

# Care Quality Commission

## Inspection Evidence Table

### Dr Gulzar Ahmed (1-520580465)

**Inspection date: 14<sup>th</sup> December 2020 (Remote review) 07-08 January 2021 (On site and Remote comprehensive Inspection)**

**Date of data download: 06 January 2021**

## Overall rating: Requires Improvement

At our previous inspection in October 2019 we rated the practice “Requires Improvement” as there were breaches in Regulation 12 and Regulation 17 of the Health and Social Care Act. We then acted on further information of concern and conducted a focused unrated inspection in September 2020 when we looked at clinical records where further concerns regarding clinical governance were found.

At this inspection, the practice had made improvements in some areas but we found that the breaches associated with clinical governance had not been addressed despite some actions being demonstrated by the practice. We also found continued poor outcomes associated with some population groups which had extended over a significant time period with no improvement.

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

## Safe Rating: Requires Improvement

At our previous inspection in October 2019, we found issues identified in relation to safeguarding, recruitment, infection control, suitable immunisation processes for staff, Patient Group Directions and clinical governance concerns associated with the Health and Social Care Act.

At our focused inspection in September 2020, we saw continued safety concerns associated with clinical governance.

At this inspection divided between a remote records assessment in December 2020 and the on-site visit in January 2021, the practice had made improvements in safeguarding, recruitment, infection control, immunisation processes for staff and Patient Group Directives. However, we found that the breaches associated with clinical governance had not been fully addressed despite actions being taken by the practice. We did note that the practice had introduced measures to improve this although it was too early to see the impact.

### Safety systems and processes

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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. At our previous inspection, we found concerns regarding safeguarding training and disclosure and barring certificates (DBS) for some staff. At this inspection, the practice were able to demonstrate these records.</li> <li>2. We observed evidence of the practice clinical meetings minutes which showed evidence that the practice were aware of active safeguarding cases and at risk patients. In addition, we were told that safeguarding meetings were conducted remotely using online platforms.</li> </ol>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. At our previous inspection, we found concerns regarding complete recruitment documentation and staff vaccination evidence. We found that these concerns had been addressed by the practice.</li> <li>2. We observed five recruitment records at the practice and found small gaps which were later verified when we asked the practice. The practice was moving to an online system when we inspected and expected it to be easier to identify specific recruitment paperwork once this had been completed.</li> </ol>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
-----------------------------------	--------------------

There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 23/11/2020	Y
There was a record of equipment calibration. Date of last calibration: 23/11/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 10/03/2020	Y
There was a log of fire drills. Date of last drill: 30/12/2020	Y
There was a record of fire alarm checks. Date of last check: 31/12/2020	Y
There was a record of fire training for staff. Date of last training: 02/2020	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 12/03/2021	Y - 1
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
1. The practice submitted a fire action plan which appeared to form part of a larger external assessment. However this document was not dated to establish when the risk assessment had been conducted. We had previously seen an action plan from October 2019 on our previous inspection but we did not see evidence of the actions taken by the practice following this or if the assessment had been renewed. "Following our observations, the provider confirmed that an updated fire risk assessment was conducted on the 12th March 2021 and there had been delays in conducting this due the Covid 19 pandemic but we did receive evidence of this to verify it had been completed. We also observed evidence of actions associated with the most recent assessment viewed in 2019"	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: No Date	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/2019	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: 12.2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. At our previous inspection, the practice could not demonstrate infection control training and appropriate sharps storage. At this inspection the practice demonstrated they had rectified these shortfalls.</li> <li>2. We observed good infection control and prevention which took into account guidance associated with the covid 19 virus. Staff were observed to be practicing in line with infection control guidance and were wearing personal protective equipment safely.</li> </ol>	

## 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.	Partial -1
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial - 2
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. We found several gaps in our clinical records review which caused us concern in relation to the ongoing governance of safety alerts. As a result, we could not be assured that comprehensive risk assessments were being completed for patients.</li> </ol>	

2. The practice had experienced a number of staff changes in the last year. Some of these changes were sudden and we had identified concerns in clinical records during this time period. As a result, we could not be reassured that the practice had fully assessed or monitored the impact on safety.

