

Care Quality Commission

Inspection Evidence Table

Mayflower Medical Group - Stirling Road Surgery (1-4349994072)

Inspection date: 21st and 26th May 2021

Date of data download: 26 April 2021

Overall rating: Inadequate

We have rated this practice as Inadequate because:

- The practice did not always have clear systems, practices and processes to keep people safe
- Services did not always meet patients' needs.
- People were not always able to access care and treatment in a timely way.
- Complaints were not used to improve the quality of care.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

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

Safe

Rating: Inadequate

We found the practice's system for managing patient and drug safety alerts did not ensure medicines were prescribed safely. We found the practice had not properly actioned any of the three alerts we reviewed. There was no evidence to show the practice had taken action to protect patients from avoidable harm.

The practice did not evidence a safe system to ensure patients on high risk medicines were appropriately managed in a timely way.

The practice did not fully evidence that patients had a structured and comprehensive medicine review. We identified reviews had been coded on the clinical system but there was no evidence in the clinical records of a structured medicine review or consultation with the patient.

The practice could not evidence they had systems in place to learn and make improvements when things went wrong.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
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.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: Eight records were reviewed for patients identified as having safeguarding concerns. Safeguarding alerts were seen on all records for both children and adults. However, for three children with safeguarding concerns, there was no alert on the parent or legal guardian's record to show that there were safeguarding concerns in the family.	

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
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: Recruitment processes for the Mayflower Medical Group were managed remotely by the Devon Doctors shared service human resource team. Not all files we reviewed were complete. For example, one recruitment file held no information other than a signed contract and induction. We could not be assured the correct recruitment procedures or	

checks had been followed. We requested further supporting evidence to demonstrate the provider had followed these checks, but no additional evidence was submitted.

Following the inspection the provider sent us supporting evidence to demonstrate recruitment processes were in place.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: May 2021.	Yes
There was a record of equipment calibration. Date of last calibration: October 2020	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 20/10/20	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: We reviewed the training matrix and found all staff had completed fire safety training.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: October 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2020	Yes
However, on the day of the inspection visit we found oxygen and compressed gas being stored in a locked room dedicated for the use of Devon Doctors out of hours service. No staff on site at the practice had access to this room in the event of a medical or health and safety emergency, for example a fire. Management assured us at the end of the day that this issue was going to be rectified.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 14 April 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
We saw the provider had taken action to incorporate guidance relating to COVID19. For example; patients were unable to enter the premises unless face masks were worn, and a one way system had been put in place to allow for social distancing.	

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.	No
There was an effective induction system for temporary staff tailored to their role.	No
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
<p>Explanation of any answers and additional evidence:</p> <p>The service used a nationally recognised rota management system. The provider confirmed that workforce scheduling was undertaken by a dedicated coordination team, who responded to changes in staffing, as best as possible, sourcing clinicians to fill the vacant sessions. However on the day of inspection we found the local practice team had limited oversight of the resources available for each shift. This meant the provider was unable to provide assurance that the system to allocate staff and clinicians to cover shifts, to meet demand or respond to changes in staffing, was effective. Over the course of the inspection staff were invited to complete a staff questionnaire. Staff told us they were working under pressure with minimal staffing numbers available. We were told that staff numbers were reduced through sickness and staff not being replaced when leaving the organisation.</p> <p>The provider told us there were recruitment difficulties in finding GP's to fill whole time equivalent roles (WTE). The service had identified it needed 10 WTE GP's to cover service needs. The service used a mix of locum, agency and remote GP's to cover the deficit in GP staffing. This meant that patients did not always experience continuity of care to achieve positive outcomes.</p>	

There was limited evidence to demonstrate a comprehensive induction for staff at all levels. One out of the six files reviewed had evidence of an induction being delivered to the member of staff. We had requested additional evidence from the provider; however, none was submitted for review during or following the inspection.

Following the inspection, the provider submitted a copy of the Devon Doctors Group induction programme

Not all staff who were patient facing had received training on how to identify a deteriorating or unwell patient.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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.	Partial
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.	No
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice had developed a Pathology Standard Operating procedure (SOP) to help the remote GPs employed by the practice manage pathology results. The GPs were asked to prioritise red (abnormal) results and microbiology results. Significantly abnormal results were phoned through to the practice or Out of Hours by the local hospital laboratory so that immediate action could be taken.</p> <p>We checked the practice's pathology inbox and there were 701 results waiting to be processed. The clinical lead GPs told us that there had been problems managing pathology results in the past ten days due to staff sickness. This meant patients with abnormal results which may need further action could be put at risk of becoming unwell or having their diagnosis delayed due to the delays in processing results.</p> <p>As part of our remote access, we reviewed a sample of patient records and patient consultations. These searches identified an area of concern regarding missed diagnosis of diabetes. From this we saw that 52 patients who had elevated HbA1c levels in their blood did not appear to have a diagnosis of diabetes or pre diabetes on their records. HbA1c is a measure of how well controlled the blood sugar has been</p>	

over a period of about three months. We reviewed five of these patient records and found that one patient had been given incorrect advice when they should have been diagnosed with diabetes based on two abnormal HbA1c tests. Two patients needed repeat HbA1c tests to confirm a diagnosis of diabetes. One of these patients had a result that was coded as “Borderline – No further action” which meant that a repeat test was not performed. A further three patients did not have an appropriate diagnosis of diabetes, or referral to a diabetic prevention programme coded in their records. The provider was not able to be assured that these patients were being monitored effectively.

