

Care Quality Commission

Inspection Evidence Table

The Grange Surgery (1-542089978)

Inspection date: 1 December 2020

Date of data download: 17 November 2020

Overall rating: Good

At our previous inspection in October 2019, we rated practice as inadequate overall because there had been ongoing issues with infection control, inconsistent management and mitigation of risk, insufficient learning when things went wrong, and governance systems that were not operating effectively.

At this inspection, we rated the practice as good overall because the practice could demonstrate they had made improvements to the systems and processes to ensure good governance in accordance with the fundamental standards of care and to ensure fit and proper persons were employed.

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

Safe

Rating: Good

At our previous inspection in October 2019, we rated the practice as inadequate for providing safe services because there were gaps in staff training, a lack of disclosure and barring system (DBS) checks and a lack of monitoring of clinical staff registration and staff vaccination status'.

We also found that infection prevention and control (IPC) audits had not been regularly completed and actions had not been carried out, there was no system for recording and acting on safety alerts, actions to mitigate risks from risk assessments were not carried out in a timely way and the system for learning and improving when things went wrong was not comprehensive.

At this inspection we rated the practice as good for providing safe services because:

- The practice was able to demonstrate improved monitoring of staff training and staff training was up to date and in line with practice policy and national guidance.
- The practice made improvements to its recruitment system to ensure newly employed staff had a DBS or appropriate risk assessment in place. The practice was also able to demonstrate that staff vaccinations were monitored in line with Public Health England guidance.
- The practice had implemented a new process to ensure that all clinical staff registration was monitored and up to date.
- IPC audits had been completed in line with practice policy and actions to mitigate risk had been completed.

- The practice had implemented a log of safety alerts and updated this accordingly to ensure actions had been completed.
- The practice could demonstrate they had completed the required actions from risk assessments for fire safety, legionella and health and safety.
- The practice had improved its system to record significant events. These were discussed at practice meetings where outcomes and learning was identified, recorded and shared with staff.

Safety systems and processes

The practice had 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection in October 2019, we found there were gaps in safeguarding training and one GP did not have up to date safeguarding adults training and two GPs did not have up to date level three child safeguarding training.</p> <p>At this inspection we found that all clinical staff had completed and were up to date with level three safeguarding training for adults and children and all non clinical staff had completed level two safeguarding training for adults and children. This was in line with the practice policy and the national intercollegiate guidance. We also found all staff we spoke with were knowledgeable about safeguarding and understood their responsibilities.</p> <p>At the October 2019 inspection, we found that Disclosure and Barring Service (DBS) checks had not been undertaken where required and two members of clinical staff and one member of reception staff did not have a completed DBS check or risk assessment in place prior to commencing employment.</p>	

Safeguarding	Y/N/Partial
<p>During our inspection in December 2020, we reviewed the DBS checks for nine members of staff, including five staff members employed within the last 12 months. We found the practice had completed risk assessments for two recently employed practice nurses who were awaiting the completion of their DBS checks. We also saw three GPs, one practice nurse and two non clinical staff members acting as chaperones had completed DBS checks and one member of the reception team, not acting as a chaperone, had a completed risk assessment in place.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a system to ensure relevant recruitment checks for practice staff and locums were being carried out. We viewed recruitment files for five members of staff recruited within the last 12 months and found that necessary background and recruitment checks had been completed in line with practice policy and schedule 3 of Health and Social Care Act 2008.</p> <p>During our inspection in October 2019, we found that staff vaccination was not consistently maintained in line with PHE guidance for all clinical staff. At a follow up inspection in January 2020, we found that all staff had been reviewed for their immunity and most staff had been tested with some awaiting a test. At this inspection, we reviewed eight staff files, including two recently employed practice nurses, one newly employed salaried GP, one long term locum GP, a further salaried GP and two members of the reception team. All eight staff members files we reviewed had a complete and up to date vaccination status.</p> <p>At the October 2019 inspection, we found the practice did not have a system to monitor the registration of nursing staff. During this inspection, we found the practice used their online system to update, record and monitor the ongoing registration of all clinical staff members. The practice told us the system would send a reminder to the practice management team when an update was due and we found that registration checks for all clinical staff were up to date.</p>	