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	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
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial - 1
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial – 1.
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> <ol style="list-style-type: none"> <li>1. Our clinical records review of the practice continued to find gaps in patient records which did not assure us that systems were in place to ensure that information being documented by staff was in line with recommended guidelines regarding record keeping. For example, in records we reviewed a rationale for continuing a medication was not always found and it was difficult to ascertain ongoing actions taken by the practice when a patient was prescribed a medication.</li> <li>2. When the practice was made aware of these concerns, we observed action was taken to preserve patient safety.</li> </ol>	

## Appropriate and safe use of medicines

### The practice did not have 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) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.59	0.47	0.82	Tending towards variation (positive)
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)	8.8%	9.9%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2020 to 30/09/2020) (NHSBSA)	6.07	5.61	5.34	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	138.4‰	50.9‰	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)	2.31	0.78	0.68	Variation (negative)

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 - 1

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 - 2
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 - 2
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N - 3
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.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	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> <ol style="list-style-type: none"> <li>Following our clinical records review, we asked the practice how their pharmacists were being supervised when conducting clinical care. We found that the practice did have a system in place to facilitate and help pharmacists, however this was not evidenced and the clinical records we reviewed indicated concerns. Interviews with staff indicated they were given advice, although records indicated this was not sufficient to ensure patient safety.</li> <li>We found during our clinical records review that a number of patients did not have a medicine review in the recommended time period. Our virtual record searches identified 800 patients on repeat medication. Searches suggested that 222 (27%) had not had a medication review in the last 15 months. Additionally, 119 (15%) did not have a medication review in the last two years. In addition to this, we found it unclear in some medical records why medicines were commenced or why doses were amended or stopped abruptly. The provider has informed us they have followed-up patients who were overdue a medication review and continue to address these concerns.</li> <li>We saw examples of medical records where patients taking controlled drugs were not being monitored in line with evidence based practice. For example, we reviewed ten records and found in all examples that addiction risk was not documented during a medication review and the provider also did not provide a clear rationale within the records for continuing the medication.</li> <li>When the practice were made aware of these findings, they took action to ensure the safety of their patients.</li> </ol>	

Medicines management	Y/N/Partial
5. We reviewed patient group directives (PGD's) following concerns we found at our last inspection. A system was demonstrated and no concerns were identified during this inspection.	

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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial - 1
There was a system for recording and acting on significant events.	Partial - 1
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial - 1
Number of events recorded in last 12 months:	15.
Number of events that required action:	13.
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>When speaking with staff who worked at the practice, some were unable to recall a recent significant event at the practice or learning lessons associated with the event. As a result, we could not be assured that there was adequate learning from significant events. We noted that significant events were discussed in practice meetings but we could not verify that the lessons learned were embedded into the practice. The significant event summary document did not give constructive detail as to how some significant events would be avoided in the future. In some examples, the practice reinforced their own systems should operate better but did not look at how.</li> <li>We saw an example of a recent significant event that has been discussed in a practice meeting but had not been fully added to the summary document.</li> </ol>	

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

Event	Specific action taken
Medication commenced by GP as a repeat prescription but not issued by the practice.	Processes regarding how a patient's recorded results should be reviewed following the introduction of a new medicine.
Patient weight identified as incorrect when checked within their consultation.	Process for acquiring information changed so that weight is only taken by a clinician during a patient consultation to ensure consistency.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial - 1
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
1. The practice did have a system for safety alerts and we saw examples of safety alerts being actioned through the practice governance structure. However, our clinical records review found that some older safety alerts were not being continuously monitored. As a result we found that some patients	



were on unsafe combinations of medication. When looking at these patient records, the provider was found to have not identified or acted upon the risks associated with the safety alerts in 21 patients. When the practice was made aware of our observations they acted to ensure safety of their patients were maintained.

## Effective

## Rating: Inadequate

At our previous rated inspection in October 2019, we rated the practice as “Requires Improvement” for providing effective services as we identified concerns regarding long-term condition patient outcomes, childhood immunisations and cervical screening uptake as data was below local and national averages. In addition, we found that some of the staff had not completed appropriate core training in line with guidance and practice policy and there was no system in place to undertake any formal appraisal or review of their long-term locum GPs or locum practice nurse in relation to all population groups.

