Care Quality Commission

Inspection Evidence Table

C.B. Patel & Partners (1-551034159)

Inspection date: 29 January 2019

Date of data download: 18 January 2019

Overall rating: Requires improvement

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

Safe Rating: Requires improvement

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.	Partial
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Partial
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: • Some staff we spoke with were not sure who was the lead member of staff for safeguarding.	

Safeguarding	Y/N/Partial
• Adult and child safeguarding policies did not include the name of the lead member of staff responsible for safeguarding processes and procedures. • We noted a child safeguarding incident was not appropriately reported to local children safeguarding team and this child was not appropriately coded with safeguarding flags and added to the practice child protection register. The practice had not treated and investigated this incident as a significant event. However, the practice informed us they actively engage with local safeguarding teams as required, but failed to do so on this occasion. The practice understood they were required to review and improve their safeguarding processes.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and 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
Staff had any necessary medical indemnity insurance.	Partial

Explanation of any answers and additional evidence:

The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. However, the three staff files we reviewed showed that appropriate recruitment checks had not been always undertaken prior to employment or they were unable to evidence all checks had been completed because they could not find the documents. In particular,

- One staff file did not have any document to evidence satisfactory conduct in previous employment, in the form of references. Two staff files had one reference each.
- Health checks (satisfactory information about any physical or mental health conditions) had not been completed and interview records were not available on the day of the inspection.
- A curriculum vitae (CV) or application forms were not always kept in staff files, these were available in the business partner's email inbox.
- Disclosure and Barring Service (DBS) checks were not always undertaken where required or documentary evidence not always kept in staff files. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had carried out risk assessment for some staff on a template which was not appropriate. In addition, the risk assessment did not include any date to explain when they were last reviewed.
- The practice informed us they had paid for all clinical staff medical indemnity insurance, but they were unable to provide evidence of medical indemnity insurance on the day of the inspection.

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: 25 September 2018.	Y
There was a record of equipment calibration. Date of last calibration: 25 September 2018.	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: 4 October 2018.	Y
There was a log of fire drills. Date of last drill: 19 January 2019.	Y
There was a record of fire alarm checks. Date of last check: No documentary evidence available on the day of the inspection.	N
There was a record of fire training for staff. Date of last training: January 2019.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 25 February 2018.	Y
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

- The practice had not completed all actions identified during recent fire risk assessment.
- There was no documented fire evacuation plan specific to the service. The provider did not carry out a risk assessment to identify how staff could support patients with limited mobility to vacate the premises.
- The practice was unable to provide documentary evidence of regular fire alarm checks.
- A fire marshal had not received enhanced fire safety training relevant to their role. However, they had received online fire safety awareness training.
- We saw door wedges were used to open the doors in the communal areas at the practice, which could not prevent the spread of fire and smoke.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: No documentary evidence available on the day of the inspection.	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	N

Explanation of any answers and additional evidence:

- Health and safety policy was reviewed in October 2018.
- Security alarm and cameras were installed in communal areas and regularly maintained.
- The practice had not carried out a formal health and safety risk assessments. However, we saw a safety policy which included information relevant to health and safety issues.
- Electrical installation condition inspection was carried out on 26 January 2019.
- Gas boiler was serviced on 23 January 2019.
- The lift was serviced on 27 November 2018.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: November 2018.	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- There was no documented policy or records available to demonstrate clinical equipment was cleaned on regular basis.
- Fabric curtains were used around the couches in the clinical rooms. Staff we spoke with was unable to provide evidence when these curtains were changed or washed.
- Yellow clinical bins were locked and stored in the carpark, however, they were not secured to the wall or floor.
- Hand washing soap was not available in the accessible toilet.
- A Legionella (a bacterium which can contaminate water systems in buildings) risk assessment was carried out on 10 July 2018. However, it did not include information that how risks would be mitigated to ensure effective management of legionella at the premises. We noted the practice was not carrying out regular water temperature checks. We noted water temperature was very high in the accessible toilet. The practice had carried out an external water sample analysis on 24 June 2015.
- The infection prevention and control (IPC) lead we spoke with was not aware of the infection control audit carried out in November 2018.