Following the inspection, the provider told us they had contacted these patients and arranged for them to have repeat HbA1c blood tests and ensured effective monitoring was in place.

Appropriate and safe use of medicines

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

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) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.95	0.78	0.76	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). (01/01/2020 to 31/12/2020) (NHSBSA)	11.7%	9.9%	9.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2020 to 31/12/2020) (NHSBSA)	5.89	5.78	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	227.6‰	145.2‰	127.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	0.83	0.82	0.67	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
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.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Not all annual medication reviews included notes on discussions with patients regarding side effects and continuing treatment. The records review highlighted Pharmacists were not checking that appropriate monitoring had been done when re-authorising medication following a review. There were examples of unsafe practice with repeat medications being dispensed for six months even though monitoring checks were not up to date. By failing to carry out appropriate medication reviews the provider could not be assured patients were safe or reduced the risk of harm through toxicity, side effects of medication and remaining on medicines that were no longer necessary or taking them for longer than was necessary.</p>	

If patients were monitored by secondary care, for example the hospital, the practice did not provide evidence they had accessed or considered the results or acted where necessary to provide assurance of safe prescribing for patients.

We reviewed a sample of 40 patient records to ascertain the appropriate monitoring and clinical review prior to providing repeat prescriptions. Of the 40 records we reviewed, we found 33 where insufficient monitoring was in place. Examples of insufficient monitoring included:

- Patients prescribed blood thinning medicines should have regular checks of their kidney function and calculation of their creatine clearance level to ensure they are being prescribed the appropriate dose, and whether it was appropriate for the patient to remain on the treatment. From the search of the practice clinical system, we found 922 patients on this type of medication with 811 patients who had potentially not received the appropriate review of creatinine clearance in the past 12 months and 637 patients who potentially had not received any monitoring at all.

Following the inspection, the provider told us they were going to develop new standard operating procedures to ensure that all appropriate monitoring for patients were carried out prior to repeat prescriptions being issued.

- 58 patients were identified as in receipt of Amiodarone, a medicine used to treat heart rhythm disturbances and of these 35 appeared not to have had the necessary monitoring carried out within the last six months. Side effects from Amiodarone include thyroid and liver dysfunction. From the sample of five records we reviewed, four patients had not had their thyroid function checked in the last six months and two patients had not had liver function monitoring. Two of the five patients had been issued with a prescription for six month's supply and one for three month's supply of the medicine without the necessary checks being carried out.
- Thirty patients were identified as being prescribed Lithium, a medicine used to treat mental health illness, of these 20 appeared not to be being monitored appropriately. We reviewed the records of five of the patients on Lithium. Although Lithium levels were being checked, other checks including blood monitoring and weight measurement were overdue for all five patients. The monitoring of patients on this medicine is important as Lithium is a potentially toxic medicine, which can alter thyroid function and calcium metabolism.

We saw from patient records that some clinical staff were potentially working outside of their scope of practice. These staff had not received any competency assessments to ensure that their care and treatment of patients was safe.

Following the inspection, the provider told us the practice pharmacist was following guidance from the Devon Clinical Commissioning Group to support patients on Lithium during the COVID-19 pandemic. The provider also confirmed they were developing new standard operating procedures to ensure that all appropriate blood testing for patients on these medicines were carried out prior to repeat prescriptions being issued.

Medicines management	Y/N/Partial
<p>On the day of inspection, we found two Patient Group Directions (PGDs) used by the home visiting team that were not in date. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a doctor or nurse prescriber. These were updated during the day of inspection.</p>	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
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:	121
Number of events that required action:	108
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process for raising and investigating incidents using the Datix system accessible from each computer desktop. Incidents raised were initially analysed and investigated remotely by the Devon Doctors shared service governance team with staff being asked to provide statements.</p> <p>Once a month the Devon Doctors governance team hold a significant event audit review of incidents in the Mayflower Group GP practices. A report on each incident was passed to the Clinical Lead GPs for review, but it could take up to six weeks for the clinical leads to get these reports. There was ineffective learning and implementation of any actions as local practice ownership and management of the process was inconsistent. It was not clear how learning from incidents was shared with the wider practice team or who had responsibility for implementing improvements.</p> <p>Staff understood their duty to raise concerns and report incidents and near misses but told us they did not always receive feedback or learning points from leaders and managers.</p> <p>From the records we reviewed we found incidents and the actions taken were listed, however no records confirmed that a root cause analysis had been completed or were available. A significant proportion of the listed incidents were patient complaints. This meant we were not assured the provider had a clear and effective system of identifying trends and managing incidents and complaints.</p> <p>There were five incidents that required statutory notifications to the CQC that were not reported in accordance with the regulations.</p>	