At this inspection the practice had improved their childhood immunisation data and their staff training was found to be up to date. However, long-term condition data parameters and cervical screening rates remained lower than the local and national average. We also did not see full evidence of staff appraisals and reviews which caused concerns regarding clinical governance and reassurance that certain staff were acting within their scope of practice. Our virtual records review also found that patients were not always reviewed in line with the evidence based guidance expectations. The practice has therefore been rated as Inadequate for providing Effective services and “Requires Improvement” for all population groups except people with long term conditions and working age people (including those recently retired and students) which are rated “Inadequate”.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N - 1
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients’ treatment was regularly reviewed and updated.	N - 1
There were appropriate referral pathways to make sure that patients’ needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: 1. During our virtual records review we found that patients were not always reviewed in line with the evidence based guidance. This included controlled drugs, medication reviews and hypertension monitoring.	

## Older people

## Population group rating: Requires Improvement

### Findings

- We rated this population group as requires improvement due to the concerns found during our virtual records review which affected the population group. This primarily concerned medication reviews as risks associated with medications not being reviewed held higher safety concerns to this population group due to the potential higher number of medications being taken and the more changeable physiological effects of the medication.
- 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.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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

- We rated this population group as inadequate due to the concerns found during our virtual records review which affected the population group. We were concerned that some performance indicators had not shown a consistent improvement when compared to local and national averages.
- Asthma reviews did show good performance. We were also encouraged by their PCA rates which were lower than local and national averages.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	94.9%	77.1%	76.6%	Significant Variation (positive)
PCA* rate (number of PCAs).	29.0% (40)	13.5%	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)	89.5%	91.3%	89.4%	No statistical variation
PCA rate (number of PCAs).	2.6% (1)	17.3%	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)	69.2%	80.6%	82.0%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.5% (2.0)	4.6%	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)	44.5%	68.9%	66.9%	Variation (negative)
PCA rate (number of PCAs).	7.0% (13.0)	13.9%	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)	61.6%	69.8%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	4.3% (13.0)	4.8%	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)	70.4%	90.1%	91.8%	Variation (negative)
PCA rate (number of PCAs).	10.0% (3)	6.4%	4.9%	N/A

### Any additional evidence or comments

1. We noted the ongoing audit activity that the practice had commenced since our initial focused inspection in September 2020 where we virtually reviewed records at the practice and found concerns associated with diabetes and hypertension care plans.
2. We noted that there was some improvement in care planning of long term conditions by the practice since we issued a warning notice expressing concern in this area. We reviewed ten care plans during this inspection virtually and were happy with all records seen. However the data reviewed still shows that over 200 patients were still affected last year and in conjunction with the clinical record keeping concerns we identified during this inspection we did not fully feel assured that patients with long term conditions are cared for effectively.

**Findings**

- We rated this population group as requires improvement due to the concerns we found during our virtual records review which affected the population group. We did see improvement from the practice in their performance for childhood immunisations and the performance did fall in line with local practices. However there is still scope for improvement.
- The practice has not met the minimum 90% for two of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- 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.

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>

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)	27	33	81.8%	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) (01/04/2019 to 31/03/2020) (NHS England)	20	23	87.0%	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) (01/04/2019 to 31/03/2020) (NHS England)	21	23	91.3%	Met 90% minimum
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)	21	23	91.3%	Met 90% minimum
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)	13	23	56.5%	Below 80% uptake

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

1. The practice operated a call system to ring parents or carers of children to invite them for their scheduled immunisations. This list was generated using their computer software data. This was given to both the reception staff and nurses to action.
2. The practice told us they had identified language barriers, patient mobility and an ethnic minority population as key challenges in continuing to improve these outcomes.

**Findings**

- We rated this population group as inadequate due to the concerns we found during our virtual records review which would have affected the population group. We also held concerns regarding the two week wait referral data which was below local and national performance levels. Additionally, bowel screening was also seen to be below local averages. Cervical screening data was also noted as low, however the practice provided unverified data through their computer system that suggested upcoming improvement which would move the practice to 75%. This snapshot however could not be compared with Public Health England data due to different parameters.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/06/2020) (Public Health England)	51.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	53.2%	53.1%	70.1%	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)	28.9%	38.1%	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)	0.0%	88.4%	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)	37.5%	55.9%	54.2%	No statistical variation

**Any additional evidence or comments**

1. The practice had recently reviewed their cervical screening recall scheme. When we raised the figures with the practice. The practice felt that the data was a little lower than they expected. The practice provided unverified data which suggested improvement in cervical screening from their own computer system. However, we were unable to verify how this data was calculated and as a result could not use this as comparable data.



