Care Quality Commission

Inspection Evidence Table

Woodside Surgery (1-549062796)

Inspection date: 24 September 2020

Date of data download: 04 September 2020

Overall rating: Inadequate

At our October 2019 inspection we rated the practice as Inadequate overall because the provider needed to make improvements to; ensure that care and treatment was provided in a safe way, safeguard service users from abuse and improper treatment and establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. In February 2020 we followed up on the breaches of regulations identified at the previous inspection on 23 October 2019 to check whether the provider had taken steps to comply with the legal requirements for these breaches; Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and Treatment, Regulation 13 HSCA (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment, Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance and Regulation 19 HSCA (RA) Regulations 2014: Fit and proper persons employed. At our September 2020 inspection we saw that some improvements had been made in the areas of concern that we previously identified, but we also identified new concerns with regard to the delivery of safe, effective and well led services. The overall rating remains inadequate and the practice continues to be in special measures.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Inadequate

At our October 2019 inspection we rated the practice as Inadequate for safe services because the arrangements in respect of; infection prevention and control, safeguarding, medical emergencies, significant events and medicines management put patients at risk of harm. At our September 2020 inspection, we saw improvements in respect of some of these areas, however we saw that some systems including recruitment, medicines' management and significant event processes were not adequate to keep patients safe. We have rated the practice as inadequate for providing safe services:

- 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 four alerts we reviewed, which affected at least 48 patients. 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. We reviewed seven out of 27 patients on high risk medicines and found that five were not appropriately managed.
- 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. We reviewed patient consultation records and found discrepancies with the coding of medical records.

- We reviewed the practice's system for managing pathology results and found that there was not a robust system to ensure urgent abnormal results were always reviewed and acted on in a timely way.

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.	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.	Partial
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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
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:	

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

The practice had recruited a clinician since our previous inspection. Written references had not been sought and there was no proof of identity held on record. There was no documentary evidence of any qualifications relevant to the duties for which the person was appointed. The recruitment procedures followed did not establish whether the clinician was able, by reasons of their health and after reasonable adjustments, to properly perform tasks intrinsic to the work for which they had been employed.

However, a disclosure and barring check had been undertaken and the practice had checked the clinician's registration with the appropriate regulatory body.

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: October 2019	Y
There was a record of equipment calibration. Date of last calibration: October 2019	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: 14.09.2020	Y
There was a log of fire drills. Date of last drill: 12.02.2020	Y
There was a record of fire alarm checks. Date of last check: 17.09.2020	Y
There was a record of fire training for staff. Date of last training: various dates completed	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 14.02.2020	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2019	Y

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:01.05.2020	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: We saw that 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, touch screens had been sealed off and there were barriers at reception to ensure social distancing was adhered to. Additional time between appointments had been added to allow for the sanitising of furniture, door handles and equipment.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
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.	Y
Explanation of any answers and additional evidence: We carried out some searches of patients records regarding care and prescribed treatments and found that in a significant amount of cases, NICE guidance was not followed. As a result of our inspection the provider agreed to look into the matter and make the relevant changes as	

recommended in the clinical guidance. The provider was aware of the guidance but had not yet implemented this into practice.

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.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N

Explanation of any answers and additional evidence:

We reviewed patient consultation records and found a pattern of a lack of coding within medical records. Some records were incorrectly coded, for example, one record had a patient coded as 'impaired glucose intolerance' rather than as diabetic. This meant that the patient was at risk from harm through potentially not receiving the right care at the right time.

We reviewed the practice's system for managing pathology results and found that there was no effective system to ensure urgent abnormal results were always reviewed and acted on in a timely way. For example: From the records that we looked at, we found 12 examples of abnormal blood test results which had not had any action taken. The oldest of these abnormal results went back to 2011.

We saw that the practice's complaints log had recurrent themes of complaints regarding delays in care and treatment spanning a 12-month period. However, this trend did not appear to have been addressed as a learning opportunity and did not lead to a process or quality change. For example, a patient had frequently attended the GP practice with worsening symptoms but was only referred to secondary care after six months of frequent appointments. The patient's presenting symptoms were diagnosed as a malignancy shortly after being referred.