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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	No
<p data-bbox="52 524 1533 575">Explanation of any answers and additional evidence:</p> <p data-bbox="52 575 1533 770">The practice did not have an effective system for acting upon patient and medicine safety alerts. We reviewed patient records relating to three medicine safety alerts (where patients were prescribed medicines where there could be potential risk to their health). The Clinical Lead GPs told us safety alerts were flagged on the Clarity TeamNet intranet and discussed at clinical meetings. However, there was limited evidence from the records reviews that safety alerts were being acted upon:</p> <ul data-bbox="105 770 1533 1568" style="list-style-type: none"><li data-bbox="105 770 1533 1048">• For example, 154 patients appeared to have been co-prescribed Clopidogrel and Omeprazole together. Omeprazole reduces the effectiveness of taking Clopidogrel to prevent cardiovascular disease. Of the five records reviewed, four of these patients were taking Clopidogrel and Omeprazole together despite a safety alert for this being issued in 2014. One patient had potentially come to harm whilst on this combination. This should have been picked up in medication reviews and the medication altered or the risks of the combination should have been discussed with the patient.<li data-bbox="105 1048 1533 1308">• There was also limited evidence in patient records to show that they had been informed of Fournier’s gangrene risk with a diabetes medication (SGLT-2 inhibitors) as per a 2019 safety alert. SGLT2 inhibitors are a class of prescription medicines that are approved for use with diet and exercise to lower blood sugar in adults with type 2 diabetes. Five patient records were reviewed. Two patients had been informed of the risks of urinary tract infections, but not the risk of Fournier’s gangrene. Two patients had been given patient information leaflets about SGLT-2 inhibitors, but it was not clear if Fournier’s gangrene had been discussed specifically.<li data-bbox="105 1308 1533 1568">• There was evidence that women of child-bearing age on Sodium Valproate had been advised of the risks of pregnancy and were being reviewed in secondary care. However, codes were added to the clinical record when prescriptions were issued by a Pharmacist with no evidence of a specific discussion with the patient. Good practice would be to ensure that these patients are reviewed annually to assess their risk of pregnancy and to check that the patient has completed an annual pregnancy risk acknowledgement form with their secondary care specialist.	

Effective

Rating: Inadequate

We rated the practice as inadequate for providing Effective services because:

- The practice could not provide assurances that patient records were coded appropriately to ensure patients received necessary monitoring.
- The practice could not provide assurances that patients presenting with symptoms indicating a serious illness, would be followed up in a timely way.
- There was limited monitoring of the outcomes of care and treatment.
- There were not effective processes to ensure staff remained qualified and competent for their role.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was 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.	Partial
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.	No
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	No
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial
<p>Patient records reviewed documented staff had given specific safety netting advice. An example seen was when an eConsult was received, a message was sent to the patient stating that the practice would aim to respond in three working days. This message included specific safety netting information to tell the patient what to do if their condition deteriorated or if they had any concerns. However, feedback received from patients was that the response time could be as long as ten days or no response at all.</p> <p>Further feedback from patients described how, due to the delay in receiving a call back from a clinician had resulted in patients' conditions deteriorating before receiving treatment or attending the local accident and emergency departments.</p> <p>Staff told us on the day of the inspection the next available time slot for a triage call back was the 7 June 2021, 13 days later. If a patient telephoned the practice for blood test results a call back had to be booked and this could be up to two weeks' time causing patients anxiety and potential delays to care and treatment. Some patients told us they attended the local Accident and Emergency department for treatment because of this delay.</p>	

We found poor monitoring and management of patients with long-term conditions, such as diabetes. For example, when we checked the records of patients with diabetes, we found instances where patients had not been referred to eye screening, patients had not been having annual reviews, patients were not appropriately coded or diagnosed as being diabetic, and patients' blood sugar levels had not been recently checked.

We identified examples of co-prescribing of medicines contrary to safety alerts, which put patients at risk of harm, and clinicians did not appear to be aware of the risk of co-prescribing these medicines.

Older people

Population group rating: Inadequate

Findings

This population group has been rated as inadequate due to concerns identified relating to care and treatment and staff training.

- The practice could not evidence that they carried out structured annual medicines reviews for older patients

However, we identified the following good practice:

- 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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings

This population group has been rated as inadequate due to concerns identified relating to care and treatment and staff training.

