Care Quality Commission

Inspection Evidence Table

Kirby Road Surgery (1-539233144)

Inspection date: 25 September 2019

Date of data download: 17 September 2019

Overall rating: Requires Improvement

The practice is rated as requires improvement as the practice did not always ensure that care and treatment was provided in a safe way to patients. Effective systems and processes to ensure good governance in accordance with the fundamental standards of care were not established.

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

Safe Rating: Requires Improvement

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

- Identified actions from infection prevention and control (IPC) audits had not been completed. We noted the work surfaces in the treatment room were cluttered allowing for the potential collection of dust and there were no foot operated pedal bins in the staff and patient toilets to ensure safe disposal of hand towels and waste without cross contamination.
- Emergency medicines were not easily accessible. Some staff did not know where to locate emergency medicines and equipment. Some recommended emergency medicines were not held in the practice and there was no risk assessment in place to mitigate this.
- A log had not been kept that demonstrated that fire drills had been completed. Fire alarm checks were only completed every two months.
- There were lapses in security in the premises. NHS smartcards were left in keyboards when staff were away from desks. The reception office was unlocked and easily accessible to patients.
- There were concerns with health and safety in the practice. The practice had not identified trip hazards. There was a mercury sphygmomanometer used for taking blood pressure readings. However, staff were unaware of the actions to take in the event of a mercury spillage.
- Blood test results for patients prescribed warfarin were not recorded in the patient computer record. We checked the hospital system and were assured that all patients prescribed warfarin had received appropriate blood monitoring.
- The temperature of the fridges used to store vaccines was checked each day. The thermometers were integral to the fridges. A second independent thermometer was not used to cross-check the accuracy of the temperature and to monitor the temperature if the electricity supply to the vaccine fridge was interrupted.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, some improvements were required.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: Staff we spoke with had an understanding of safeguarding and who the leads were within the practice. Local authority contact details were available on noticeboards throughout the practice.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: N/A	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: May 2019	Y
There was a record of equipment calibration. Date of last calibration: October 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: March 2019	Y
There was a log of fire drills. Date of last drill: None	N
There was a record of fire alarm checks. Date of last check: September 2019	Partial
There was a record of fire training for staff. Date of last training: Various dates online training	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 2015	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: We were informed that the practice had completed fire drills and had an evacuation of the premises due to the fire alarm activating. There was no log or record kept of these. A fire risk assessment had been completed in 2015. There had been no changes to the building that would indicate a new risk assessment was needed. However, fire alarm checks that had been completed weekly until May 2019 were now only done every two months. We were informed this was because they took too long to do. A further fire risk assessment had not been completed to support this decision.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	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: There had been no security risk assessment completed for the premises. We noted that NHS smartcards were not kept on person by individuals. We witnessed staff left smartcards in their keyboards when away from their desks. The reception office was easily accessible to patients; the door was open all day we were inspecting and patients could have entered and taken a smartcard or accessed other information. We were informed that staff did not take their smartcards home, they were locked in a cupboard at night	

so all staff had access to all cards. NHS smartcards enable healthcare staff to access clinical and personal information appropriate to their role.

There had been no health and safety risk assessments completed. We were informed that visual checks of the building were completed once a week, these were not documented. We noted there was raised wood on the floor at internal doorways in the practice that had not been identified as a trip hazard. There was a mercury sphygmomanometer in one of the GPs rooms for taking blood pressure readings. There was a mercury spillage kit available. However, when asked, the GP was not aware of this and did not know what actions to take in case of a mercury spillage. Mercury can pose a risk to staff and patients if not handled correctly.

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
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2019	Y
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.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

Infection prevention and control (IPC) audits had been completed every six months. However, some actions identified on every audit since 2017 had not been actioned and there was no action plan in place to complete what was required. The identified actions included replacing splashbacks at sinks and redecoration. On the inspection, we noted the work surfaces in the treatment room were cluttered allowing for the potential collection of dust and there were no foot operated pedal bins in the staff and patient toilets to ensure safe disposal of hand towels and waste without cross contamination.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
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.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: Some of the non-clinical staff we spoke with did not know where to locate the emergency medicines and they were not easily accessible in case of an emergency. They were kept in a locked cupboard in a locked room.	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

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

Appropriate and safe use of medicines

The practice did not have adequate 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)	1.13	0.89	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	8.5%	8.7%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	6.04	5.97	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)	3.51	2.15	2.08	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.	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/A
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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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.	N
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:

The system for checking the monitoring of patients who were prescribed warfarin was not evident. We were informed that the GPs were responsible for checking the blood test results prior to issuing a prescription. However, these were not recorded in the patient computer record. We checked the hospital system and were assured that all patients prescribed warfarin had received appropriate blood monitoring.