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) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	1.18	1.00	0.85	Tending towards variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA)	15.2%	8.6%	8.6%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2020 to 30/06/2020) (NHSBSA)	6.18	5.63	5.35	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	5.43	2.41	1.92	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
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
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
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N

Medicines management	Y/N/Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N
For remote or online prescribing there were effective protocols for verifying patient identity.	N
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

Explanation of any answers and additional evidence:

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. We identified patients who were not appropriately monitored and who were on high risk medicines and patients affected by drug or patient safety alerts had a medicine review coded but no actions were taken to reduce the risks for these patients. By failing to carry out appropriate medication reviews the provider could not assure themselves that patients were safe and exposed to 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.

The practice did not evidence an effective system to ensure patients on high risk medicines were appropriately managed in a timely way. We reviewed seven high risk medicines and found that five were not appropriately managed, affecting at least 27 patients. If patients were monitored by secondary care, the practice did not provide evidence they had accessed or considered the results

The practice accepted requests for repeat prescriptions, in addition to other methods, via a 24-hour telephone answering machine service. This has the potential to increase the risk of prescribing errors and we saw that an incident of this nature had been logged on the practice's significant event log however, changes had not been considered to prevent recurrence.

We found that patients who were overdue monitoring had had numerous interactions with the practice, but at no point was blood monitoring requested or undertaken.

Although antimicrobial prescribing remains higher than the local CCG and England averages, there had been an improvement in this data since our previous inspection. In our discussions with the provider, they demonstrated their awareness of the need to continue to monitor this over time, in order to sustain these improvements.

Track record on safety and lessons learned and improvements made

The system for learning and making improvements when things went wrong needed improving.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	31
Number of events that required action:	31
Explanation of any answers and additional evidence: Since our previous inspections the practice had implemented effective systems to record significant events. It was clear from information received from staff that they were fully aware of how to identify and report concerns and there was a culture which supported staff to do so. However, we saw from both the complaints log and the significant events log that some potentially serious clinical incidents (including patient deaths) had not been recorded as significant events but dealt with under the practice's complaints procedures.In all of these cases, the practice had sent a three-day acknowledgement response letter but had not commenced any investigation into the circumstances of the incidents for between four and eight weeks. In this way, there had been no evidence of lessons learned which may have prevented further incidences from occurring.	

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

Event	Specific action taken
A Patient requested a medicine named 'Titropium' by leaving a message on the practice's answering machine. In error, a medicine named 'Trimethoprin' was issued.	All GPs were informed individually. All staff involved in the prescriptions' process were informed to check with more senior person if unsure, or call the patient to confirm.
While checking cervical smear results a clinician discovered a number of results which had been unfiled in a laboratory report for up to 6 weeks. Some of the results were abnormal.	The patients had been invited to colposcopy but the results had not been coded. The practice initiated a change in procedure to ensure the incident could not be repeated.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence: The practice did not evidence an effective system for acting upon patient and medicine safety alerts. We reviewed patient records relating to four medicine safety alerts (where patients were prescribed	

medicines where there could be potential risk to their health). In all of these records which we reviewed, we could not find any evidence recorded that the risks had been considered or discussed with the patients.

Effective Rating: Inadequate

At our October 2019 inspection we rated the practice as requires improvement for the Effective key question because the arrangements in respect of; regular reviews, staff training, and clinical audit needed improving. This applied to all the population groups, so we also rated all the population groups as requires improvement. At our September 2020 inspection we saw further concerns about effective care and treatment:

- The practice failed to evidence patients' needs were adequately assessed. We found care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance
- We found a number of examples where clinical coding was missing from patient records or the clinical coding applied was not accurate. This meant that patient's needs were not always identified and therefore they were not always given appropriate care and treatment.
- Due to the failings of the practice to ensure clear and accurate record keeping we were not assured care was effective for patients across all population groups.
- The practice failed to have an effective system in place for recalling, monitoring or treating patients with a potential diagnosis of diabetes. This did not ensure these patients received proactive care and advice to make informed choices and life style changes to prevent further deterioration of their health.
- The practice's quality improvement program did not reliably identify or respond to patients needs to ensure they received appropriate or proactive care in line with guidance. This was further impacted by inappropriate, incorrect or missing coding.

