Care Quality Commission

Inspection Evidence Table

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Inspection date: 23 October 2019

Date of data download: 11 October 2019

Overall rating: Inadequate

We have rated the practice as Inadequate overall because the provider **must** make improvements to:

- Ensure that care and treatment is provided in a safe way.
- Safeguard service users from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Inadequate

At our July 2016 inspection we rated the practice as good for providing safe services. We have now 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.

Safety systems and processes

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

Safeguarding	Y/N/Partial
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.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	N
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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	N
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.	N
Explanation of any answers and additional evidence: We saw no evidence that safeguarding was widely and regularly discussed within the practice. We saw evidence of a delay in making a safeguarding referral about a baby. There was insufficient documentation about the progress of the case and follow-up information was not recorded within the significant event form. The practice told us they had invited, but been unable to engage with, the local health visiting team and other key agencies and, as such, was not always able to act upon the most appropriate information to safeguard patients and their families. Some non-clinical staff acted as chaperones but had received no training for this and had not undergone a disclosure and barring service check. The provider had not undertaken any risk assessments in respect of this.	

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.	N
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: Not all recruitment files we sampled (three files) demonstrated that recruitment checks had been carried out in accordance with regulations. Of the three files that we sampled; only one contained a Disclosure and Barring Service check (DBS). Only one contained photographic identification and one contained employment history. None of these files contained employment references or records of medical indemnity. There were no records kept of staff vaccinations.	

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: April 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:	Y

There was a log of fire drills. Date of last drill: 21 October 2019	Y
There was a record of fire alarm checks. Date of last check: 18 October 2019	Y
There was a record of fire training for staff. Date of last training:	N
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: July 2019	Y
Actions from fire risk assessment were identified and completed.	partial

Explanation of any answers and additional evidence: The practice could not evidence that all staff had completed fire training. We were told that some staff had completed this online but there was no up-to-date matrix of training records.

Some actions from the fire risk assessment had not been completed, for example, in July 2019 the assessment highlighted that:

- the fire door at the end of the clinical corridor was locked (from the inside) with a key being store in a nearby wall-mounted cupboard. This needed to be urgently actioned.
- Emergency lighting and a smoke detector needed to be urgently installed at the top of the stairs.

On the day of our inspection, we saw that these actions remained outstanding from July 2019 and the practice of locking the fire door with a key continued.

The storage of medical gases (oxygen and Entonox) on site did not comply with the Health and Safety Executive HTM02 guidance. The cupboards were not well ventilated. The storage of the medical gases had not been risk assessed. The environment in which they were stored was crowded with supplies and equipment. There was a potential risk for large items to fall and knock the gases over as they were not well secured. We saw that a significant event had occurred a month prior to our inspection where a sharps bin in the store room had fallen onto a cryotherapy tank and the tank had started hissing. Staff were able to remedy the situation without sustaining any injuries. This significant event was not reviewed at the team meeting that followed.

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: not seen	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2019	Y

Explanation of any answers and additional evidence: Some of the health and safety risks identified within that assessment related to premises and security.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	N
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	N
The practice had acted on any issues identified in infection prevention and control audits.	N
There was a system to notify Public Health England of suspected notifiable diseases.	N
The arrangements for managing waste and clinical specimens kept people safe.	N

Explanation of any answers and additional evidence: A clinician had recently been given the role of infection control lead. On the day of inspection, we did not see evidence that the infection prevention and control (IPC) lead had undertaken any additional training, but this was supplied to us by the provider after our inspection. We saw no evidence of infection prevention and control (IPC) training for all other staff. We were told that some staff had completed this online but there was no up-to-date matrix of training records.

No IPC audits had been undertaken although the provider told us they had done some spot-checks of the clinical sinks but had not documented this. The environment was visibly clean, but we saw that the cleaning team were not using specific colour-coded mops and buckets to clean the practice, in accordance with the cleaning schedule. There was no effective system of monitoring the cleaning other than unscheduled spot-checks by a manager. We saw no evidence of a system for informing Public Health England of notifiable diseases and staff could not demonstrate they were familiar with a process. We saw that a full waste wheelie bin had been left outside the practice overnight, and not housed in the bin store. It was not due to be collected for two more days. The practice did not have specimen fridge so had to either use a medicine fridge to store specimens or place an embargo on when specimens could be obtained. Staff told us they had not been trained to handle spillages, but we did see that spillage kits were available.