The practice had not acted on all issues identified in infection prevention and control audits. In

particular,

- A spill kit was not available in the premises. There was no documented policy to explain how to clean bodily fluids, or to consider which personal protective equipment (PPE) were required.
- A contractor was responsible for cleaning the premises. However, no cleaning schedule was available on-site. The practice was unable to provide documented evidence to demonstrate the cleaning standards were checked on a regular basis.
- Appropriate colour coded or disposable cleaning mops were not used. We found only one mop was used to clean the whole premises, and this was not appropriately stored.
- We observed that appropriate decluttering had not been carried out in the nurses' treatment room.

Risks to patients

There were systems in place to assess, monitor and manage risks to patient safety. However, some improvements were required.

	Y
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.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	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.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Partial
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:

- A clinical staff we spoke with was not fully aware regarding recently published guidelines relevant to sepsis.
- Some non-clinical staff we spoke with did not know how to identify patients with severe infections including sepsis.
- The practice operated a system to organise annual leave and cover for unexpected absences. The practice had sufficient resilience to cover any additional absences.
- All requests for home visits were triaged by the duty GP.
- There were public awareness posters in the waiting area and on the screen.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, some improvements were required.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
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:

- On the day of the inspection, the provider informed us that all pathology results were managed and checked on a regular basis to ensure all were appropriate and actioned. However, we found some abnormal or concerning blood test results which were not actioned swiftly. We did not find evidence of actual harm however, the risk of harm remained. We noted the practice had not appointed a dedicated clinical lead to oversee the management of test results and there was no monitoring system in place to ensure that patient correspondence across the practice was managed in a timely manner.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	0.94	0.87	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	7.3%	9.9%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N
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.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A

Medicines management	Y/N/Partial
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
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial

Explanation of any answers and additional evidence:

- On the day of the inspection, we saw blank prescription forms for use in printers and handwritten pads were not recorded appropriately and tracked through the practice at all times.
- A nurse prescriber was employed by the practice. However, the practice could not demonstrate that they had any formal clinical supervision arrangements in place to review and monitor their prescribing decisions and clinical performance.
- Protocols for checking stock levels and equipment were not being followed. We found expired needles and syringes used to collect blood samples.
- There were emergency medicines available at the practice. However, not all non-clinical staff we spoke with knew of their location. All the medicines we checked were in date and stored securely. We noted they did not have medicines to deal with a range of common emergencies in GP practices, such as Benzylpenicillin (used to treat suspected bacterial meningitis) and there was no risk assessment showing they had considered what to do in its absence.
- Staff we spoke with informed us that medical oxygen and a defibrillator were checked on a regular basis. However, written records of these checks were not maintained.
- The practice was unable to demonstrate that they had an effective system to identify and monitor who was collecting the repeat prescriptions for controlled drugs from the reception.
- The practice was unable to demonstrate that they had an effective system to ensure uncollected prescriptions were monitored. There was no formal monitoring system for following up patients experiencing poor mental health and patients with dementia who failed to collect their prescriptions.
- Medicines that required refrigeration were stored and monitored appropriately, however, the practice did not have a second thermometer, which could log all the data and provide assurance that temperatures had been within the required range, nor was the existing thermometer calibrated at least monthly, as recommended in Public Health England guidance.
- The practice's cold chain policy did not include information regarding what to do in case of fridge failure.
- The practice was recently registered as a yellow fever vaccination centre.

Track record on safety and lessons learned and improvements made

The practice learned and made some improvements when things went wrong. However, they did not have effective system and improvements were required.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	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:	6
Number of events that required action:	6

Explanation of any answers and additional evidence:

- We saw staff were recording and acting on significant events. However, we noted they were not always collated, analysed and discussed with all staff. We found some significant events were recorded and investigated by individual GPs which were not in the practice record and were not shared with relevant staff.
- We saw in staff meeting minutes significant events were not always discussed and documented. Some clinical staff we spoke with did not have any knowledge regarding recent significant events. They informed us details and learning from significant events had not been shared with them on a regular basis.