Effective needs assessment, care and treatment

Patients' needs were not properly 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.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	N

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N

Explanation of any answers and additional evidence:

We found the practice team were not always up to date with current evidence-based practice. For example, partners at the practice were unable to evidence that they were aware of the requirements of monitoring high risk medicines.

We reviewed patient consultation records and found discrepancies with the coding of medical records: We found examples of patients where concerns had been identified, but there was no coding or alerts on the patient records to ensure the patient was identified appropriately in order to receive effective support, care and treatment.

As the coding in patient's records was so inconsistent, it was not possible to conclusively search for and find all patients and determine the risks these patients were exposed to. This meant there was a risk that other clinicians or services seeing the patient would not be aware of all of the relevant information to enable them to provide appropriate care and treatment.

We found the practice did not have a system in place for recalling, monitoring or treating patients with a potential diagnosis of diabetes. We found nine patients with raised HbA1c levels (this a blood test which indicates how well-controlled a patient's diabetes is, over time) identified during a blood test. We reviewed two of these patient records but there was no evidence of any follow up from the practice.

We found patients did not always receive an appropriate review of their care in line with guidance. For example:

- The practice did not always complete documented medicine reviews for patients and therefore the practice were unable to evidence these patients received regular reviews of their care. We found a number of patient records containing (an administrative) coded medication review but the consultation of that medication review contained no information.

We identified a number of patients with abnormal results who had not been followed up appropriately by the practice. One patient had a blood test in 29/04/2014 which recorded an abnormal result. There was no information in the patient's record to evidence any follow up actions to the abnormal result and the blood test result was filed as 'happy with result' by Doctor 'x' on 09/05/2020.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHSBSA)	1.46	0.66	0.70	Tending towards variation (negative)

Older people

Population group rating: inadequate

Findings

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given effective care and treatment. The practice failed to evidence that they conducted structured medicine reviews for patients. As a result of these significant concerns all population groups are rated as inadequate.

We saw evidence from patient records regarding older people that the recording of information, the follow-up and management of this group of patients needed to be improved. For example, we saw minimal record keeping for some patients on end of life care pathways.

People with long-term conditions — Population group rating: inadequate

Findings

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given effective care and treatment. The practice failed to evidence that they conducted structured medicine reviews for patients. As a result of these significant concerns all population groups are rated as inadequate.

The practice told us patients with long-term conditions were offered a review to check their health and medicines needs were being met. However, we found the practice did not have a consistent approach to this. We found the coding of medical records did not ensure all patients with a long-term condition were identified to ensure they received follow up care and annual reviews.

The practice could not demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes. Records we reviewed showed patients had blood test results that required further monitoring and discussion with the patients. The practice had not taken action to review these patients in a timely manner.

There was an overprescribing of salbutamol inhalers for patients diagnosed with asthma, at the practice. Asthmatic patients who require more than ten salbutamol inhalers in 12 months (without appropriate management) are at risk of unstable asthma control, potentially resulting in hospitalisation and death. We saw evidence of significant discrepancies in asthma management. From the searches that we looked at, eight patients had entries in their records stating they had good control when they had been prescribed up to 40 inhalers per year. There was no follow-up of at least three out of these eight patients. One patient had their inhaler use underestimated by 50% at asthma review. Some patients had been reviewed but there was no evidence of any appointment in the practice appointments' ledger.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	71.4%	78.3%	76.6%	No statistical variation
Exception rate (number of exceptions).	15.4% (61)	14.9%	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)	92.0%	91.8%	89.4%	No statistical variation
Exception rate (number of exceptions).	9.9% (22)	15.6%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	93.4%	93.0%	91.8%	No statistical variation
Exception rate (number of exceptions).	6.2% (8)	4.2%	4.9%	N/A

Families, children and young people **Population group rating: inadequate**

Findings

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given effective care and treatment. The practice failed to evidence that they conducted structured medicine reviews for patients. As a result of these significant concerns all population groups are rated as inadequate.

Nationally reported data for the period April 2018 to March 2019 shows the practice performed at a fraction below the minimum 90% for three of four childhood immunisation uptake indicators. However, unverified practice derived data from September 2020 ("How Am I Driving?") indicated that it achieved booster uptake rates of between 93%-94%

The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four out of four childhood immunisation uptake indicators.