- The records review showed that blood monitoring for patients with long term conditions was not up to date and in some cases pharmacists were issuing medicines for long periods of time with no documentation that blood tests had been checked or any evidence that the patient had been asked to attend for blood tests.
- We were not assured that staff who were responsible for reviews of patients with long-term conditions had received up to date specific training.
- We were not assured that staff had the appropriate skills and training to carry out reviews for this population group.

However:

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

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)	68.2%	76.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	23.8% (753)	17.0%	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)	85.9%	91.2%	89.4%	No statistical variation
PCA rate (number of PCAs).	20.4% (261)	16.1%	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)	66.9%	81.8%	82.0%	Significant Variation (negative)
PCA rate (number of PCAs).	3.4% (43)	8.1%	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)	59.1%	71.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	8.3% (174)	19.6%	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)	61.2%	73.8%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	6.9% (350)	11.6%	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)	85.0%	92.0%	91.8%	Tending towards variation (negative)

PCA rate (number of PCAs).	1.1% (9)	5.4%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	65.3%	76.7%	75.9%	No statistical variation
PCA rate (number of PCAs).	9.0% (189)	14.5%	10.4%	N/A

Any additional evidence or comments

The Clinical GP leads were unaware of the higher percentage of Personalised Care Adjustments (PCA's) so unable to give an explanation for this. PCA's have replaced exception reporting to better reflect individual clinical situations and patients' wishes.

We were told that a Director of Devon Doctors/Access Healthcare oversees a dashboard for the monitoring of performance. Areas of priority are disseminated to clinical teams at the weekly huddle meeting.

Findings

This population group has been rated as inadequate due to concerns identified relating to care and treatment and staff training.

- The practice did not have in place arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- We were not assured that staff had the appropriate skills and training to carry out reviews for this population group.

However:

- The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- E-Consult did not allow people under 16 to complete an e-Consult, therefore policies were amended to ensure patients under 16 wanting to access healthcare, were added to a list for same day care.

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)	359	366	98.1%	Met 95% WHO based target
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)	418	434	96.3%	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)	418	434	96.3%	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)	421	434	97.0%	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)	460	482	95.4%	Met 95% WHO based target

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

Any additional evidence or comments

The nursing staff told us that they had a member of the administration team who contacted, either by letter or telephone call, all parents to invite them in for their child's immunisations.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

This population group has been rated as inadequate due to concerns identified relating to care and treatment and staff training.

- Patients experienced difficulties booking or cancelling appointments online and ordering repeat medicines without the need to attend the surgery.

However:

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

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: 30/09/2020) (Public Health England)	72.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	76.3%	71.8%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	63.2%	N/A	63.8%	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)	70.7%	93.1%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	61.7%	56.8%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

This population group has been rated as inadequate due to concerns identified relating to care and treatment and staff training. However:

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

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

This population group has been rated as inadequate due to concerns identified relating to care and treatment and staff training.

In the most recently published outcomes in the Quality and Outcomes Framework (QOF) 2019-20 we saw that outcomes were particularly low for the mental health indicators. Patients with a psychosis and an agreed care plan was 30.1% and for patients with Dementia 38.6% which were significantly lower than local and national averages.

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>	30.1%	81.3%	85.4%	Significant Variation (negative)
PCA rate (number of PCAs).	2.6% (10)	21.5%	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>	38.6%	82.3%	81.4%	Significant Variation (negative)
PCA rate (number of PCAs).	7.9% (25)	10.3%	8.0%	N/A

Any additional evidence or comments

The clinical leads were unaware of the higher PCA rates so were unable to provide an explanation.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	448.94	Not Available	533.9
Overall QOF score (as a percentage of maximum)	80.3%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	6.5%	Not Available	5.9%

Any additional evidence or comments

The outbreak of COVID-19 in the last quarter of 2019-20 led to unprecedented changes in the work and behaviour of GP practices and consequently the data may have been impacted upon. We acknowledge that Plymouth was in lockdown due to the pandemic from June 2020, and QOF was paused in April 2020 and then resumed in November 2020. However, the QOF data used in this report relates to 2019-20 and the practice's performance in QOF was well below local and national figures, but we do acknowledge that the pandemic would have had some impact towards the end of the QOF year.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	No

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

The practice provided two audits for review. This did not demonstrate that the practice had effective systems to review and improve performance or quality.

National Cancer Diagnosis Audit (1 cycle audit – September 2020): Review of 23 patients with a recent diagnosis of cancer to identify if there had been any delays in making the cancer diagnosis and any learning from specific cases to help improve cancer care. The audit had identified six patients who had had unavoidable delays in being diagnosed with cancer. For three of these patients, the delay had occurred in primary care. A number of learning points were identified from this audit including providing better safety netting advice to patients and following the NICE suspected cancer guide-lines, but it was not clear how this learning had been shared within the practice and what specific actions had been taken to improve patient care. NICE stands for The National Institute for Health and Care Excellence. It is an independent organisation set up by the Government in 1999. Its aim was to decide which drugs and treatments are available on the NHS in England.