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

Event	Specific action taken
Aggressive and abusive behaviour towards the staff by a patient	The practice had investigated the incident and sent a warning letter to the patient. The practice had advised staff to stay calm in challenging situations and consider alternative options.
Emergency situation – patient fainted	The practice had investigated the incident, reviewed the emergency procedure and steps taken to ensure emergency procedure and policy was available to all staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	Partial

Explanation of any answers and additional evidence:

- We noticed national patient safety and medicines alerts were not systematically received and shared with the team. We noted the GPs were individually registered to receive safety alerts directly and were responsible to follow the alerts as required.
- The practice was unable to provide documentary evidence to confirm that they had carried out searches to identify patients at risk and action had been taken relevant to the alert. The practice did not maintain a log of historic alerts or keep a record of action taken in response to historic alerts.

Effective Rating: 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 supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	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 were in place 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
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) (01/10/2017 to 30/09/2018) (NHSBSA)	0.34	0.60	0.81	Variation (positive)

Older people

Population group rating: Requires improvement

Findings
The practice is rated as requires improvement for effective domain. The concerns which led to these ratings apply to everyone using the practice, including this population group. • 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. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for effective domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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 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.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

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)	63.2%	78.1%	78.8%	Variation (negative)
Exception rate (number of exceptions).	11.9% (102)	9.3%	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)	81.6%	80.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.9% (68)	8.4%	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)	62.8%	77.2%	80.1%	Significant Variation (negative)
Exception rate (number of exceptions).	4.4% (38)	10.0%	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)	72.4%	77.5%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.2% (6)	2.6%	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)	92.3%	92.9%	89.7%	No statistical variation
Exception rate (number of exceptions).	1.3% (1)	8.7%	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)	83.2%	83.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.6% (48)	3.5%	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)	93.4%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.2% (4)	9.5%	6.7%	N/A

Any additional evidence or comments

- The practice's performance on quality indicators for long term conditions was in line with the local and the national averages with the exception of quality indicators related to patients with diabetes.
- The practice informed us they had the highest list size (940 out of 13,890) of patients with diabetes in the locality.
- The practice had recruited a diabetes specialist nurse.
- On the day of the inspection, the practice had demonstrated that they had taken steps to improve the outcomes for patients with diabetes. However, it was too early to assess the impact of the improvements.

Families, children and young people

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for effective domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% for one out of four immunisations measured (in 2017/18) for children under two years of age. The practice explained that this was due to the transient population and known cultural challenges within the practice population. The practice understood they needed to improve in this area and had developed an action plan which included plans to engage with health visitors.
- 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.
- 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	203	221	91.9%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	177	218	81.2%	Below 90% minimum (variation negative)
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) (01/04/2017 to 31/03/2018) (NHS England)	182	218	83.5%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	187	218	85.8%	Below 90% minimum (variation negative)

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for effective domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice had systems 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)	53.6%	66.9%	71.7%	Significant Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	65.4%	70.9%	70.0%	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)	36.2%	48.0%	54.5%	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)	57.1%	74.8%	70.3%	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)	32.3%	49.7%	51.9%	No statistical variation

Any additional evidence or comments

- The practice was aware of these results and explained that this was due to transient population and known cultural challenges within the practice population, which had an impact on the cervical and bowel screening uptake. The practice had taken steps to encourage the uptake. For example, there was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

- The practice had a system to ensure results were received for all samples sent for the cervical screening programme. However, there were no failsafe systems to follow up women who were referred as a result of abnormal results.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for effective domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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 is rated as requires improvement for effective domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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.
- 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.
- Not all staff had received dementia training in the last 12 months.