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.

Children who needed a consultation were seen on the same day, where this was indicated.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	66	73	90.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	68	76	89.5%	Below 90% minimum

The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	68	76	89.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	67	76	88.2%	Below 90% minimum

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

Working age people (including those recently retired and students) **Population group rating: inadequate**

Findings
The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given effective care and treatment. The practice failed to evidence that they conducted structured medicine reviews for patients. As a result of these significant concerns all population groups are rated as inadequate. Practice derived data from September 2020 indicated that the practice had achieved an 80% screening uptake for 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).

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England)	74.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) **(PHE)**	72.3%	71.1%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) **(PHE)**	56.6%	55.3%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) **(PHE)**	58.6%	66.8%	68.1%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	63.6%	58.0%	53.8%	No statistical variation

Any additional evidence or comments
Unverified “How Am I Driving data?” indicated that the practice had improved its uptake for cervical screening during the COVID19 pandemic. Although this data is not directly aligned to nationally reported public health England data, it did provide the inspection team with evidence of a trajectory of improvement for providing effective services. In discussions with the provider, they showed an awareness of the need to continue to monitor this upward trend in order to sustain improvements, within a population demographic of high deprivation. The provider employed a clinician who, being more vulnerable to the risks of COVID19, was unable to undertake face-to-face contacts with patients between March 2020 and August 2020. As such, this clinician dedicated their working hours to contacting eligible patients via the telephone, inviting them in for their screening appointment and answering any questions they might have had in relation to cervical screening.

People whose circumstances make them vulnerable

Population group rating: inadequate

Findings
The poor-quality coding of patient records affected all population groups. Through the poor coding, patient’s needs were not always identified and therefore they were not always given effective care and treatment. The practice failed to evidence that they conducted structured medicine reviews for patients. As a result of these significant concerns all population groups are rated as inadequate. The practice had not fully reviewed all patients whose circumstances make them vulnerable to ensure their medicines were managed effectively and specific risks discussed with them or their carers.

People experiencing poor mental health (including people with dementia)

Population group rating: inadequate

Findings
The poor-quality coding of patient records affected all population groups. Through the poor coding, patient’s needs were not always identified and therefore they were not always given effective care and treatment. The practice failed to evidence that they conducted structured medicine reviews for patients. As a result of these significant concerns all population groups are rated as inadequate. We found examples where patients may have been at risk of suicide or self-harm and the practice had failed to evidence that arrangements were in place to help them to remain safe. There was no assessment undertaken in respect of their personal safety. For example, nursing staff at the practice told us that they would refer any patients will mental health concerns (with the exception of mild depression) to a GP. However, we saw evidence from records that complex mental health problems were dealt with by a nurse which was outside the scope of their

practice. In one case, this resulted in an emergency admission to hospital for the patient, some days later.

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) (QOF)	80.0%	88.2%	85.4%	No statistical variation
Exception rate (number of exceptions).	12.8% (11)	25.1%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	78.0%	82.9%	81.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	8.2%	8.0%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity but did not routinely reviewe the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	533.7	541.4	539.2
Overall QOF score (as a percentage of maximum)	95.5%	97.1%	96.7%
Overall QOF exception reporting (all domains)	7.6%	6.8%	5.9%

	Y/N/Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N
Explanation of any answers and additional evidence: Whilst we found the practice had a system for completing clinical audits, we found the practice had failed to target quality improvement activity at the areas where there were concerns.	

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

We saw evidence that four clinical audits had been carried out since our October 2019 inspection. Some of the improvement activity which had led to changes in clinical practice included:

1. **High dose opioid audit**. All 15 patients were invited for a face-to-face review appointment and the practice developed a new opioid policy.
2. **Mid-stream urine samples in residential care home settings**. Of the 151 urine samples obtained from patients in residential care homes in the previous year, only 50% needed antibiotic treatment. The practice took action to ensure it followed the local CCG guidelines, going forward. The care homes were reminded of the local policy and a re-audit will take place in April 2021.
3. **Chronic Obstructive Pulmonary Disease (COPD) exceptions reporting**. Exceptions were reduced from 54 to 24 in a 12-month period. The practice is considering offering remote reviews of COPD where possible, rather than excepting for non-attendance of review.