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 October 2019	Partial
There was a record of equipment calibration. Date of last calibration: 3 November 2020	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 28 October 2020	Yes
There was a log of fire drills. Date of last drill: 13 November 2020	Yes
There was a record of fire alarm checks. Date of last check: 13 November 2020	Yes
There was a record of fire training for staff. Date of last training: 12 November 2020	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 11 December 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p data-bbox="57 1223 810 1256">Explanation of any answers and additional evidence:</p> <p data-bbox="57 1267 1528 1379">The practice told us there had been a delay in booking the portable appliance testing due to the COVID-19 pandemic and showed us emails demonstrating they had scheduled the testing for 3 December 2020 and had sought assurances from the external company about the implications of the delay.</p> <p data-bbox="57 1447 1528 1711">During our October 2019 inspection, we found that a fire risk assessment had been completed but the practice had not carried out the action required. At this inspection we found that the practice had completed a fire risk assessment on 11 December 2019 with a total of 26 actions. Seven actions required immediate completion, nine required action within one month, four required action within three months and a further six actions were advisory. We found that 25 of these actions had been completed and the practice had scheduled to complete the final advisory action, to produce an emergency information folder to provide to the fire service when they first arrive on scene, by 1 January 2021.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 16 December 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14 January 2020	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the October 2019 inspection, we found that a legionella risk assessment had not been completed every two years as required and actions from the risk assessment had not been completed. (Legionella is a bacterium commonly found in water supplies. Maintaining a specific temperature and keeping water moving through pipes helps to reduce the opportunity for the legionella bacteria to grow and spread). We also found there was no clear date to complete actions from a premises risk assessment in relation to rotting window frames.</p> <p>At this inspection, the practice had appointed a specialist company to carry out an annual legionella risk assessment at the practice and we saw the practice had been assessed as low risk following an assessment carried out on 23 October 2020. In addition, the practice had a dedicated staff member to carry out monthly routine monitoring checks of water temperatures and to carry out water flushing to minimise the risk of legionella.</p> <p>During our inspection in January 2020, we followed up on the health and safety risks relating to the window frames and found that an updated risk assessment had been carried out on 14 January 2020. The practice was a listed building and required planning permission to replace the windows, which was the landlords responsibility and we saw repeated requests to the landlord to repair the windows. At this inspection, the practice told us the landlord had arranged for a local surveyor to attend the practice in March 2020 and had submitted a request for planning permission to the local council to replace the windows. We saw further emails sent to the landlord and the surveyor requesting timescales for this work to be completed but the practice were still awaiting a confirmed date at the time of this inspection.</p> <p>We also saw monthly health and safety checklists had been completed by a dedicated and trained staff member and all actions identified had been addressed. For example, a window was reported as not closing properly on 3 September 2020 and this had been fixed and recorded as resolved on 11 September 2020.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 8 July 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our October 2019 inspection, we found that Infection Prevention and Control (IPC) audits were not being carried out regularly or comprehensively and the practice had not addressed actions identified. During this inspection, we reviewed two six-monthly IPC audits from January 2020 and July 2020 and found that all actions had been completed. For example, fabric chairs in consulting rooms were replaced with wipeable chairs and soft toys were removed from the waiting area and replaced with wipeable wall mounted toys.</p> <p>In response to COVID-19, the practice had also amended their daily cleaning schedules and a new process was implemented to allow the logs to be kept up to date on the staff shared drive. However, the practice identified gaps in the log and agreed to return to paper logs in each individual room as this was more efficient and ensured all cleaning had been completed by staff before leaving the room. We reviewed a sample of these paper logs and found these had been completed on a daily basis to provide assurances the room was clean.</p>	