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)	93.8%	92.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.9%	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)	97.9%	91.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.5%	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)	97.1%	82.4%	83.0%	Variation (positive)
Exception rate (number of exceptions).	2.9% (1)	4.6%	6.6%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	532.8	543.5	537.5
Overall QOF exception reporting (all domains)	7.2%	5.5%	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.	Y

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

- The practice had carried out repeated audits to ensure the effective management of patients diagnosed with asthma. The practice had selected a random sample of patients and reviewed the appropriateness of medicines prescribed in line with national guidance. The practice had identified patients who had not attended the appointment for annual reviews. They developed a plan and had taken steps to improve the outcomes for patients with asthma. The practice had demonstrated improvement since the initial audit and ensured all patients were correctly read coded, attended annual reviews and taking medicines in line with national guidance.
- The practice had carried out a clinical audit to ensure the effective management of patients diagnosed with diabetes and taking medicines to manage their blood sugar levels. The practice had identified patients who had not attended the appointment for annual blood tests and annual reviews. The practice had developed a plan and taken steps to improve the outcomes for patients with diabetes.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, some improvement was required.

	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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y

There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: • The practice could not demonstrate how they assured the ongoing competence of a nurse prescriber because they did not have a formal clinical supervision arrangement in place to review their prescribing decisions.	

Coordinating care and treatment

Staff worked 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 (01/04/2017 to 31/03/2018) (QOF)	Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: • On the day of the inspection, the provider was unable to provide the meeting minutes of multidisciplinary case review meetings. We noted the practice had maintained the palliative care register.	

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
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)	94.2%	96.0%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (11)	0.8%	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: Good

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
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	11
Number of CQC comments received which were positive about the service.	9
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Discussion with patients, the patient participation group (PPG) member and comment cards	• Three patients and a member of the patient participation group (PPG) we spoke with said staff were helpful, caring and treated them with dignity and respect. • Nine of the 11 patient CQC comment cards we received were positive about the service experienced. Two of the 11 patient CQC comment cards we received were neutral and raised some concerns regarding access to the service. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
13740	428	89	20.8%	0.65%

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 (01/01/2018 to 31/03/2018)	79.9%	83.0%	89.0%	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 (01/01/2018 to 31/03/2018)	74.8%	81.1%	87.4%	Variation (negative)
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 (01/01/2018 to 31/03/2018)	98.2%	92.9%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	70.3%	77.5%	83.8%	No statistical variation

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

Any additional evidence
• We noted the NHS friends and family test (FFT) results for the last 10 months (April 2018 to January 2019) and 86% (out of 141 responses) of patients were likely or extremely likely recommending this practice.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Discussion with the patients, the patient participation group (PPG) member and comment cards	• Feedback from patients demonstrated they felt involved and that their personal decisions were taken into account. • Patients told us they felt listened to and supported by their doctor and had sufficient time during consultations.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	95.4%	90.8%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Partial
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	N
Explanation of any answers and additional evidence: • The practice had multi-lingual staff who might be able to support patients when required. • Written information was not available for carers in the waiting area or on the practice website to ensure they understood the various avenues of support available to them.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 58 patients as carers (0.42% of the practice patient list size).
How the practice supported carers.	The practice's computer system alerted GPs if a patient was also a carer. They were being supported by offering health checks and referral for social services support.
How the practice supported recently bereaved patients.	Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: • Staff recognised the importance of patients' dignity and respect.	

Responsive Rating: Requires improvement

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However, some improvements were required.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Explanation of any answers and additional evidence:

- The premises were accessible to those with limited mobility. However, we saw the front door did not have an automatic door activation system to assist patients with mobility issues.
- There were accessible toilet and baby changing facility. The practice however, did not have a hearing loop system.
- The accessible toilet did not have a lock which allowed easy access in the event of an emergency.
- The practice had installed a touch screen self check-in facility to reduce the queue at the reception desk.
- The practice installed an automatic floor mounted blood pressure monitor in the premises for patients to use independently.
- The practice website was clear and simple to use. The practice was proactive in offering online services, which included online appointment booking; an electronic prescription service and online registration. However, the practice website did not include a translation facility.
- The practice sent text message reminders of appointments and test results.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Appointments available:	
Monday	9am-6pm
Tuesday	9am-6pm
Wednesday	9am-6pm
Thursday	9am-6pm
Friday	9am-6pm
Extended hours opening:	
Monday to Friday	6.30pm to 7pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
13740	428	89	20.8%	0.65%

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 (01/01/2018 to 31/03/2018)	91.2%	91.7%	94.8%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for responsive domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- An in-house phlebotomy service was offered onsite, resulting in patients who required this service not having to travel to local hospitals. Patients from other local practices were also able to book an appointment for the phlebotomy service at the practice.