Steroid Audit (One cycle audit – February 2021): This audit assessed whether patients receiving repeated courses of oral steroids for asthma and chronic obstructive pulmonary disease (COPD) were being prescribed medication to protect their bones. The audit identified that 41 out of 73 patients who had been prescribed more than three courses of steroids in 12 months were not on any bone protection. It also showed that there was insufficient monitoring of the issuing of repeat prescriptions for rescue packs of medication for asthma and COPD. Recommendations had been made to improve patient care as a result

of this audit including making changes to the practice's steroid prescribing protocol. No actions had been recorded or taken as a result of the audit findings. The Clinical Lead GPs were planning to review the patients who had not been prescribed bone protection to see if they had been offered it.

Any additional evidence or comments

- There was no formal plan for audit or quality improvement in place at the practice although some prescribing audits (e.g. antibiotic prescribing) were also being completed by the practice's pharmacy team.
- Audits were being undertaken on an ad-hoc basis, but there was no evidence of specific actions being taken to improve patient care or review to demonstrate assurance that improvements were embedded in practice
- The Clinical Lead GPs said that audits done by the practice were discussed at clinical meetings to share learning. However, audits seen had not been repeated so the provider could not be assured any improvements made were embedded.

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	No
There was an induction programme for new staff.	Partial
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.	No
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:	
There was no overall record or location of staff training and development. There were several departments which kept different staff training records such as clinical competencies, mandatory training and basic life support. This meant there was no overall scrutiny or clarity on an individual's training compliance.	
Following the inspection, the provider sent us copies of emails containing a training tracker and a summary file confirming further staff training which had been completed, these were not available to view during inspection.	
Not all staff were able to find protected time to complete their mandatory training in a timely manner. While the provider encouraged staff to complete their training some teams and staff groups found it	

hard to find the time to complete some modules on time. Staff told us they completed training in their own time or inbetween calls.

At the time of inspection, we could see how staff were progressing with mandatory training. We had asked for training records for non-clinical and clinical competencies for staff, however this was not supplied before, or at the inspection. Therefore, the provider was unable to demonstrate that staff had the skills, knowledge and experience to deliver effective care, support and treatment.

Following the inspection the provider sent us copies of certificates for nursing staffs' completion of training in diabetic care.

Not all staff had received up to date annual appraisals, seven staff, including clinical and non clinical, told us that they had never received an appraisal.

There was no evidence that staff employed in advanced clinical practice roles were appropriately up-to-date with training and supervision to ensure they had the clinical skills and competencies to deliver care and treatment to some of these complex patients, or that this was within the scope of practice.

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:	

Patients wanting to receive an assessment for their condition, for example, asthma and blood pressure were invited to complete a form on E- consult found on the practice website.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
Explanation of any answers and additional evidence: There was evidence staff recorded consent in patient records. A consent form containing information on risks and complications was seen during the records review for the administration of a joint injection. Evidence was seen from the records review of mental capacity being assessed when DNACPR (full term) orders were put in place. There was also evidence of discussions with family members about DNACPR where patients lacked capacity. However, in three of the five DNACPR records reviewed, the mental capacity section of the treatment escalation plan (TEP) had not been completed when it was stated that the patient lacked capacity. There was also no indication of planned review dates on TEP forms.	

Caring

Rating: Requires Improvement

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

- Feedback from patients raised concerns about staff attitude and access to timely information.

Kindness, respect and compassion

Feedback from patients was often negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: From January 2021 to May 2021, CQC received 32 complaints from patients regarding the service. Concerns included a lack of support from staff, staff attitude and concerns with the level of care and treatment received. Staff told us the wait for an e-consultation response was too long and patients were frustrated with the long response times which added additional stressors to the role. Patients did not always receive appropriate and timely information, which they told us increased their anxiety. For example, records we looked at showed that some patients had not been informed or had the appropriate action taken with their abnormal blood test results.	

Source	Feedback
NHS Choices	Since August 2020, twelve patients had placed comments on the website. Nine were negative with comments on the access to speak with a clinician and three were positive comments on the care they had received.

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)	84.8%	91.7%	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)	80.4%	90.8%	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)	95.5%	97.1%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	61.9%	86.2%	81.8%	Variation (negative)

Any additional evidence or comments

The practice's complaints log had recurrent themes of complaints regarding delays in care and treatment spanning a 12-month period. The Mayflower Medical group had introduced a new telephony system, but it was too early to assess the effectiveness of this.

The level of complaints received by the local Healthwatch in Plymouth prompted Healthwatch to conduct its own survey on patient access. The Mayflower Medical Group developed an action plan to address these issues.