Risks to patients

There were adequate 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes

When there were changes to services or staff, the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence that all staff members had completed and were up to date with the online Basic Life Support training. However, five members of staff employed within the last six months including a GP, two practice nurses, a receptionist and an administrator, had not yet completed cardiopulmonary resuscitation (CPR) training. The practice provided evidence to demonstrate the CPR training course had been scheduled to be carried out in April 2020 but, due to the COVID-19 pandemic, it had been postponed. We also saw the practice remained in communication with the CPR trainer and had rescheduled the training for 3 December 2020, taking into consideration new COVID-19 measures. All staff we spoke with were able to report how they would respond in an emergency and were aware of where emergency equipment was stored.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the October 2019 inspection, we found there was a backlog in summarising new patient notes, which dated back four months and affected 200 new patients. At this inspection, the practice told us that since the last inspection they had made staff roles and responsibilities more clear to all staff and now had a designated member of staff who was responsible for summarising new patient notes. At the time of the inspection, we found the notes awaiting summarisation did not date back more than five days before our visit.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.64	0.83	0.85	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA)	8.8%	9.3%	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 (01/01/2020 to 30/06/2020) (NHSBSA)	6.13	5.45	5.35	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2020 to 30/06/2020) (NHSBSA)	73.2‰	108.2‰	123.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHSBSA)	0.80	0.66	0.70	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes

Medicines management	Y/N/Partial
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.	Yes
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).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection, our remote searches revealed that 123 patients prescribed novel oral anticoagulants (NOACs), a medicine which thins the blood, had not had their creatinine clearance measured in the last 12 months to help to calculate dosage requirements. During the inspection, the CQC specialist advisor reviewed eight patient records and highlighted that five patients had not had their creatinine clearance levels measured in last 12 months. However, we noted the practice had identified the issue and had an action plan to improve this.</p> <p>Following the inspection, the practice told us they had continued to review the patients' records and found that many patients had their creatinine levels measured but their estimated creatinine clearance had not been coded. They also found that some patients had short term prescriptions from secondary care and were no longer taking the medication. The practice told us they were in the process of reviewing these patients and, following the inspection, provided us with evidence they had re-run the search and found that the number of patients prescribed NOACs that had not had their creatinine clearance measured in the last 12 months had reduced to 12. The practice advised their plan was to continue to review all patients in this cohort and told us this would be added as a regular search to their medicines monitoring to ensure that the creatinine clearance is regularly being updated.</p> <p>The practice had a system in place to record temperatures of fridges used to store medicines. We found that temperatures for one fridge had not been recorded on four separate occasions between 29 October 2020 and 20 November 2020 and no recorded explanation was noted on these occasions. From recordings we reviewed, we did not see any occasions where the fridge had gone out of temperature</p>	

Medicines management	Y/N/Partial
range. The practice acknowledged the recording of temperatures during this time had not been consistent and told us they had identified these gaps were due to a staff member leaving. After the inspection, the practice manager told us they had recently implemented a data logging system and the nurse manager would carry out weekly checks of the downloaded data, in addition to the daily checks being carried out by staff to ensure the fridge temperatures stayed within range.	

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	23
Number of events that required action:	23
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in October 2019, we found that minutes of meetings did not consistently show that incidents had been discussed. During our January 2020 inspection, we found the practice had improved its system for recording significant events and the practice now used a quality surveillance system to record all incidents, complaints and compliments. At this inspection, we found the practice discussed significant events at quarterly practice meetings or at a weekly meeting if a more urgent discussion was required. All staff we spoke with were aware of the process to report significant events and outcomes and learning identified was recorded and accessible to staff.</p> <p>The practice had identified themes from significant events, for example, in relation to staff not following the practice procedure to confirm a patient's identity. We saw the practice had carried out a telephone audit in June 2020 to determine whether staff followed the correct procedure to confirm a patient's identity. The audit demonstrated that, out of the 25 calls reviewed, only two were found to have achieved 100% and a further 21 calls were found to have achieved 67%. This was shared with staff at a team meeting in June 2020 and staff discussed the importance of confirming a patient's identity and were reminded of the correct three-stage process to follow. The practice told us a second audit was due to be completed by the end of December 2020 to identify improvements or areas for additional learning. However, we noted that no further significant events had been raised in relation to identification checks since June 2020.</p>	