Effective staffing

The practice could not demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Partial
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
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N

Explanation of any answers and additional evidence:

The provider had no oversight of the competenece of staff employed in advanced clinical practice. For example:

In one record that we looked at, a clinician had prescribed a ‘class C’ controlled substance to a patient (who was already taking some prescribed controlled substances) despite documenting that they did not feel comfortable to prescribe this. [The class of a controlled substance is intended to reflect the

harmfulness attributable to it when it is misused. Class 'C' controlled substances include, for example, benzodiazepines and some steroids.]

We saw the records of a patient who had presented with significant symptoms suggestive of type one diabetes. A blood test was requested but not completed and not followed up. No follow-up or further investigation of this patient took place, which could have resulted in significant harm.
A patient was issued with a prescription for Doxycycline, a powerful broad-spectrum antibiotic, via a telephone consultation without the staff member speaking to or examining the patient.

There was no evidence that staff employed in advanced clinical practice roles were appropriately up-to-date with training and supervison 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.

We requested supervision records on two occasions during our inspection, but these were not provided until two days after our inspection. The information provided was not of sufficient depth to describe the learning from these sessions and did not encompass their prescribing behaviours in line with national guidance.

Some staff told us they had protected time for learning, others reported they needed to do this in their own time, or as overtime.

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.	N
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N
Patients had access to appropriate health assessments and checks.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y

Explanation of any answers and additional evidence:

We saw evidence from patient records that the recording of information and the follow-up and management of some groups of patients needed to be improved. For example, we saw minimal record keeping for some patients on end of life care pathways. Patients with long term conditions did not receive appropriate monitoring from clinicians and were not involved in monitoring and managing their own health as they had not been alerted to this lack of clinical monitoring.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	90.4%*	95.8%	94.5%	Tending towards variation (negative)

Exception rate (number of exceptions).	0.7% (13)	0.9%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Caring Rating: Requires Improvement

We did not inspect the Caring key question at our October 2019 inspection. At our September 2020 inspection we saw that:

- The percent age of respondents to the GP patient survey who responded positively to the overall experience of their GP practice was below the national local averages.
- Patients were not always given timely and appropriate information about their care, treatment or condition.
- The provider had not carried out its own patient survey in the last 12 months.
- The provider did not always make contact with bereaved families.
- End of life care arrangements needed to be improved overall.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: Patients did not always receive appropriate and timely information. For example, records we looked at showed that some patients had never been informed about their abnormal test results.	

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)	85.3%	88.8%	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)	87.5%	87.5%	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)	94.2%	94.6%	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)	67.7%	82.2%	81.8%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N
Explanation of answers and additional evidence: The practice had not undertaken a patient survey or a patient feedback exercise in the previous months but this was due in part to COVID19 arrangements and the fact that the patient participation group had been suspended.	

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Y

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	94.0%	93.9%	93.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
about their care and treatment (01/01/2020 to 31/03/2020)				

	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.	There were 272 patients coded as carers, which equated to just over 4% of the 6400 patients on the practice list.
How the practice supported carers (including young carers).	The practice signposted patients and their carers, where appropriate, and provided written information. The practice website also signposted patients to appropriate resources.
How the practice supported recently bereaved patients.	The practice sometimes made contact by letter or telephone, however, we saw evidence in some patient records that contact was not made with families when a patient had died.

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

	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

Online consultations took place in appropriate environments to ensure confidentiality.	Y

Responsive Rating: Requires Improvement

We did not inspect the Responsive key question at our October 2019 inspection. At our September 2020 inspection we saw that:

- Overall access to appointments was adequate and there were plenty of appointments available during Covid19.
- The practice had successfully moved to a total triage model as a result of the pandemic.
- 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' was lower than the national average.
- Complaints were not used to drive improvements at the practice.