The practice had records in place to show that the medical oxygen and defibrillator were regularly checked. However, when we checked the equipment we found an out of date defibrillator pad and oxygen mask. These were immediately removed from the practice.

Some recommended emergency medicines (dexamethasone oral solution, dexamethasone injection, midazolam buccal or opiates) were not held in the practice and there was no risk assessment in place to mitigate this.

The temperature of the fridges used to store vaccines was checked each day. The thermometers were integral to the fridges. A second independent thermometer was not used to cross-check the accuracy of the temperature and to monitor the temperature if the electricity supply to the vaccine fridge was interrupted. We found a data logger in one of the fridges. However, the staff we spoke with were unaware of its existence and the purpose of it. Information from the data logger was not downloaded or monitored. Data loggers are useful to gain more detailed information about the fridge temperature if there was a cold chain failure, for example, a power cut.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	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.	Partial
Number of events recorded in last 12 months:	12
Number of events that required action:	12
Explanation of any answers and additional evidence: Learning from events was identified. The learning was not shared widely with the practice staff.	

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

Event	Specific action taken
Vaccines were not stored correctly.	The manufacturer were contacted for advice on whether the vaccines remained viable. Staff were informed of the correct procedure to maintain the cold chain for vaccines.
A local pharmacist issued the wrong medicine to a patient.	The pharmacist was made aware and the correct medicine was dispensed.
Incorrect hormone replacement therapy was prescribed.	Discussed in the clinical meeting. An audit was completed of all patients prescribed hormone replacement therapy to ensure appropriate prescribing.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts, for example, regarding sodium valproate.	

Effective Rating: Requires Improvement

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

- Exception reporting was high in some areas of the Quality and Outcomes Framework monitoring.
- The uptake for cervical screening was below the 80% target set by Public Health England.
- Some single-cycle audits had been undertaken by individual GPs. However, these were not shared with other clinicians and two-cycle audits and not been completed to demonstrate quality improvement. There was no other quality improvement activity demonstrated in the practice.
- Staff development was not supported by the use of appraisals.

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
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.	N/A
Explanation of any answers and additional evidence: N/A	

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)	1.40	0.84	0.75	Tending towards variation (negative)

Older people Population group rating: Requires

Improvement

Findings

- The concerns identified with the effectiveness of the services affected all population groups.
- 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

- The concerns identified with the effectiveness of the services affected all population groups.
- Patients with long-term conditions were offered 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.
- The health care assistants were trained to support the clinical team with the review of patients with long-term conditions.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.
- Patients with asthma were offered an asthma management plan.
- Respiratory packs were available for patients with asthma or chronic obstructive pulmonary disease.

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)	78.4%	79.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	9.5% (41)	15.8%	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	77.2%	76.0%	77.7%	No statistical variation

to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	6.0% (26)	13.8%	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)	80.5%	82.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	13.0% (56)	15.7%	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)	65.5%	76.6%	76.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.1% (15)	8.1%	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)	73.4%	90.1%	89.7%	Variation (negative)
Exception rate (number of exceptions).	11.3% (22)	13.9%	11.5%	N/A

Any additional evidence or comments
QOF data for 2018/19, published in October 2019, showed that the practice achieved: • 89.6% for 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. However, the exception rate for this indicator was 20.3%. • 96.8% for 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.

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)	78.7%	82.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.2% (32)	5.1%	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)	100.0%	92.6%	90.0%	Significant Variation (positive)
Exception rate (number of exceptions).	8.9% (13)	5.0%	6.7%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The concerns identified with the effectiveness of the services affected all population groups.
- Childhood immunisation uptake rates exceeded the World Health Organisation (WHO) targets.
- 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)	102	102	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	104	105	99.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	104	105	99.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	104	105	99.0%	Met 95% WHO based target