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.	N
Comprehensive risk assessments were carried out for patients.	N
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.	N
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.	N
There was a process in the practice for urgent clinical review of such patients.	N
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N
Explanation of any answers and additional evidence: Staff and managers told us they had been short-staffed for some time and had actively tried to recruit a GP. Non-clinical staff told us they had felt the pressures of dealing with a lack of administrative staff for some time and had recently secured agreement from managers for further recruitment. We saw no evidence of training, knowledge checks or assessment around medical emergencies, including sepsis, for non-clinical staff. Clinical staff could access this information through clinical templates. Urgent clinical reviews were managed by receptionists using their skills and experience to pass on to a GP or nurse, but there was no medical emergency policy and no pathway for dealing with a deteriorating patient, for non-clinicians to refer to.	

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.	partial
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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
Explanation of any answers and additional evidence: Two-week-wait referral forms based on the most up-to-date clinical guidance were not always used when GPs made urgent referrals. However, we did see that they composed letters and sent appropriate clinical history and pertinent information, when making these referrals. Clinicians responded to test results in different ways to each other and there was no policy or process in place which supported a universal approach within the practice. We saw one complaint where a patient had experienced a four-month delay in being referred for a scan by the GP. There was no effective system for ensuring that referrals were not missed.	

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.36	1.11	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	18.7%	10.1%	8.6%	Significant 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 (01/01/2019 to 30/06/2019) (NHSBSA)	5.92	5.86	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	6.14	3.32	2.08	Significant 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.	Y
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

Medicines management	Y/N/Partial
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.	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.	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.	partial
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 saw no evidence of prescribing supervision for nurse practitioners, nor regular review of their prescribing practice supported by clinical supervision or peer review. The nurses did not meet for peer or prescribing support with other nurses in the wider network, either. We saw two significant events in the last 12 months that related to medicines or prescribing errors where changes had not been communicated correctly. This related to the lack of a process for the management of medicines, resulting in no clear audit trail of information. The process for monitoring high risk medicines was not robust enough and needed to be improved. We saw evidence of inappropriate antimicrobial use and the practice was an outlier in its results for prescribing certain antibiotics. The practice had a near-patient testing machine for c-reactive protein which identified the need for antibiotics at the point of testing. It was not common practice for the GPs to use this machine. The practice stocked emergency medicines but the system and checklist for recording the stock levels and expiry dates was not completed correctly. We saw that the person checking placed a tick in a column which specifically asked for details of the stock name and expiry date. Emergency medicines were checked on a monthly basis.	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial

The practice monitored and reviewed safety using information from a variety of sources.	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.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	14
Number of events that required action:	9

Explanation of any answers and additional evidence: The practice had a significant event form which all staff were asked to complete, when an event occurred. The policy supporting the significant event process was not adequate and needed to be improved; for example, it did not detail the expectations of the reporting person or whether/when they could expect to receive feedback following investigation. We saw evidence from significant events that the practice's own policy was not being correctly followed; There was a lack of evidence that significant events were properly recorded, investigated, discussed or disseminated. There was no analysis of themes or trends which could have prevented incidents from recurring. The practice allocated an importance level of 'urgent' or 'routine' to the event, but there was no evidence that this affected the timeframe in which it was handled. Out of the 14 significant event forms that we analysed, only six of the forms had been fully completed. Out of the 14, none of the forms indicated any learning from lessons or any feedback of information to the reporting person. On the day of our inspection few staff were able to recall or describe an example of a significant event or describe the outcome.

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

Event	Specific action taken
Safeguarding team contacted the practice to enquire why 6-8-week postnatal check invitation letters were not being sent to mothers.	Practice manager spoke to staff who stated they no longer sent these letters. Practice manager ran a search of all children born in last 12 months and results showed that 55 out of 71 babies had been seen for a 6-8-week check. Meeting arranged with admin staff to agree a new procedure.
Thermometer on medicines' refrigerator was reading out of range.	One type of vaccination was destroyed as per the licence. Other vaccinations were marked to indicate that they could be used off licence, if the incident was explained to the patient before being administered.
A patient was alerted by public health about a positive result for a notifiable disease. GP had viewed result but not forward any task or action to receptionists.	Admin asked the GP to speak to the patient to give reassurance. Significant event form and patient records showed that this was not done, and the event appeared to have been left without investigation or closure.

