see or speak to a GP for urgent and ongoing needs had not been responded to or followed up.
- For example, on one day in the week prior to our inspection, 18 appointments did not appear to have been dealt with. We reviewed 13 of these and found the majority had no evidence of review or follow up by the GP as requested. This meant patients were put at significant risk of harm by not being given timely care and treatment.
- There were multiple examples of appointments for patients requesting medication which did not appear to have been dealt with, including patients whose medications had run out.

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)	40.8%	N/A	65.2%	Variation (negative)
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)	63.7%	67.2%	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)	62.9%	65.1%	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)	64.3%	74.3%	72.7%	No statistical variation

Any additional evidence or comments

- Since the last inspection, the practice had employed additional administration staff and provided more telephone appointments in light of the COVID-19 pandemic. Patients who needed to see a clinician were triaged on the telephone first and if the clinician felt a face to face appointment was required then they would be booked to attend the practice. The practice nurses offered face to face appointments only.
- At this inspection we observed that there was a long recorded message on the practice telephone which cut off callers if they listened to the whole message before selecting an option for redirection. The practice told us most patients knew how to get through on the telephone by immediately selecting option 1. This had been raised with the provider prior to our inspection. The provider agreed to review the message.

Source	Feedback
Patient interview	We spoke to one patient who was a member of the patient participation group over the telephone. They told us they were aware of the problems getting through to

	the practice telephone, and the practice had employed more administration staff to answer the telephones in response to this.
CQC patient feedback	Since the last inspection in December 2019, we received negative feedback from two patients registered at the practice. Some of the comments related to waiting for a long time to get through on the practice telephone and being given an appointment with a nurse who was not qualified for the procedure which required a GP.
Healthwatch	We asked Healthwatch if they had received any feedback about the practice, but no response was received from them.
NHS Choices	There were no new comments submitted since our inspection in December 2019.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	2
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice received two complaints reported via NHS England. Whilst they followed up the complaints with the individual patients, they failed to respond to communications from NHS England about the complaints despite several reminders. The provider told us they must have been busy with the increased workload due to the COVID-19 pandemic and they would review this in future.</p>	

Example of learning from complaints.

Complaint	Specific action taken
A patient attended the practice for a face to face appointment with a nurse and did not realise a telephone appointment had been booked for them. They were seen by a GP whom they felt was dismissive and unhelpful. They felt they were not listened to by the GP and the GP had not asked about other medications which could have been relevant to their problems.	The practice reviewed the patient's records and determined that the reason for the patient's visit was unclear. The practice wrote to the patient to apologise for the GP's attitude, and offered them a face to face meeting to discuss matters further if they wished to.

Well-led

Rating: Inadequate

At the last inspection we found the practice to be inadequate in providing well-led services because:

- Leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice had a clear vision, but it was not supported by a strategy and fully effective processes to provide high quality sustainable care.
- There were defined responsibilities, roles and systems of accountability to support good governance and management, however, we found these not to be fully effective.
- The practice did not have fully clear and effective processes for managing risks, issues and performance.
- The practice did not fully involve the public, staff and external partners to sustain high quality and sustainable care.
- There were some evidence of systems and processes for learning, continuous improvement and innovation, however, they could be further improved.

At this inspection, we found minor improvements had been made in these areas, and additional concerns were found relating to poor management of the service. Therefore, we rated the practice as inadequate for providing well-led services because:

- Leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice had a clear vision, but it was not supported by a strategy and fully effective processes to provide high quality sustainable care.
- There were defined responsibilities, roles and systems of accountability to support good governance and management, however, we found these not to be fully effective.
- The practice did not have fully clear and effective processes for managing risks, issues and performance.
- The practice did not fully involve the public, staff and external partners to sustain high quality and sustainable care.
- There were some evidence of systems and processes for learning, continuous improvement and innovation, however, they could be further improved.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N ¹
They had identified the actions necessary to address these challenges.	N ¹
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N ²
Explanation of any answers and additional evidence:	
¹ At the last inspection, the lead GP had appointed an administration manager who was working in conjunction with a neighbouring practice's practice manager to continue to identify challenges to	

quality and sustainability. At this inspection we found the administration manager and a healthcare assistant had left the practice. The practice still had not managed to recruit a practice manager and had vacancies for a healthcare assistant and permanent practice nurse. Practice management support was obtained externally on an ad hoc basis from various external practice managers. At the time of our inspection, the practice was in the process of shortlisting candidates for the practice manager role. A locum practice nurse provided phlebotomy services over the two days a week when she worked at the practice, and both nurses and doctors undertook tasks usually provided by a healthcare assistant.

During this inspection, we found significant clinical failings which indicated a serious lack of leadership and managerial processes and systems to support the delivery of safe and effective care and treatment. These included clinicians not always responding to patients' immediate and ongoing needs; clinical coding was not always done appropriately; medicine management and medicine reviews were done poorly and there was evidence of missed diagnoses.

²There was no improvement in developing succession plans for the practice or a leadership development programme. The provider's vision and strategy stated there were no plans to recruit a partner in the business. The provider remained supported by temporary GPs and had no practice manager, therefore the risk that the practice would close in his absence remained unmitigated.