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

Any additional evidence

We were sent the results of the patient survey: 651 forms were sent out and 248 were returned. There was no narrative in the document demonstrating what actions had put in place by the provider to improve on areas where feedback was poor.

PERCENTAGE	FEEDBACK	CC
53%	Find it easy to get through to this GP practice by phone	
84%	Find the receptionists at this GP practice helpful.	
38%	are satisfied with the general practice appointment times available	
28.5%	usually get to see or speak to their preferred GP when they would like to.	
51%	were offered an appointment when they last tried to make a general practice appointment.	
67%	were satisfied with the type of appointment they were offered.	
92%	took the appointment they were offered.	
86.5%	say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment.	
87.5%	say the healthcare professional they saw or spoke to was good at treating them with concern during their last general practice appointment.	
91.5%	were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment.	
55%	describe their experience of making an appointment as good.	
67%	waited 15 minutes or less after their appointment time to be seen at their last general practice appointment.	
86%	say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment.	
77%	say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s).	
76.5%	describe their overall experience of this GP practice as good.	

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. However, resource limitations and virtual processes meant patients did not always feel appropriate care and treatment or advice was offered or provided.

	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.	Yes
Explanation of any answers and additional evidence:	

Feedback from patients included that they did not always receive appropriate advice for their care and treatment. For example, patients experienced long delays in receiving results of blood testing. Patients also told us that making follow up appointments with a GP, when the GP had requested them to do so, was difficult as they had to go through the e-consult process again.

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)	87.2%	95.2%	93.0%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Partial
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: Staff told us due to Covid pandemic all information leaflets had been removed from the waiting room and placed behind the reception desk. There was a notice advising patients to ask the receptionist if they required any further information and additional signposting was available on their website.	

Carers	Narrative
Percentage and number of carers identified.	The provider had identified 676 patients (1.69%) as carers.
How the practice supported carers (including young carers).	Information on local charities that can provide support were on their website.

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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Inadequate

We rated the practice as inadequate for providing responsive services because:

- The GP patient survey reflected patient's dissatisfaction on access to the clinicians with percentages lower than the national average.
- Feedback from patients to the CQC and Healthwatch routinely highlighted concerns and issues regarding access for appointments, advice and requesting repeat medicines.
- Complaints were not used to drive improvements at the practice.

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.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Partial
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>All patients were required to complete an e-consult form to be triaged by a clinician. For patients unable to complete an e-consult when they telephoned the practice, a call handler would complete one on their behalf. We were told this could take up to an hour. We were told by the call handlers that a new shorter version of e-consult had been introduced which made this process quicker to improve call handling times.</p> <p>We saw evidence of patient information leaflets being given to patients in the records review for example, for diabetes care.</p> <p>Evidence of signposting patients to other services was seen during the patient records review.</p> <p>There was no evidence from the records review of patients with pre-diabetes being referred to a diabetes prevention programme.</p>	

Practice Opening Times

Day	Time
Opening times:	
Monday	07.00 – 18.30
Tuesday	07.00 – 18.30

Wednesday	07.00 – 18.30
Thursday	07.00 – 18.30
Friday	08.00 – 18.30

Appointments available: All patient calls were managed by GPs working remotely who triaged patients. The provider changed to the total triage model during the COVID pandemic and increased the use of e-Consults during this time to reduce the footfall into the practice and safely triage the patients. They had also adopted the use of a remote system for video consultations, photographs and text interactions.

Older people

Population group rating: Inadequate

Findings

This population group was rated as inadequate due to concerns identified relating to patient access and complaints. However, we identified areas of good practice:

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

People with long-term conditions

Population group rating: Inadequate

Findings

This population group was rated as inadequate due to concerns identified relating to patient access and complaints. However, we identified areas of good practice:

- 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

This population group was rated as inadequate due to concerns identified relating to patient access and complaints. However, we identified areas of good practice:

- Additional nurse appointments were available from 7am for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

This population group was rated as inadequate due to concerns identified relating to patient access and complaints. However, we identified areas of good practice:

- The use of e-consult as a digital method of access allows people to contact the Practice 24 hours a day, 7 days a week.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

This population group was rated as inadequate due to concerns identified relating to patient access and complaints. However, we identified areas of good practice:

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Annual health checks were undertaken by a dedicated practice nurse.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

This population group was rated as inadequate due to concerns identified relating to patient access and complaints. However, we identified areas of good practice:

- 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.