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

Event	Specific action taken
Patient aggressive towards staff members.	Discussed at practice meeting and agreed for staff to complete additional training for conflict management. Staff reminded to request support in conflict situations and to use EMIS alert button when required. Sent a letter to patient to advise of practice zero tolerance policy.
Patient attended with shortness of breath and staff did not have access to a nebuliser.	Discussed at practice meeting and two nebulisers were purchased and added to the daily emergency equipment checks. Medical emergency policy was also updated to include this.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the October 2019 inspection, we found that the system for acting on safety alerts was unclear as there was no record kept within the practice of alerts received and action taken to address them. At this inspection, we found the practice had implemented and maintained a log of safety alerts. All safety alerts were monitored, reviewed and updated accordingly to ensure actions had been completed. Meeting minutes we reviewed showed that alerts were discussed at weekly practice meetings as a standard agenda item.</p> <p>In addition, the practice had carried out four audits in the last 12 months to review the percentage of staff who had recorded their acknowledgement of the alerts distributed to them. The first audit was carried out on 8 April 2020 and demonstrated that, on average, the overall percentage of recorded acknowledgements was 65%. Staff were reminded of recording their acknowledgement and the audit was re-run on 15 April 2020 and demonstrated this had improved to 78%. A further audit was carried out on 5 October 2020 and provided that, on average, the overall percentage of recorded acknowledgements remained 78%. We saw practice meeting minutes which showed the practice raised this with staff and highlighted the importance of ensuring they recorded their acknowledgements. This audit was re-run on 1 December 2020 and demonstrated an improvement to 89% and also highlighted that, due to an issue accessing the system, one staff member had not been able to record their acknowledgement. The practice had set an action to ensure the access was resolved.</p>	

Effective

Rating: Good

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none">• 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: Good

Findings

- 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- 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.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	74.2%	75.6%	76.6%	No statistical variation
PCA* rate (number of PCAs).	2.2% (14)	10.3%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	93.5%	87.6%	89.4%	No statistical variation
PCA rate (number of PCAs).	1.8% (2)	10.1%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.1%	82.0%	82.0%	Tending towards variation (positive)
PCA rate (number of PCAs).	1.3% (2.0)	4.8%	No Data	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	63.9%	67.8%	66.9%	No statistical variation
PCA rate (number of PCAs).	4.0% (14.0)	15.6%	No Data	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.9%	73.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.5% (19.0)	6.7%	No Data	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	88.2%	89.4%	91.8%	No statistical variation
PCA rate (number of PCAs).	4.3% (8)	5.3%	4.9%	N/A

Findings

- The practice met the WHO-based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators and the fourth indicator met the minimum 90% for childhood immunisation uptake. The practice recognised there had been an impact on childhood immunisations since the COVID-19 pandemic and to further improve uptake, the practice told us they contacted parents and guardians by letter and telephone to advise that the practice was able to continue providing childhood immunisations and provide reassurance on the safety measures in place.
- 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 liaised 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 and national 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)	53	58	91.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	61	63	96.8%	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)	61	63	96.8%	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)	60	63	95.2%	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: **Good**

Findings
<ul style="list-style-type: none"> 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). (Snapshot date: 31/03/2020) (Public Health England)	78.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	75.0%	73.2%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	62.5%	63.1%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	92.50%	94.8%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	48.4%	48.1%	53.8%	No statistical variation

Any additional evidence or comments
<p>Whilst the most recently published data for the uptake of cervical cancer screening showed the practice fell below the 80% target, data showed that uptake had improved since the October 2019 inspection in which the practice cervical cancer screening uptake was previously 76.1%.</p> <p>The practice recognised that the COVID-19 pandemic had an impact on uptake since March 2020 but to further encourage uptake, they had used text message reminders and sent letters headed on pink paper to make them more noticeable and to remind patients to attend. In addition, the practice nurse told us she actively contacted patients by telephone if they did not attend and discussed their concerns and the importance of cervical screening. The practice also set up Monday evening clinics to run between 5pm and 7pm to improve uptake outside of normal working hours.</p>

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- 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.
- The practice were involved with the Primary Care network in setting up a mental health support service for young people which aimed to promote mental health support and work in collaboration with the voluntary sector to improve outcomes for young people.
- 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	94.6%	85.7%	85.4%	No statistical variation
PCA rate (number of PCAs).	8.2% (5)	14.0%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	95.2%	81.2%	81.4%	Variation (positive)
PCA rate (number of PCAs).	6.0% (4)	6.4%	8.0%	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)	551.87	Not Available	533.9
Overall QOF score (as a percentage of maximum)	98.7%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	3.2%	Not Available	5.9%