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.	N ¹
There was a realistic strategy to achieve their priorities.	N ²
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	N ³

Explanation of any answers and additional evidence:

¹The concerns found at this inspection did not demonstrate quality care as stated in the practice's mission statement.

²Whilst the practice had a documented vision and strategy in place, this remained aspirational with little progress made since our last inspection. For example, the theme of succession planning and continuity had no realistic or measurable plans against it.

³The strategy document had been updated in November 2020. However, it indicated the recruitment of up to two prescribing nurses was targeted to be completed by January 2021, yet there was one vacant post advertised which remained open at the time of our inspection. Furthermore, the objective to obtain patient feedback had no specified methods and no measurable targets against it, therefore progress against delivery could not be monitored.

Culture

The practice culture did not always drive high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N ¹
Staff reported that they felt able to raise concerns without fear of retribution.	Y ²
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹The concerns found during the inspection did not demonstrate behavior consistent with the vision and values of high quality care by the lead clinician. Furthermore, there was no evidence of the concerns being raised by any other staff at the practice.</p> <p>²Staff told us they felt able to raise concerns with the provider. They felt able to raise any concerns with their Freedom to Speak Up Guardian and external bodies such as the Care Quality Commission.</p>	

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

Source	Feedback
Staff Interviews	Staff told us they generally felt happy to work at the practice. They had raised the need for a permanent practice manager to support them and the lead GP as well who was taking on management responsibilities in addition to clinical tasks. They were aware recruitment was in progress and felt this was a positive move. They felt supported by external practice managers.

Governance arrangements

There were not always clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:
 At the last inspection in December 2019 we found governance arrangements were being further developed following the recruitment of the administration manager. However, at this inspection we found the administration manager had left the practice. Management support in the interim was ad hoc, therefore governance and management systems were not fully effective.
 The lead clinician failed to fulfil their responsibilities in ensuring patients who had booked appointments to be telephoned back had been assessed and contacted as appropriate.

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 ¹
There were processes to manage performance.	N ²
There was a systematic programme of clinical and internal audit.	N ³
There were effective arrangements for identifying, managing and mitigating risks.	N ⁴
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence: ¹ At the last inspection in December 2019 we found assurance systems were not fully comprehensive. At this inspection we found the practice had developed a risk register. However, most of the risks identified were reliant on a practice manager (who was yet to be recruited) taking on responsibilities currently being managed by the lead GP. ² There was evidence that one clinician had not seen patients booked in for appointments assigned to them, and no evidence that this had been challenged by other clinicians and staff. ³ We saw evidence of some clinical audits that had been undertaken; however, there was no ongoing systematic programme for clinical audits. Several audits had been undertaken in response to clinical searches undertaken by the CQC as part of the inspection. ⁴ The practice had not mitigated the risk of not seeing patients for their immediate needs and ongoing monitoring.	

Appropriate and accurate information

The practice did not act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N

There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in December 2019 we found data was available but had not been used proactively to improve performance in several clinical areas which were below local and national averages. At this inspection we found the practice had improved on some areas identified at the last inspection. However, we found clinicians did not always respond to patients' immediate and ongoing needs; therefore, we could not be assured that information was accurate, valid, reliable and timely.</p>	

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.	Partial ¹
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Partial ²
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N ³
<p>Explanation of any answers and additional evidence:</p> <p>¹The practice had not acted on feedback regarding the telephone message which hampered some patients from getting through to the practice telephone.</p> <p>²Staff had raised concerns regarding staffing levels at the last inspection. Their concerns had been partially addressed with the employment of additional administration support, but a practice manager was yet to be employed.</p> <p>³Since our last inspection, stakeholders worked with the practice to promote improvements. However, feedback from stakeholders indicated they were concerned about sustainability of changes because of the provider's reluctance to make longer term changes, for example, through the employment of permanent staff.</p>	

Feedback from Patient Participation Group.

Feedback
Feedback from a member of the patient participation group was highly positive about changes made to the premises of the practice in light of the COVID-19 pandemic, for example, the removal of carpets and changes to the layout of the reception area to promote social distancing. They told us patients were able to obtain extended prescriptions where appropriate for up to a year and the practice was now open on Thursday afternoons to patients; it was previously closed at this time. They felt this indicated there had been some improvements at the practice.

Continuous improvement and innovation

There were some evidence of systems and processes for learning, continuous improvement and innovation. However, they could be further improved.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:</p> <p>Whilst the provider took actions to address some of the concerns identified by us at the last inspection, we found overall systems in place did not promote sustainability of the changes. There was no systematic programme of audits to drive improvements; audits were prompted by alerts or more recently, clinical searches undertaken by the CQC as part of the inspection.</p> <p>There was no evidence of results from audits being shared with other clinicians. The provider told us learning was shared with individuals involved as and when events occurred that required learning.</p>	

Examples of continuous learning and improvement
<p>At the inspection we saw evidence of learning from complaints and significant events. For example, following a significant event where diagnosis of diabetes was missed in a child, learning was shared with other members of clinical team (locum GPs including the doctor involved), and the reception team. A poster was made for all treatment rooms encouraging clinicians to be vigilant for diabetic ketoacidosis in undiagnosed diabetic patients, in particular children, and the checking of blood sugars if in any doubt regarding this.</p>

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- $\%$ = per thousand.