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:

There was no effective system of assurance for dealing with safety alerts. The practice manager printed

them and left them on the GPs desk but there was no evidence that appropriate searches were run, as a result. There was no assurance system that the alert had been read, actioned or revisited.

We saw that action had been taken on a recent alert, regarding sodium valproate. However, although the search had been run and identified four patients on sodium valproate of child-bearing age without contraception, the action taken was not adequate. At least one of these patients should have been referred to neurology, in line with clinical guidance.

Effective Rating: Requires Improvement

At our July 2016 inspection we rated the practice as good for providing effective services and good for all population groups. We have now rated the practice as requires improvement for this key question because the arrangements in respect of; regular reviews, staff training, and clinical audit need improving. This applied to all the population groups, so we have now rated all the population groups as requires improvement.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance.

	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.	Y
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.	Y
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:	

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) (01/07/2018 to 30/06/2019) (NHSBSA)	1.72	1.01	0.75	Variation (negative)

Older people

Population group rating: requires improvement

Findings
The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. 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. Health checks, including frailty assessments, were offered to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: requires improvement

Findings
Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Staff who were responsible for reviews of patients with long-term conditions had received specific training GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions. The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Adults with newly diagnosed cardio-vascular disease were offered statins.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	71.5%	77.1%	78.8%	No statistical variation
Exception rate (number of exceptions).	15.0% (64)	16.3%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	70.4%	76.2%	77.7%	No statistical variation

Exception rate (number of exceptions).	16.0% (68)	11.9%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	78.2%	79.0%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.1% (73)	16.4%	13.5%	N/A

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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	64.9%	74.5%	76.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	29.0% (99)	13.0%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	78.2%	87.5%	89.7%	Variation (negative)
Exception rate (number of exceptions).	29.5% (69)	16.4%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	79.8%	82.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.8% (82)	4.8%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	87.3%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.3% (8)	6.0%	6.7%	N/A

Any additional evidence or comments

The practice told us that they sent three invitation letters to patients to invite them for a review of their condition. After this point, if they did not make an appointment they implemented an exception.

Families, children and young people

Population group rating: Requires improvement

Findings

The practice had not met the minimum 90% target for three out of four childhood immunisation uptake indicators. 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 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.

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:

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings
The practice had a poster in the waiting area to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. 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) (01/04/2017 to 31/03/2018) (Public Health England)	72.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	69.2%	70.9%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	56.1%	53.6%	57.3%	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. (01/04/2017 to 31/03/2018) **(PHE)**	70.0%	62.7%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	45.7%	50.3%	51.9%	No statistical variation

Any additional evidence or comments
The practice told us they had a system of sending three reminder letters to women to invite them for cervical screening.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings
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
The practice employed a psychotherapist for one day per week. This arrangement offered five appointments per week to patients with poor mental health. One appointment out of five was allocated to a child.
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 (01/04/2017 to 31/03/2018) (QOF)	73.8%	87.7%	89.5%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.4% (3)	15.9%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	75.9%	90.7%	90.0%	Tending towards variation (negative)

Exception rate (number of exceptions).	4.6% (4)	11.8%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	88.6%	83.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.9% (3)	8.7%	6.6%	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)	533.2	522.1	537.5
Overall QOF score (as a percentage of maximum)	95.4%	93.4%	96.2%
Overall QOF exception reporting (all domains)	7.7%	7.3%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N
Quality improvement activity was targeted at the areas where there were concerns.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	

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

The practice carried out a broad-spectrum antibiotic prescribing audit which showed individual clinicians' prescribing activity and highlighted some inappropriate prescribing. However, this audit did not demonstrate quality improvement. An end of life care audit showed that the practice was meeting patients' needs but there was room for significant improvements in palliative care. This audit was only one-cycle and it was therefore too early to demonstrate quality improvement.

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.	N
The practice had a programme of learning and development.	N

Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	partial
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.	N
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:

There was an induction checklist for reception staff but not for clinicians.

As a result of our inspection some appraisals had been arranged and carried out and others were planned to be completed. Some staff told us they had not had regular annual appraisals. There was limited evidence to support that staff had regular access to clinical supervision or one-to-ones.