Access to the service

People were not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Patients were able to make appointments in a way which met their needs.	No
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
There were systems in place to support patients who face communication barriers to access treatment.	Partial
Patients with urgent needs had their care prioritised.	Partial
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Patient feedback about access to the practice included difficulty in obtaining appointments to gain feedback on blood tests and x-rays without completing an e-consult. Difficulties with getting through on the telephone, and then having to complete an e consult with the receptionist increased patient frustration. A significant number of patients reported experiencing delays in receiving a call back from a clinician and being given advice to call 999, 111 or attend the local minor injuries unit. This was supported by feedback from patients to the CQC and Healthwatch.</p> <p>The provider had recently introduced a new telephony system to help alleviate the difficulties patients experienced with access. However, patients reported that they experienced the line being cut off after waiting so long in a call queue so the provider will need to make further improvements to the system. The provider had introduced a shortened econsult process for the call handlers to complete on behalf of the patients.</p>	

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)	29.3%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to	40.7%	72.1%	65.5%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
the overall experience of making an appointment (01/01/2020 to 31/03/2020)				
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)	38.3%	67.8%	63.0%	Variation (negative)
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)	56.7%	78.6%	72.7%	Tending towards variation (negative)

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	83
Number of complaints we examined.	83

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
Explanation of any answers and additional evidence: From the 83 records reviewed in the complaints log we identified: <ul style="list-style-type: none">28 did not meet the policy target to provide written acknowledgement to the complainant within the three days. Acknowledgement timescales ranged from four days to 88 days. Some complaints remained unacknowledged. 15 records had conflicting date information which indicated they had been acknowledged before they were opened or had date ranges that could not be explained. We could not be assured that all complaints were handled effectively, and lessons learned to drive improvement.	

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing well led services, because:

- Leaders lacked capacity to deliver a high quality service and drive improvement.
- The culture of the organisation is poor and the shortage of resource means staff are overwhelmed with work, which impacted their well-being.
- The provider oversight of shared service arrangements was ineffective and had not identified the issues which have led to poor governance.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not have adequate systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.
- Quality improvement opportunities were not consistently recognised and systems and processes to support this were ineffective.

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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Partial
<p>The practice told us that the main challenges they faced included GP recruitment and managing patient expectations. The practice told us that they had tried recruiting additional GPs but had so far been unsuccessful. The practice had recently recruited some remote working GPs to help with clinical administrative tasks.</p> <p>The provider had high QOF personal care adjustment (exception) rates for chronic obstructive pulmonary disease (COPD) and asthma. There was also some negative variation in some QOF areas for example, mental health and dementia care planning compared with Clinical Commissioning Group and National averages. The clinical lead GPs were unaware of these rates. They said that the QOF data could have been impacted by the amalgamation of several practices into one single practice since 2017 and the day-to-day pressures of supporting acute care needs, especially during the COVID-19 pandemic, resulting in ongoing long term condition improvement and monitoring work not being done.</p> <p>The practice was implementing a transformation programme which involved using nurses and advanced nurse practitioners to manage the acute work to free up GP time to deal with patients with more complex needs and multi-morbidities.</p>	

47% of the staff felt that some members of the practice leadership team were approachable. Feedback included that some staff did not feel they could raise concerns or that when they did, they weren't listened to.

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.	Yes
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The service had a vision and strategy to deliver high quality care and promote good outcomes for patients. However, some staff told us that they were unaware of the practice visions and values.</p> <p>The practice had not conducted any patient engagement since the start of the Covid-19 pandemic.</p> <p>The practice was unable to provide audits that had been completed to demonstrate quality improvements and improve service delivery.</p>	

Culture

The practice culture did not effectively support 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.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	No
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

Feedback from staff interviewed showed that there was low staff morale and that relationships in the practice were poor. Some reported that they felt able to raise concerns, although some stated there may be a reticence to approach members of the management team. Some staff we spoke with told us that they felt concerns were not listened to or actioned.

We sent out a staff survey prior to inspection and staff raised with us that they felt stressed by working at the practice. In particular, staff felt the lack of capacity had a negative impact on their working life and wellbeing.

The management team told us the practice has weekly clinical huddles for information sharing. These were set up to share information in response to the COVID-19 pandemic.

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

Source	Feedback
Staff Questionnaire	Morale is extremely low at present, understaffed, a lot of sickness. Staff feel management are not listening to concerns and worries.
Staff Questionnaire	Clinicians and administrative staff are trying hard to deliver a service to our practice population. Overall, I believe the standard of clinical care is good given current restrictions and staff on the ground are caring and considerate to patients and each other.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	No

Explanation of any answers and additional evidence:

The Mayflower Medical Group had evolved over the past four years from 10 different practices with different systems and processes. Governance is provided as a shared service by the remote provider Access Health Care Ltd in Exeter. This company sits under Devon Doctors.

We found the practice **did not have** clear governance structures and systems in place. For example, we found the practice did not have systems in place to ensure that:

- Medicine reviews were fully completed.
- High risk drug monitoring was undertaken in line with guidance.
- Medicine and patient safety alerts were appropriately managed.
- There was no performance monitoring of the prescribing practices of non-medical prescribers.
- That significant events and complaints were recorded, learnt from and led to quality and safety improvements.