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

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

The practice carried out a two-cycled audit for prescribing and monitoring of Denosumab (medication used for the treatment of osteoporosis). The first cycle audit in February 2020 demonstrated that 68.2% of the 22 patients prescribed Denosumab had the correct calcium monitoring carried out in time for the Denosumab injection. From this audit, the practice agreed to implement a new template to record clinical data and ensure the correct monitoring was being carried out. The second audit in November 2020 showed that of the 32 patients prescribed Denosumab, 87.5% patients had the correct calcium monitoring carried out. In addition, the audit showed that the new template was used in 100% patients who had received their Denosumab injection at the practice. The practice concluded the new system had improved their monitoring of calcium and timely provision of Denosumab injections.

The practice also carried out a two-cycled audit to assess the number of inadequate cervical screening results received from practice nurses. To remain within the NICE guidelines, the inadequate cervical screening results were required to remain below 10%. The first audit was completed in June 2019 and demonstrated that from a total of 271 cervical smears taken over a six month period, 11 returned with inadequate results, which averaged at 4.05%. The second audit was carried out in June 2020 and showed that from a total of 102 cervical smears taken over a six month period, one returned with an inadequate result which averaged at 1.44%. Whilst this demonstrated an improvement since 2019, the practice recognised the impact of the COVID-19 pandemic had reduced the number of cervical smears which had taken place within a six month period and planned to carry out a third audit in June 2021. However, the practice noted that both audits demonstrated the practice nurses inadequate smear results had remained below 10% and within the NICE guidelines.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the October 2019 inspection, we found there were some gaps relating to GP training updates. During this inspection, we reviewed training records for all staff members and found this to be complete and up to date. This included level three safeguarding training for all clinical staff, in line with practice policy and national intercolleagiate guidance.</p> <p>Staff we spoke with told us that managers encouraged them to further their development by completing additional training courses. For example, the newly appointed practice nurse manager had recently completed a lead nurse development course. Another staff member told us they had been supported to complete a recognised qualification in health and safety and was in discussion with the practice about further development.</p>	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff were aware of local initiatives to improve patients' health and were able to signpost patients to appropriate services. The practice provided support to patients on lifestyle management, weight management and smoking cessation and this was in line with the practice ethos which promoted self care with support from the practice. In addition, three social prescribers had been employed within the Primary Care Network in the last 12 months and the practice was able to refer patients to this service. Social prescribing is when health professionals refer patients to support in the community, in order to improve their health and wellbeing.</p>	

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: All staff had completed the Mental Capacity Act training and staff we spoke to were clear on the requirement to obtain consent and provided clear examples to demonstrate their understanding of mental capacity.	

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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Source	Feedback
Patient feedback	As part of this inspection, we received patient feedback from two members of the Patient Participation Group (PPG) and both provided positive feedback about the service at the practice. Both patients told us the online access system worked well and they were able to book appointments or order repeat medication when required. They said they had enough time in appointments and if previous appointments had run late, staff would always inform them. Both patients told us the staff always respected their privacy and dignity and were aware of the chaperone system.
NHS UK	There had been no new reviews on the NHS UK website in the last year.
Feedback from local care home	We spoke with a representative from a local care home where patients were registered with the practice. We were told the care home had a good working relationship with the practice and found the practice was always responsive and acted quickly when required. The representative told us that prescriptions were managed effectively and in a timely manner and told us residents spoke positively about the care from the GPs.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	92.2%	91.5%	88.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	90.9%	88.9%	87.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	98.5%	97.2%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	87.3%	83.6%	81.8%	No statistical variation

Any additional evidence or comments

The GP Patient survey results were better than both local and national averages for patients' experiences of care and treatment.