2. The practice was planning to have a dedicated cervical screening day each week including mass text messaging and letter correspondence to their patient population. The business managers intention was to call patients directly to initiate this in order to utilise a personal approach.
3. The practice told us that patients who did not attend appointments would be taken into consideration as part of this scheme and the practice provided a method for chasing these patients. Text messaging would be used at specific times which would be allocated ahead of time as part of their planning. The practice told us they would review population categories one at a time over the next year with a continuous process being implemented across the year.

## People whose circumstances make them vulnerable

## Population group rating: Requires Improvement

### Findings

- We rated this population group as requires improvement due to the concerns found during our virtual records review which would have affected the population group. For example, 52 patients were on pain medication that could cause addiction whom had not received a medication review. The practice also did not always give a clear rationale for continuing this medication on occasions. The practice have a register of vulnerable families and homeless.
- Same day appointments and longer appointments were offered when required.
- 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.
- 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: Requires Improvement

### Findings

- We rated this population group as requires improvement due to the concerns found during our virtual records review which would have affected the population group. Additionally, we noted data that identified the practice were lower than local and national averages in comprehensive care planning for the population group. The practice supplied unverified data from their own systems to show they were addressing this concern.
- The practice held a mental health register of 94 patients.
- The practice held a dementia register of nine patients
- 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.
- Same day and longer appointments were offered when required.
- 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>	55.4%	77.4%	85.4%	Variation (negative)
PCA rate (number of PCAs).	2.6% (2)	10.9%	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>	85.7%	81.5%	81.4%	No statistical variation
PCA rate (number of PCAs).	12.5% (1)	7.8%	8.0%	N/A

## 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)	500.45	Not Available	533.9
Overall QOF score (as a percentage of maximum)	89.5%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	6.2%	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.	Partial - 1
Quality improvement activity was targeted at the areas where there were concerns.	Y
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

We observed the audits in the following areas from the past two years:

- Anti-biotic prescribing.
- Dependence forming drug prescribing.
- Medication Reviews.

We also observed a matrix that outlined a further ten audits. However we were unable to see these in more detail and any improvements identified and carried forward by the practice.

### Any additional evidence or comments

1. The practice conducted an anti-biotic prescribing audit which looked at prescribing rationale. A search was conducted as part of the audit, but no actions were taken from the evidence we reviewed. In addition, a two cycle audit was conducted on dependence forming drugs and how they were reviewed. A clear template to measure performance and adherence was used by the practice but ongoing changes to their approach were not included in the evidence we observed. Additionally, we found continued concerns in our virtual records review which showed that this audit did not fully mitigate the concerns we held regarding the review of dependence forming drugs. We also reviewed evidence of a two cycle audit into medicine reviews. The second cycle of the search occurred following our virtual records review and did show improvement from the sample searched. However, our virtual records review found significant concerns which covered a higher sample size of the practice patient population. The practice acted on this information promptly when we made them aware of this.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Partial – 1.
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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial – 1.
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial - 1
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N – 3.
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. The practice had clinical staff who were being supervised informally by the lead GP. There were no records of supervision or clinical review with either pharmacists or nurses found until December 2020 following our virtual records review. When we asked staff about this, they confirmed that they were supervised and were comfortable within their roles, but that formal arrangements had only been recently introduced. We observed an appraisal matrix for staff at the practice however did not see evidence of appraisal templates being filled out to evidence that appraisals had been completed. We also asked staff who were unaware that they were due to receive an appraisal. Following our inspection, evidence was submitted which showed more consideration for supervision of the lead clinical pharmacist and one staff member. We did not see evidence for the majority of staff at the practice and could not be assured that the process was embedded well at the practice.</li> <li>2. The practice conducted mandatory training with staff using an online platform which was supported by a new online matrix to support this. However, we did not see evidence of a further structured programme of staff development which extended beyond their online training system to support staff development.</li> <li>3. The practice had recently had staff changes. When reviewing recruitment files we did not see evidence of paperwork that supported the practice followed their policies in discipline or sickness scenarios which were outlined to us when we spoke with the management of the practice.</li> </ol>	