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 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	8am – 6pm
Tuesday	8am – 6pm
Wednesday	8am – 6pm
Thursday	8am – 6pm
Friday	8am – 6pm
Appointments available:	
Monday	8.10am – 7.45pm
Tuesday	8.10am – 5.50pm
Wednesday	8.10am – 5.50pm
Thursday	7.30am – 5.50pm
Friday	7.30am – 5.50pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	92.3%	94.1%	94.2%	No statistical variation

Any additional evidence or comments
The premises are open from 8am to 6pm Monday to Friday and extended hours are available on Mondays from 6.30pm to 8pm, and Thursdays and Fridays from 7.30am to 8am. There are a range of appointments spread over the day. Appointments are available from 8.05am every day (but from 7.35am on Thursdays and Fridays) till 12pm. Afternoon surgeries run from 1.30 pm to 5.50 pm (up to 7.45 pm on Mondays). Nurses and HCA appointments run from 8.10 am to 5.40pm throughout Monday to Friday. In addition the HCA has appointments from 7.35am on Thursdays and Fridays. The practice began operating an online consultation system during the Coronavirus pandemic and this remains in place at the time of reporting.

Older people **Population group rating: requires improvement**

Findings
The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given responsive care and treatment. We could not be assured that care was co-ordinated for these patients. As a result of these significant concerns all population groups are rated as requires improvement. The practice needed to improve the way in which it responded to older people. For example, in the records that we looked at, cause of death was not always recorded in the patient's notes and we saw no evidence that the provider had contacted the families of older people in the event of their death. The significant lack of coding in patient records meant that the practice could not provide effective care coordination to enable older patients to access appropriate services.

People with long-term conditions **Population group rating: requires improvement**

Findings
The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given responsive care and treatment. We could not be assured that care was co-ordinated for these patients. As a result of these significant concerns all population groups are rated as requires improvement.

From records that we looked at, we saw that patients with long-term conditions were not always able to access appropriate services.

Care and treatment for people with long-term conditions approaching the end of life needed to be improved, from the records that we looked at.

Families, children and young people

Population group rating: requires improvement

Findings

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given responsive care and treatment. We could not be assured that care was co-ordinated for these patients. As a result of these significant concerns all population groups are rated as requires improvement.

Additional nurse appointments were available until 7pm 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.

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

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given responsive care and treatment. We could not be assured that care was co-ordinated for these patients. As a result of these significant concerns all population groups are rated as requires improvement.

The practice was open until 8pm on a Monday and from 7.30am on a Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available on a Saturday and a Sunday via the federation.

The provider employed a clinician who, being more vulnerable to the risks of COVID19, was unable to undertake face-to-face contacts with patients between March 2020 and August 2020. As such, this clinician dedicated their working hours to contacting eligible patients via the telephone, inviting them in for their screening appointment and answering any questions they might have had in relation to cervical screening.

People whose circumstances make them vulnerable

Population group rating: requires improvement

Findings

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given responsive care and treatment. We could not be assured that care was co-ordinated for these

patients. As a result of these significant concerns all population groups are rated as requires improvement.

The practice could identify patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.

People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

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

The poor-quality coding of patient records affected all population groups. Through the poor coding, patient's needs were not always identified and therefore they were not always given responsive care and treatment. We could not be assured that care was co-ordinated for these patients. As a result of these significant concerns all population groups are rated 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 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)	56.2%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	59.4%	66.6%	65.5%	No statistical variation

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)	60.2%	64.5%	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)	72.4%	74.7%	72.7%	No statistical variation

Source	Feedback
NHS website	There was one negative review on the NHS website from October 2019, regarding receptionists' attitude, which the practice has not responded to.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care but not always investigated at the earliest opportunity.

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	3
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
Number of complaints being handled by an independent advocacy service.	3

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: Of the eight complaints documented on the practice's matrix, only two had led to any learning and changes to prevent recurrence.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Carer complaint on behalf of patient as unhappy with a six month delay in referral	Letter sent to patient apolgising and explaining that clinician had thought they had done referral for MRI, but in fact had

for an MRI. Patient had a Low grade cancerous tumour.	not completed the referral. Clinician reverted to using a pen and paper record to support completion of referrals.
Complaint from a next of kin about; a delayed diagnosis, too many appointments before a diagnosis and problems with prescriptions, which complainant felt may have contributed to patient's death.	Relevant NICE guidance circulated to all clinicians. Significant event form completed.