People with long-term conditions

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for responsive domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- An electrocardiogram (ECG) service was offered onsite. An electrocardiogram (ECG) is a simple test that can be used to check the heart's rhythm and electrical activity. Sensors attached to the

skin are used to detect the electrical signals produced by heart each time it beats.

- The practice offered clinical system integrated spirometry. (Spirometry is a simple test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath).

Families, children and young people

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for responsive domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for responsive domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7pm Monday to Friday. Pre-bookable appointments were also available to all patients at additional hub locations within the area. Appointments were available Monday to Friday from 6.30pm to 8pm, Saturday and Sunday from 8am to 8pm at hub locations. This extended hours service was funded by the local CCG.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

The practice is rated as requires improvement for responsive domain. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- 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 practice is rated as requires improvement for responsive domain. The concerns which led to these ratings apply to everyone using the practice, including this population group. • Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly. However, some clinical staff we spoke with did not demonstrate appropriate understanding of social prescribing.

Timely access to the service

People were not always 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

Explanation of any answers and additional evidence:

- In addition to pre-bookable appointments that could be booked up to one week in advance, urgent appointments were also available for patients that needed them. The practice informed us they had introduced this arrangement to reduce the high rate of 'do not attend' (DNA) appointments.
- Appointments were available to book online.

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 (01/01/2018 to 31/03/2018)	52.9%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	52.6%	63.2%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	61.3%	59.9%	65.9%	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 (01/01/2018 to 31/03/2018)	60.8%	68.4%	74.4%	No statistical variation

Any additional evidence or comments
• Results from the August 2018 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below the local and national averages in most indicators.

- The practice had analysed the survey results and took steps to improve the access to the service in the last few months including:
- Reviewing and changing the appointment booking system.
- They had started offering extended hours on Friday evening (in addition to Monday to Thursday) from 6.30pm to 7pm.
- To take pressure off the phone lines they had encouraged patients to register for online services. For example, 49% of patients were registered to use online Patient Access.
- The practice was planning to install a new telephone system in March 2019 to improve telephone access. The practice informed us that the new telephone system would help in reducing telephone waiting times.
- They were planning on starting appointments from 8am from March 2019.
- While the practice had taken steps to improve the access, it was too early to assess the impact on patient experience.

Source	Feedback
Discussion with patients, the patient participation group (PPG) member and comment cards	• Feedback from three patients and a member of the patient participation group (PPG) had reflected that patients were not always able to get appointments when they needed them. • Two of the 11 patient CQC comment cards we received were neutral and raised some concerns regarding access to the service.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care. However, some improvements were required.

Complaints	
Number of complaints received in the last year.	14 (5 written & 9 verbal)
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

- Two different complaint policy and procedures were available. One procedure was not in line with recognised guidance because it did not include correct information of the complainant's right to escalate the complaint to the Ombudsman if dissatisfied with the response. The second procedure was in line with recognised guidance but it did not include the details of the person responsible at the practice for dealing with complaints. Both procedures did not include the name of the author and they were not dated so it was not clear when they were written or when they had been reviewed.
- We found that all written complaints had been addressed in a timely manner. However, we noted the practice had not always included necessary information of the complainant's right to escalate the complaint to the Ombudsman if dissatisfied with the response.

Example(s) of learning from complaints.

Complaint	Specific action taken
Long waiting time in the waiting area	The practice had offered appointments with alternative GPs when running very late, discussed with the GPs and advised to book double appointment if required.
Repeat prescription sent to the wrong pharmacy	Implemented change, developed a slip and requested to submit any change of pharmacy details in writing to the practice, so the record could be updated accordingly.