## 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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

## Consent to care and treatment

### The practice always obtained 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



# Caring

Rating: Good

## Kindness, respect and compassion

Staff demonstrated that they treated patients with kindness, respect and compassion. However, some feedback from patients was mixed 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.	Y

Source	Feedback
Google Reviews	2.3 out of 5 stars based on 25 reviews. Very different experiences identified from the reviews. Negative experiences involved negative or rude staff manner, however the GP's at the practice are also praised on occasions.
NHS Reviews	4.1 out of 5 stars based on 9 reviews. Praise for GP care observed. Some isolated poor experiences.

## 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)	82.0%	87.1%	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)	79.7%	84.9%	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)	92.8%	93.3%	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)	79.6%	78.4%	81.8%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N - 2

Any additional evidence
<ol style="list-style-type: none"> <li>1. The practice had conducted an analysis of the GP survey results they had received and were pro active at understanding where they could improve.</li> <li>2. We did not see any additional evidence regarding the practice conducting their own independent surveys on patient experience.</li> <li>3. The practice had a Friends and Family Test survey running until January 2020 but this was discontinued due to the Covid 19 pandemic.</li> </ol>

### Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Partial - 1
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. During our inspection, the practice demonstrated mechanisms to support, identify and assist potential carers, however the processes could have been enhanced further with the use of a carers board for service users.</li> </ol>	

### 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)	89.3%	89.9%	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

Carers	Narrative
Percentage and number of carers identified.	3,642 patient population. 136 carers. 3.7% of patient population.
How the practice supported carers (including young carers).	The practice computer system has an alert for young carer involvement. The practice pro-actively identify through clinic appointments, registration forms and referrals from their care navigator.
How the practice supported recently bereaved patients.	The practice send a condolence card and a support telephone call is made.

## 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

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

## Responsive

## Rating: Requires Improvement

At the previous inspection in December 2019, the practice was rated as “Good” for responsive services. During this inspection, we found documentation gaps in the way complaints were managed as they did not identify all aspects of how the complaint was managed and resolved within their practice complaint log. There were also some examples of complaints seen in meeting minutes which were not included on the complaint log of the practice. Despite this, the practice did demonstrate some learning associated with their most recent GP survey results. Due to this, we rated the responsive key question as “Requires Improvement”.

### Responding to and meeting people’s needs

#### The practice organised and delivered services to meet patients’ needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

### Practice Opening Times

Day	Time	
Opening times:		
Monday	09.00 – 12.30	13.30 – 20.00
Tuesday	09.00 – 12.30	13.30 – 18.00
Wednesday	09.00 – 12.30	13.30 – 18.00
Thursday	09.00 – 12.30	13.30 – 18.00
Friday	09.00 – 12.30	13.30 – 18.00
Appointments available:		
Monday	09.00 – 12.30	13.30 – 20.00
Tuesday	09.00 – 12.30	13.30 – 18.00
Wednesday	09.00 – 12.30	13.30 – 18.00
Thursday	09.00 – 12.30	13.30 – 18.00
Friday	09.00 – 12.30	13.30 – 18.00

## Older people

## Population group rating: Requires Improvement

### Findings

- Due to the concerns identified in the management and learning of complaints, we were not assured that this wouldn't affect the population group. We therefore rated this population group as requires improvement.
- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- Due to the concerns identified in the management and learning of complaints, we were not assured that this wouldn't affect the population group. We therefore rated this population group as requires improvement.
- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided 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: Requires Improvement**

### **Findings**

- Due to the concerns identified in the management and learning of complaints, we were not assured that this wouldn't affect the population group. We therefore rated this population group as requires improvement.
- Additional appointments were available until 8pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- 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: Requires Improvement**

### **Findings**

- Due to the concerns identified in the management and learning of complaints, we were not assured that this wouldn't affect the population group. We therefore rated this population group as requires improvement.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8.00pm on Mondays to supported extended operating hours.