We saw no evidence of competency assessment for clinicians, however, clinicians that we spoke with on the day of inspection provided evidence of professional development and revalidation with their relevant regulatory body.

All clinicians had achieved recent (within three years) revalidation.

The practice told us they offered protected learning to all staff on a quarterly basis.

There was no formal system for performance management within the practice.

Coordinating care and treatment

Staff did not work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	N
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

Explanation of any answers and additional evidence:

Palliative care meeting minutes that we sampled did not indicate who had attended the meeting or the outcomes of any discussions.

The practice had had difficulties in engaging staff from other disciplines. They told us they had invited

other health professionals to their meetings, but they had not attended. The practice was working hard to improve its involvement with the health visiting team and school nursing team, among others.

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

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 (01/04/2017 to 31/03/2018) (QOF)	96.1%	95.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	2.4% (45)	0.7%	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
Policies for any online services offered were in line with national guidance.	Y

Well-led Rating: Inadequate

At our July 2016 inspection we rated the practice as good for providing well led services. We have now rated the practice as inadequate for providing well led services. This is 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 has not been embedded into the organisation.

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.	Y
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.	Y

Explanation of any answers and additional evidence:

Leaders and managers were aware, open and transparent about the areas that needed improving within their governance but had not identified some of the actions to address these. The partners told us that they spent all their time seeing, treating and caring for patients and had struggled to deal with the systems and governance which underpinned that care. Each of the departments within the practice (GP, nursing and administration) worked separately from one another and there was no overarching leadership which integrated these departments and systems together, providing oversight of the actions that needed to be addressed.

The practice manager had undertaken a leadership course and there was active succession planning in place.

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.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N

Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: Staff at the practice told us they were striving to achieve the best for their patients but there was no business strategy in place which supported the team in achieving quality and sustainability. There was no documented strategy including vision and values.	

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
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.	N
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.	N
Staff had undertaken equality and diversity training.	N
Explanation of any answers and additional evidence: Staff we spoke to were not always clear about the vision and the values of the practice. Staff morale was low, and some felt unsupported. There was a whistleblowing policy, but it had not been reviewed for some time, however, staff could describe the process of how to raise concerns. There was no Freedom to Speak Up Guardian. The practice could not provide evidence of equality and diversity training on the day of inspection.	

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

Source	Feedback
CQC interviews and questionnaires	Staff work well as a team. All members of the team go 'above and beyond' for patients. Relationships between staff and managers can feel strained. Communication isn't always good enough. Staff don't always feel appreciated by managers and leaders.

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.	Y
Explanation of any answers and additional evidence: There were few embedded governance structures and systems within the practice. There was no manager or leader who had oversight of all departments, systems and processes, and each department within the practice was detached from another. We saw that communication between departments and between leaders and staff needed to be improved.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence: There were few comprehensive assurance systems. For example: significant events, medicines management, and safety alerts had no assurance built in to the process to provide safety for patients. We saw no evidence of a performance management system. However, the practice had recently begun to complete some appraisals. The system of clinical and internal audit was not carried out effectively, proactively or regularly. Risks were identified but not always documented or managed effectively. Staff told us they had not received training in dealing with major incidents.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y

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 was aware of its poor data in some areas, but we saw no evidence that this was discussed and addressed using a team approach. On the day of our inspection it was apparent that communication between different teams and departments needed to be improved. We saw some delays in referrals and safeguarding processes. A lack of documentation and review of policies and procedures meant that some information that enabled staff to carry out their roles was not accurate or valid. We observed, during the inspection, that some staff had difficulty in navigating the shared drive on the computer system to locate key information, such as policies and procedures. No statutory notifications had been made to CQC regarding; the retirement of the Registered Manager, several partners leaving, safeguarding referrals and the notification of death of a service user, in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	

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 did not involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence: The practice told us that they try to engage with staff, and if they have an area of interest they can take a lead on it. As a result of patient complaints, the practice increased its phone line capacity.	

Feedback from Patient Participation Group.

Feedback
No feedback received at time of report.

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.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: The GPs had provided care and treatment to their patients for more than 30 years at this practice. They told us they prioritised clinical care and needed support with the implementation of processes and policies.	
Examples of continuous learning and improvement	
Nurses undertook additional training in chronic disease management.	

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.