- Patients with a long term condition such as diabetes were appropriately managed in line with guidance.
- There was evidence from the clinical records review of staff potentially working outside their level of competency for example, a paramedic reinitiating a blood-thinning medication without ensuring appropriate blood monitoring checks had been done, and a nurse who was not part of the diabetes team giving advice on diabetes blood tests.
- There was no oversight of recruitment processes at practice level.

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.	No
There were processes to manage performance.	No
There was a quality improvement programme in place.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
Explanation of any answers and additional evidence:	
<p>The practice was unable to demonstrate that coding on patient records was applied consistently. Coding facilitates searches so that patients needing following up are easily identified. We identified patients with a missed diagnosis of diabetes. However, appropriate clinical coding had not been added to their medical records to ensure they were referred for targeted intervention and regular screening.</p> <p>We were not assured that all staff would check to see if blood monitoring has been completed before issuing repeat prescriptions. We saw evidence that patients had been issued medicines when they had not received the necessary monitoring.</p> <p>The practice did not have a programme of targeted quality improvement audits to improve care and treatment.</p> <p>There was no effective oversight to ensure staff remained suitably qualified for their role. For example: Staff training was not monitored effectively. This included training identified as mandatory by the practice as well as role specific external training and updates undertaken by staff.</p> <p>From the responses of the staff survey we were told not all staff had received an up to date annual appraisal. Five staff members told us their last appraisal was in 2019 and nine had not received an appraisal at all.</p>	

The practice was unable to demonstrate that they were assured of the competencies of non-medical prescribers.

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.	Partial
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.	Partial
There were recovery plans in place to manage backlogs of activity and delays to treatment.	No
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>The practice had continued to offer virtual GP, and Nurse appointments for patients during the pandemic. However, there were no pre-bookable appointments, all appointments were made on the day and triaged remotely. All consultations followed an eConsult, where patients were unable to complete for themselves, the patient call handlers completed on their behalf.</p> <p>The service had adapted its pedestrian access to the premises to reduce the risk to patients of Covid19. A one-way system had been introduced to move patients through the building. Seating had been reduced to help maintain social distancing as well as additional hand sanitising stations.</p> <p>A new telephony system had been recently installed to improve the service for bookings and enquiries. Patient’s had reported frustrations about the previous systems and inability to get through. While the new system has only been active for a short time, issues still remained where patients were cut off after waiting to be connected.</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.	No
Performance information was used to hold staff and management to account.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	No
Explanation of any answers and additional evidence:	
<p>We identified a number of events which had occurred which were reportable to the Care Quality Commission (CQC) through statutory notifications. However, the practice had failed to notify CQC of these events. The practice leadership team did not demonstrate an awareness of the regulatory requirements to notify.</p> <p>There were systems of assurance in place, but they did not always reflect risk and the management of these risks was not always timely. For example, there were some serious clinical complaints on the practice's complaints log which had never been entered onto the significant events log and were dealt with through the complaints' process. We saw that this process often took several weeks before investigation began and that there was no assessment of risk assigned to them, in order to prioritise investigation of these events.</p>	

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 did not 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.	No
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	No
Explanation of any answers and additional evidence:	
<p>We saw limited evidence of how the practice used patient feedback to improve the service. Patients continued to experience difficulties when contacting the practice.</p> <p>Prior to the pandemic, The Mayflower Medical Group (MMG) had a few Patient Participation Group (PPG) members from the various practices that had merged. It had started to disband and the last PPG in place was at the now branch surgery at Mannamead GP practice. Leaders told us that as the pandemic eases the MMG have plans to create a new PPG.</p> <p>Feedback received from the staff prior to the inspection indicated that staff views were not always listened to when planning service delivery.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence:	
<p>The clinical lead told us the team of clinicians was loyal and enthusiastic to deliver high quality care through evidence based practice. However, recruitment problems had necessitated focus and priority of management of acute day-to day pressures.</p> <p>There was no evidence that the practice was making improvements to address issues identified in the first cycle audits provided and these were not repeated.</p> <p>The significant event process did not work effectively within the practice.</p> <p>Staff reported that events and any learning from these were not routinely shared.</p> <p>There was only limited evidence of effective clinical audit within the practice. The Clinical Lead GPs had some ideas for future quality improvement projects. They were planning to have a quality improvement file stored on the practice shared drive to record audit ideas and quality improvement projects.</p>	

Examples of continuous learning and improvement

The group was planning changes to improve workload management and patient care including:

- Implementing the 'Klinik' system to replace eConsult to improve the management of online patient queries and to help reduce telephone call volumes.
- Co-locating the Acute Care Team in the same room to help promote teamwork and provide easy access to a GP for advice. This we were told would give the opportunity for staff to be involved in daily mini teaching sessions on clinical topics.

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.