## People whose circumstances make them vulnerable

## Population group rating: Requires Improvement

### Findings

- Due to the concerns identified in the management and learning of complaints, we were not assured that this wouldn't affect the population group. We therefore rated this population group as requires improvement.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## People experiencing poor mental health (including people with dementia)

## Population group rating: Requires Improvement

### Findings

- Due to the concerns identified in the management and learning of complaints, we were not assured that this wouldn't affect the population group. We therefore rated this population group as requires improvement.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Timely access to the service

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

#### National GP Survey results

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

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)	84.9%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	71.2%	63.9%	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)	62.3%	62.7%	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)	69.5%	67.3%	72.7%	No statistical variation

#### Any additional evidence or comments

1. The practice provided analysis from their most recent GP survey data. From this analysis, there was a clear plan for how to improve upon patients experiences. For example, the practice noted concern around waiting times and looked to rearrange how appointments were released so that appointments were more numerous for on the day bookings. The Patient Participation Group views were sought by the practice in creating initiatives to respond to the survey however there was a lack of detail in how this was done in the minutes of the meeting we observed.
2. The practice had implemented new systems which promoted remote access to the practice due to the Covid 19 virus. This included the use of digital platforms to assist patients with contacting the practice increasing the number of methods available to them.

## 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.	5
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N – 1.
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. We saw evidence of a spreadsheet the practice had been using which covered four complaints from the past 12 months. The spreadsheet did not give any ongoing actions to drive improvement following the resolution of the complaint. In one example from July 2020, the practice had not recorded any actions following the complaint being made despite it now being five months since the complaint had been logged. In addition, another complaint was recorded in June 2020 and did not have a documented resolution until December 2020.</li> <li>2. Lessons from complaints were discussed in clinical meetings. However, learning outcomes were not always identified. For example, an incomplete entry on the complaints log submitted to us was looked at by comparing practice meeting minutes for the same time range. The complaint was documented as handled by the registered manager and that a formal complaint was going to be made externally regarding the experience. No learning to drive improvement was identified and this information was not documented in the complaints log.</li> </ol>	

### Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint made regarding GP stopping medication despite advice from secondary care indicating that medicine was still indicated.	Meeting was conducted with the patient and an alternative appointment was made. No specific learning identified.
Complaint made as parent wanted to discuss two children in one appointment.	Apology given to patient and review has been booked. No specific learning identified.

## Well-led

## Rating: Requires Improvement

At our previous inspection in October 2019 we found that there were gaps in governance systems and processes which included safe recruitment, infection prevention and control and staff core training. We also did not see a formal written strategy for the practice. At our focused inspection in September 2020, we also found concerns in how clinical governance was undertaken at the practice. At this inspection, we found some changes, however we still found ongoing concerns regarding clinical governance and continued poor data indicators for population groups which indicated that these changes were not effective.

### Leadership capacity and capability

**Leaders could 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.	Y
They had identified the actions necessary to address these challenges.	Partial - 1
Staff reported that leaders were visible and approachable.	Partial - 1
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ol style="list-style-type: none"><li>1. The practice leadership did demonstrate a desire to improve upon their performance. The practice had started to explore the best way to pursue this and submitted an action plan to us in September 2020 to outline how they would pursue this. However, following this inspection the actions the practice had put in place had not resolved the concerns we had with clinical governance but it is felt that there is potential behind this action plan. It was expressed that ongoing monitoring was of significant importance to ensure the proposed actions resulted in improvements and that the practice were able to demonstrate this.</li><li>2. Staff we spoke with were happy in their roles, however there had been increased staff turnover at the practice recently and evidence found during the remote phase of the inspection showed that clinical oversight had been affected at the practice.</li></ol>	

### Vision and strategy

**The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Partial - 1
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N - 2

Staff knew and understood the vision, values and strategy and their role in achieving them.	N - 2
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The practice did outline a strategy to improve but this has not demonstrated improvement yet in the areas we found concerns in.</li> <li>2. Limited staff had an active involvement in the practice strategy. When we interviewed staff at the practice, many were on locum contracts and felt they did not have a role to play in the practice vision. For example, one member of staff was involved in clinical care but not involved in strategies that involved improving clinical performance parameters. Additionally, when we asked staff what they understood by the practice vision, it was unclear that staff understood this and how it applied to them. Staff were involved in practice meetings but there was limited learning from incidents such as complaints or significant events that staff were able to recall. Additionally, a lack of documentation surrounding appraisals and quality improvement projects for staff was not evidenced by the practice.</li> </ol>	