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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The concerns identified with the effectiveness of the services affected all population groups.
- The uptake for cervical screening was below the 80% target set by NHS England.
- The uptake for breast and bowel cancer screening was in line with other practices both locally and nationally.
- 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)	75.5%	N/A	N/A	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)	75.9%	73.2%	69.9%	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)	58.3%	56.3%	54.4%	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)	62.7%	60.9%	70.2%	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)	37.8%	55.8%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The concerns identified with the effectiveness of the services affected all population groups.
- Same day appointments and longer appointments were offered when required.
- The practice informed vulnerable patients about how to access support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children.
- 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 had identified 261 patients as carers which equated to approximately 3% of the patient population.
- The practice had a specific information board in the waiting areas which advised carers of how to register at the practice and where to access support.
- The practice sent letters to carers inviting them to attend for health reviews and flu vaccinations.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The concerns identified with the effectiveness of the services affected all population groups.
- 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)	95.5%	90.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	46.3% (19)	20.2%	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)	100.0%	91.3%	90.0%	Variation (positive)
Exception rate (number of exceptions).	43.9% (18)	17.1%	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)	84.5%	83.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	9.4% (6)	8.4%	6.6%	N/A

Any additional evidence or comments

The practice informed us that three attempts were made to contact the patient and invite them in for a review prior to exception reporting. No further measures were taken to target patients who did not take up the offer.

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)	536.1	538.7	537.5
Overall QOF score (as a percentage of maximum)	95.9%	96.4%	96.2%
Overall QOF exception reporting (all domains)	6.2%	6.4%	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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Any additional evidence or comments
There were some prescribing audits completed. Individual GPs had undertaken clinical audits, for example, a single cycle audit had been done in response to significant events related to the prescribing of hormone replacement therapy. However, these were not shared with other clinicians and two-cycle audits had not been completed to demonstrate quality improvement. There was no other quality improvement activity demonstrated in the practice.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, they were not supported by appraisals.

	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.	N/A
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.	Y
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: Only two members of staff had received an appraisal in the past two years. Some staff informed us it had been more than two years since they had received one.	

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)	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.	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.	N/A
Explanation of any answers and additional evidence: N/A	

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)	93.3%	94.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.9% (21)	1.0%	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.	N/A

Well-led Rating: Inadequate

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

- There were flaws in the leadership and governance of the practice.
- Staff were not supported fully by the GP partners.
- Systems and processes in place were not adequately followed.
- A fire risk assessment had not been completed to support decisions made in relation to fire alarm checks.
- Essential risk assessments had not been completed in relation to security and, health and safety.
- There was a lack of staff meetings and formal communications with staff. Outcomes and learning from significant events and complaints were not shared with practice staff.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: The GP partners did not fully engage with the inspection process. The practice had a management team that consisted of two practice managers who also had roles as reception manager and secretary. There was a lack of knowledge of some aspects of the practice management. For example, they were unaware of whether risk assessments had been completed, they did not have an overview of the training staff had undertaken and they were unaware of the location of emergency equipment and emergency medicines. Staff informed us that they did not feel supported by the GP partners. We were informed that one of the GPs was due to retire. However, there was no succession plan in place.	

Vision and strategy

The practice had a 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.	Partial
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.	Partial
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: The practice did not have a formal documented vision and values for the practice. We were informed there was no formal objectives or strategy. Staff we spoke with were clear they were working to do the best for their patients.	

Culture

The practice culture did not always effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: Staff we spoke with felt that not all of the GPs were supportive and one GP in particular was rude and dismissive of staff. Staff did not find all of the GPs approachable.	

Governance arrangements

The responsibilities, roles and systems of accountability to support good governance and management were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice had policies and procedures in place. However, feedback from staff was that the GPs all had their own individual ways of working that they had to adapt to. There were no consistent systems for	

them to follow.
Some of the systems in place were not adequately followed. For example, the system for checking the monitoring of patients who were prescribed Warfarin was not evident. GPs were responsible for checking the blood test results prior to issuing a prescription but these are were recorded in the patient computer record.

Managing risks, issues and performance

The practice did not always 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.	Y
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Partial
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: Staff performance and development was not supported by appraisals. Single-cycle audits had been undertaken. There were no full-cycle audits to demonstrate quality improvement. There was an absence of essential risk assessments. For example, security and, health and safety. Changes had been made to fire safety procedures in the practice that were not supported by a current fire risk assessment. Actions had not been completed following the infection control and prevention (IPC) audits.	

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
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	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

Feedback from Patient Participation Group.

Feedback
The patient participation group consisted of approximately 10 members. The practice manager attended meetings. The group was aiming to work with the practice to gather feedback from patients and implement changes in response.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: Outcomes and learning from significant events and complaints were not shared with practice staff. There were no all practice staff meetings. There was a communication book in the reception office where some information was conveyed to staff. However, there was no record or indication that the information had been read by all staff.	

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.
- 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.