Well-led Rating: Inadequate

At our October 2019 inspection we rated the practice as inadequate for providing well led services. This was because; The provider's incident reporting system was not robust or effective enough, staff appraisals were overdue, audit and quality improvement activity we viewed was not adequate, and safeguarding activity was not always timely and well documented. There were few systems of assurance, and overarching governance had not been embedded into the organisation. At our September 2020 inspection we saw that there had been some improvements to some overarching systems but we found new areas of concern regarding leadership. We have again rated this key question as inadequate because:

- We found a lack of leadership capacity and capability to successfully manage challenges and implement and sustain improvements. The GP partners failed to provide leadership to ensure effective and cohesive team working.
- The practice could not evidence that risks, issues and performance were managed to ensure that services were safe or that the quality of those services was effectively managed. We found examples where patient care was of poor quality and the practice had failed to act.
- We found a lack of governance and assurance structures and systems which led to significant patient safety concerns identified at this inspection.
- The practice did not evidence that learning was shared effectively and used to make improvements. We found learning from previous events was not taken forward and similar errors were repeated leading to significant patient safety concerns.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	

We found a lack of leadership capacity and capability to successfully identify and manage challenges. The practice leadership team told us they were unaware of the majority of the significant failings identified at this inspection. We were not assured leaders at the practice understood the regulations and how to meet them. The leaders failed to ensure effective and cohesive team working. The practice did not have a succession plan in place and had not identified any future planning at the practice.

Culture

The practice culture was beginning to effectively support sustainable care.

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

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

Source	Feedback
CQC staff questionnaires	Some staff told us they felt supported by managers and by the wider team. Some told us that relationships between managers and staff have begun to improve over recent months. We were also told; Staff have worked well together, particularly during COVID. Communication could be better. Relationships between some members of the team were sometimes difficult.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
Explanation of answers and additional evidence:	

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. • Staff were provided with training appropriate to their roles. • The coding of medical records is accurate and relevant to their needs. • That significant events were recorded and learnt from. • Patients with a long term condition such as asthma or diabetes were appropriately managed in line with guidance.	

Managing risks, issues and performance

The practice had few clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a programme of clinical and internal audit.	Y
A major incident plan was in place.	Y
Explanation of any answers and additional evidence: The practice did not provide evidence to show comprehensive assurance systems were in place and we found the practice did not have effective arrangements for identifying, managing and mitigating risks. We found the practice had failed to identify the significant risks to patient safety which we found on the day of the inspection. Where there were some systems of assurance in place, these needed to be improved, and some needed to be correctly followed. For example, there was a recruitment process which kept patients safe, but the provider had not followed its own procedure in a record that we looked at, when recruiting a clinician. There was no assessment of staff competence and no monitoring of performance.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information, and not always in a timely manner.

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N

Staff whose responsibilities included making statutory notifications understood what this entails.	N
Explanation of any answers and additional evidence: The practice did not provide evidence to show performance data was used to drive improvement, such as; QoF data. We found that clinical coding was so inaccurate that it was not possible to accurately assess the risks within the practice or the quality of care provided to patients. As patients were so frequently incorrectly coded, it was not possible to search for and identify all patients potentially at risk. 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 requirements of notifications. 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.	

Engagement with patients, the public, staff and external partners

	Y/N/Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
Explanation of any answers and additional evidence: Activity among the patient participation group had been suspended due to the Coronavirus pandemic, to keep patients and staff safe.	

Feedback from Patient Participation Group.

Feedback
Members told us they felt listened to and valued. They told us that the leaders are open and honest and they learn from mistakes and complaints.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: The practice had been striving to make improvements since our previous inspection. While it had addressed some of the specific concerns, this change did not constitute a systemic improvement, or show proactive improvement, to identify new areas of concern.	

We found the staff meeting minutes did not always demonstrate learning or actions were shared and the practice did not hold a complete record of significant events and complaints, reducing the ability to learn from and make improvements.

Team discussions had become difficult due to Covid19 measures. For example, only a limited number of people were able to access the meeting room at one time, and the provider found that video-conferencing was not always reliable. As such, risks were not always discussed as regularly as they could have been.

The practice did not evidence systems for learning to monitor and improve the care provided.

Examples of continuous learning and improvement

The practice had introduced numerous cloud-based systems to streamline processes, and to try to improve quality and efficiency within the practice.

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 practices 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.