Question

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

Any additional evidence

The practice carried out two patient surveys in February 2020. The patient satisfaction survey received seven responses and a short patient questionnaire received 133 responses. We reviewed a sample of 50 responses which all shared positive comments, in particular, about the improvements made to the practice telephone system. We also reviewed all seven responses to the patient satisfaction survey, which all had positive responses about access, staff attitude, communication from the practice, and the care and treatment in appointments. In addition, all said they would recommend the practice to others.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Easy read and pictorial materials were available. The practice was also able to refer patients to the social prescribers employed within the Primary Care Network to ensure patients were able to access community support.	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	98.4%	95.0%	93.0%	Tending towards variation (positive)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 185 patients as carers. This was more than 2% of the practice population. We noted the practice had improved its identification of carers since the October 2019 inspection which was previously less than 1%.
How the practice supported carers (including young carers).	All identified carers were sent a carers pack which provided information on support services available and carers had access to flu vaccinations. The practice was able to offer referrals to the social prescribers employed within the Primary Care Network for additional support. Carers information was also available on the practice website.

How the practice supported recently bereaved patients.	The practice told us that bereaved patients received a phone call from the registered GP and were offered an appointment as required. The registered GP would offer support and signpost to support services.
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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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: All incoming calls to the practice were answered in the back office area to ensure patients in the waiting area and at reception could not hear conversations.	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: In response to the COVID-19 pandemic, the provider used digital technology and offered patients an electronic prescription service as well as online and video consultations to reduce footfall within the practice and to limit the spread of COVID-19.	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The services were provided from rooms on two floors and we saw that the practice had a lift and a stair lift to ensure all patients had access to both floors. In addition, we saw that the entrance, waiting area, treatment and consultation rooms were able to accommodate wheelchair users and prams.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 7pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	7.30am to 6.30pm
Appointments available:	
Monday	9am to 12pm and 4pm to 7pm
Tuesday	9am to 12pm and 4pm to 6pm
Wednesday	9am to 12pm and 4pm to 6pm
Thursday	9am to 12pm and 4pm to 6pm
Friday	9am to 12pm and 4pm to 6pm
The practice had extended hours prebookable appointments from 6pm to 7pm every Monday and from 7.30am to 8.30am every Friday. Due to the COVID-19 pandemic, the practice told us the extended hours that had previously been available from 9am to 11am every Saturday had been temporarily suspended.	

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice had baby changing facilities available.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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.
- Telephone, online and video consultations were available.
- The practice was open until 7pm on Mondays and from 7.30am on Fridays. Pre-bookable appointments were also available to all patients at additional locations within the area. Appointments were available Monday to Friday from 6.30pm to 10.30pm and available Saturday and Sunday 8am until 10.30pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. For example, appointment times would be extended and alerts would be added to patient records to notify staff of the patient's individual needs or requirements.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	71.5%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	73.6%	67.9%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	71.8%	63.3%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	81.5%	76.3%	72.7%	No statistical variation

Any additional evidence or comments

The GP Patient survey results were better than both local and national averages for access to appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	13
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection in October 2019, we found the practice could not demonstrate all complaints had been discussed as not all meetings were minuted. At this inspection, we found the practice had improved its system for recording complaints and the practice now used an electronic system to record all complaints, incidents and compliments. We found the practice discussed complaints at quarterly practice meetings and the practice kept a log of complaints to help to monitor actions taken by the practice.</p> <p>We saw evidence that complaints were fully investigated and the practice were open and transparent with patients. Information about how to complain was readily available on the practice website, in the practice leaflet and in the practice complaints leaflet. We found the practice response letter to complaints did not include details of the Parliamentary and Health Services Ombudsman (PHSO), to advise patients on how to escalate their concerns if they were not satisfied with the practice response, and we noted this had previously been raised during the October 2019 inspection. However, the details of the PHSO were accessible to patients on the practice website and on the practice complaints leaflet. We discussed this with the practice who acknowledged this and after the inspection, told us this process had been reviewed and responses would now include these details for patients.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A complaint from a patient about lack of coil appointment availability.	The practice responded to the patient and apologised for lack of availability. An appointment was booked and the practice discussed this at a practice meeting. The practice increased the number of coil appointments to improve availability.
A complaint from a patient who felt failed by the GP after cancer diagnosis.	The named GP responded to the patient directly to express sympathy and offer additional support to the patient. This was discussed at a practice meeting.