Well-led Rating: Requires improvement

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels.

	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.	Y
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:

- Staff we spoke to were complimentary about the leadership at the practice. We were told that the leaders were approachable, supportive and inclusive. Staff told us this made them feel motivated.
- The practice was planning to apply for funding to extend the premises. The practice patients list size had increased from 10,400 (in 2015/16) to 13,890 (in 2018/19).

Vision and strategy

The practice had a clear vision and aspire 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.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial

Explanation of any answers and additional evidence:

- The practice statement of purpose included practice's aims and objectives. This included to provide a dedicated, efficient and patient orientated approach to health care. This included to provide the highest quality NHS healthcare services, which was monitored, audited and continually improving.
- The levels of risk found at this inspection was a direct result of the provider not ensuring appropriate systems had been implemented to effectively monitor progress against delivery of the strategy.

Culture

The practice had a culture which drove high quality 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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

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

Source	Feedback
Staff interviews	• Staff told us they felt involved in decisions on how the practice was managed. • We were informed that the practice culture was one of being open and supportive of one another. • Clinical staff said they had prompt access to the senior GP when they needed clinical advice. • Staff felt they were treated equally.

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
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence: • There was a lack of good governance. • Clinical lead responsibilities were not always shared with other clinicians and the senior GP was responsible for monitoring most activities. For example, the practice had not appointed a dedicated clinical lead to oversee the management of test results and there was ineffective monitoring system in place to ensure that patient correspondence across the practice was managed in a timely manner. • While service specific policies were available, most did not include name of the lead member of staff including adult and child safeguarding policies. Most of the policies did not include the name of the author and they were not dated so it was not clear when they were written or when they had	

been reviewed.

- Some staff we spoke with were not sure or there was confusion regarding who was the lead member of staff for safeguarding.
- Infection control procedures were not always managed effectively.
- There was no formal monitoring system for following up patients experiencing poor mental health and patients with dementia who failed to collect their prescriptions in a timely manner, or to identify and monitor who was collecting the repeat prescriptions of controlled drugs from the reception.
- There was an ineffective system in place to monitor the use of blank prescription forms for use in printers and handwritten pads.
- Protocols for checking medicines stock levels and equipment were not always being followed. Written records of monitoring checks were not always maintained.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Y
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.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

- There were processes to ensure risks to patients were assessed and well managed in some areas, with the exception of those relating to safety alerts, some safeguarding procedures, infection control procedures, recruitment checks and the appropriate and safe use of medicines.
- The practice did not have effective systems in place to ensure the management of legionella, premises risk assessment and some fire safety procedures were appropriately managed.
- The business continuity plan did not include list of emergency contact numbers.
- There was no formal supervision arrangement in place to monitor the clinical performance and decision making of a nurse prescriber.
- There were no failsafe systems to follow up women who were referred as a result of abnormal results after the cervical screening.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: • The provider had not always monitored progress to identify and mitigate risks within the service.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: • Patients had a variety of means of engaging with the practice all of which were effective: text messages, emails and complaints/comments. • Staff feedback highlighted a strong team with a positive supporting ethos. • Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered.	

Feedback from Patient Participation Group.

Feedback
• The practice had a patient participation group (PPG). We spoke with a PPG member and they were positive about the care and treatment offered by the practice, which met their needs. They were satisfied with online access provided by the practice. They told us that their views and ideas were listened and accommodated as much as possible. However, they raised some dissatisfaction regarding access to the service.

Continuous improvement and innovation

There was some 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.	N
Explanation of any answers and additional evidence: • There was a lack of communication across the practice and there was limited evidence the learning from significant events had been shared to improve safety in the practice.	

Examples of continuous learning and improvement
• All staff received individualised training opportunities which were discussed at their appraisals. The practice used this information to inform its overall training plan. • The practice was supporting a practice nurse to complete the advanced nurse practitioner (ANP) course.

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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	No statistical variation	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.
- 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.

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

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.