## 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.	N - 1
Staff reported that they felt able to raise concerns without fear of retribution.	N - 1
There was a strong emphasis on the safety and well-being of staff.	N - 1
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.	Partial - 2
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. We noted that the practice had changes in staff during our inspection process. We could not find any evidence that the internal policies of the practice had been followed to allow for performance reviews or wellbeing checks of staff. We were also concerned that the nominated clinical lead for the practice was on long term sick leave, but that formal wellness checks conducted with the staff member since their sickness period had not been occurring.</li> <li>2. The documentation of significant events and complaints was not complete from the past year. It was clear that the practice did resolve incidents with patients, but there was an absence of lessons learnt</li> </ol>	

or changes in processes at the practice. We also did not see any evidence of these lessons in practice meeting minutes.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N - 1
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The practice did respond to our concerns regarding clinical governance from our previous inspection. But there were continued areas of concern found in medicines management, safety alerts and medication reviews from our virtual records review that did not assure us that the changes in governance was effective and safe. The audits designed to pick up on the effectiveness of these changes did not identify the risks of our virtual records review due to the sample size of the searches conducted.</li> <li>2. There was no effective process to ensure all staff could understand the actions taken and learning points shared, particularly if they were not present at a meeting.</li> </ol>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial - 1
There were processes to manage performance.	N – 2.
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial – 3.
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.	Partial – 4.
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. Audits were in use to monitor effectiveness of the practice systems, but they did not identify all areas of concern and we did not find evidence of these systems being reviewed.</li> <li>2. We did not see sufficient evidence of performance reviews for all staff. The practice operated on informal peer reviews for clinical staff which were not documented. When we identified this during the inspection, the practice started to formalise the process.</li> </ol>	

3. The practice audit programme did identify some risks, but lessons and ongoing actions associated with the audit results were lacking. Our concerns from the virtual records review also did not assure us that clinical risk to patients was being identified.
4. Some medications were suddenly stopped by the practice following our initial virtual record review in mid-December. The practice did not make patients aware of these actions when they initiated this which could have caused difficulties with patients who were not consulted. The practice was being proactive to our findings by doing this, but it raised concerns that patients were not being notified of such a significant change and raised concerns about how these changes were communicated to patients. The practice was able to verify our concerns by explaining that a telephone call would be made to make patients aware of this and that their computer system would make them aware that a change had occurred. The practice also demonstrated text messages to patients to make them aware of the change when we visited the practice on the 7th January 2021.

### Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial - 1
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N – 2.
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The practice did demonstrate the use of data to us when tracking their performance. However, the sources of this data was often unverified data. The practice worked closely with their clinical commissioning group and primary care network to establish reliable data streams to assess performance, but we were unable to see the improvements of these actions in our verified data sources.</li> <li>2. Owing to this observation, we could not be assured that the practice were mitigating risks associated with their usage of data to drive performance. These concerns were in addition to those found during the virtual records review.</li> </ol>	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial - 1
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	N - 2
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: 1. The practice complaint log wasn't complete and did not show evidence of how patients views were used to improve their processes. The patient participation group had been held once virtually in 2020 but the minutes associated with this meeting were very limited and did not suggest any actions associated with improvements. 2. The staff views did not seem to be taken into consideration when planning to improve services. Staff attended practice meetings but the minutes from the meetings did not suggest active collaboration with staff, this was further confirmed from our interviews with staff.	

Feedback from Patient Participation Group.

Feedback
The patient participation group were not spoken with during the inspection process.

## Continuous improvement and innovation

**There were 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 – 1.
Learning was shared effectively and used to make improvements.	N – 2.
Explanation of any answers and additional evidence: 1. The practice did conduct some internal learning at the practice. However there was scope for this to be extended much further. 2. Meeting minutes did not evidence learning was shared effectively.	

Examples of continuous learning and improvement
1. Record keeping presentation by Lead Pharmacist. 2. First aid practical Training by Lead Pharmacist.



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

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

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

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

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

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

## Glossary of terms used in the data.

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