Well-led

Rating: Good

At our previous inspection in October 2019, we rated the practice as inadequate for well-led as governance systems were operating ineffectively and arrangements for managing and mitigating risks were inconsistent.

At this inspection we rated the practice as good for well-led, because:

- The practice had reviewed and updated their systems and processes to ensure compliance with practice policies and national guidance.
- Practice policies were fully embedded, appropriately reviewed and accessible to staff.
- The practice sought assurances that newly employed staff had appropriate recruitment checks before working at the practice.
- Appropriate risk assessments had been carried out and acted upon in a timely manner.
- The practice had improved the system for recording significant events and complaints. These were discussed at practice meetings and actions and learning identified was recorded and shared with staff.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: During the October 2019 inspection, we found there had been changes to the management structure which was in the process of being embedded. At this inspection, we found there was a clear management structure and staff we spoke to told us leaders and managers were supportive and approachable.	

Vision and strategy

The practice had a clear vision and 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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes

Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The visions and values of the practice were detailed in the practice statement of purpose and on the practice website. The practice had an ethos of 'Your health in your hands with our help' and the practice encouraged patients to be proactive about their own health with the support of the practice.	

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: Staff we spoke to told us they felt able to raise concerns with the management team and were confident their concerns would be handled appropriately. Significant events and complaints information showed the practice was open and honest when things went wrong and we saw the practice apologised to patients where appropriate.	

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

Source	Feedback
Practice staff survey	<p>We saw a practice staff survey had been carried out in September 2020 and received 15 staff member responses. The survey showed:</p> <ul style="list-style-type: none"> • 87% of staff who completed the survey agreed or strongly agreed that they felt proud to work for the practice; a further 13% neither agreed nor disagreed. • 87% of staff who completed the survey agreed or strongly agreed that patients were at the heart of everything they do at the practice; a further 13% neither agreed nor disagreed. • 100% of staff who completed the survey agreed or strongly agreed their line manager was fair and approachable at all times.

	<ul style="list-style-type: none"> • 53% of staff who completed the survey agreed or strongly agreed they felt supported, respected and valued in the workplace; 27% neither agreed nor disagreed and a further 20% disagreed. • 47% of staff who completed the survey agreed that they had a manageable workload. However, 53% of staff who completed the survey disagreed or strongly disagreed with this statement. • 100% of staff who completed the survey agreed or strongly agreed that they were aware of the process for raising concerns at the practice. 87% of staff who completed the survey somewhat agreed, agreed or strongly agreed that they felt able to raise concerns. However, 13% of staff who completed the survey somewhat disagreed or disagreed that they felt able to raise concerns. • 53% of staff who completed the survey somewhat agreed, agreed or strongly agreed that the working morale in the practice was good. However, 47% of staff who completed the survey somewhat disagreed, disagreed or strongly disagreed. • 73% of staff who completed the survey somewhat agreed, agreed or strongly agreed that the values and behaviours of the management team reflected the vision and values of the practice; 13% neither agreed nor disagreed and a further 13% somewhat disagreed or disagreed with this statement. <p>The practice told us they had briefly discussed the survey at a partners meeting on 30 November 2020 and had a provisional plan to carry out a team building event to improve morale. However, the practice manager told us that the survey required a more detailed review and was on the set agenda for the next scheduled meeting on 14 December 2020.</p>
Staff feedback	<p>As part of this inspection, staff provided feedback to us during remote interviews and we invited all staff to provide written feedback to the inspection team. Most staff felt there was enough staff within the practice and told us staff worked well as a team and supported each other. Staff told us managers were open and approachable and they felt their views were listened to and acted upon. For example, staff told us their views were taken into consideration when planning how to organise and run the flu vaccination clinics during the COVID-19 pandemic, to ensure patients remained socially distanced and safe. Some staff told us they would like the management team to check in with staff more often to see how they were feeling after a busy period. Staff told us the practice manager had implemented a lot of changes since the October 2019 inspection and they felt that the staff skill mix was now being used to ensure staff worked to their strengths and this helped the practice to run more effectively. It was clear from staff feedback that patient care and safety was the main focus and staff told us they strived to ensure patients received the best possible care. Overall, staff told us they enjoyed working at the practice.</p>

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: At the October 2019 inspection, we found governance systems were operating ineffectively and arrangements for managing and mitigating risks were inconsistent. For example, we found different versions of infection control policies available, recruitment systems did not provide assurance that staff had disclosure and barring checks completed, there was no system in place to check the ongoing registration status of clinical staff and staff immunisations were not completed in line with Public Health England guidance. At this inspection, we found the practice had reviewed and updated their systems and processes to ensure compliance with practice policies and national guidance. We found policies had been reviewed, were up to date and were stored in a central computer system accessible to all staff. The practice had also improved their recruitment system to ensure staff had all the appropriate checks completed before starting employment. Ongoing registration status' of clinical staff were up to date. Since the October 2019 inspection, the practice had embedded their new management structure and developed clear roles and responsibilities for each staff member. Staff we spoke with on the day understood their own roles within the practice as well as the roles and responsibilities of other practice staff.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During the October 2019 inspection, we found legionella risk assessments had not been carried out at the recommended intervals and the practice did not have clear timelines to complete actions from the legionella risk assessment, fire risk assessment and health and safety risk assessment. We also found the practice had not carried out risk assessments for staff who had not received a DBS check.</p> <p>At this inspection, we found that a legionella risk assessment had been completed on 23 October 2020 and the practice were carrying out the ongoing required action of monthly monitoring checks. We also found the practice had taken action to address the risks highlighted in the January 2020 health and safety risk assessment and we found that the practice had completed 25 of the 26 actions set from the December 2019 fire risk assessment and the practice had a plan in place to complete the final advisory action by 1 January 2021.</p> <p>Since the October 2019 inspection, the practice reviewed their DBS protocol and from our review of nine staff members records, we found that two clinical staff members waiting for their DBS to be completed and one non clinical staff member that did not have a DBS check completed had appropriate risk assessments in place.</p>	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence: At the October 2019 inspection, we found that minutes of meetings were not always maintained.</p> <p>At this inspection, we found the practice had a clear meeting structure in place and we reviewed minutes from weekly clinical meetings, weekly business meetings, monthly nurse meetings, monthly reception and admin meetings and weekly practice meetings. From minutes we reviewed, we found there was a set agenda and notes and actions from the meeting were clearly set out.</p>	

If the practice offered online services:

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

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<p>Staff we spoke with and received feedback from told us the management team would listen to and act upon their views and suggestions. For example, staff told us the practice updated the telephone system as the previous system was outdated and only allowed four telephone lines to be in use at one time, across the practice. This upgrade made the telephone system more efficient and accessible for patients and practice staff.</p> <p>One staff member told us that following a recent training course, the practice purchased a new doppler machine to enhance patient tissue viability procedures and the practice told us this had significantly reduced appointment times for patients.</p>	

Feedback from Patient Participation Group.

Feedback
<p>We spoke with two members of the Patient Participation Group (PPG) who both spoke positively about the practice. Due to COVID-19, the PPG had not been able to hold regular meetings this year but told us they continued to have regular communication with the practice manager. They told us they felt valued, included and listened to by the practice.</p> <p>The PPG told us that, in response to patient feedback about finding it difficult to obtain medications, the practice staff spent time supporting patients to sign up to the Enhanced Prescription Service (a service that sends prescriptions from GP practices to pharmacies electronically), to make the process more efficient and convenient for patients.</p> <p>The PPG felt the practice had adapted well to the difficulties faced as a result of the COVID-19 pandemic and told us they felt the practice met the needs of the patient population. Some PPG members had recently supported the practice as queue marshals at flu vaccination clinics, helping to ensure patients remained socially distanced.</p>

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: The practice was working within the Primary Care Network (PCN) to improve and increase services to the local population. For example, the PCN had recently employed social prescribers and the practice was involved in setting up a mental health support service for young people with an aim to promote mental health and work in collaboration with the voluntary sector to improve patient outcomes. The practice also told us about their future plans to raise awareness of COVID-19 in local primary schools, to work closer with local pharmacists and to hold educational events with topics chosen by the patient population. The practice held a variety of regular meetings to ensure staff had the opportunity to have team discussions and share suggestions for improvements.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

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

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

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

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

Glossary of terms used in the data.

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