

# Care Quality Commission

## Inspection Evidence Table

### Haigh Hall Medical Centre (1-7807948112)

Inspection date: 23 & 24 November 2022

Date of data download: 21 November 2022

**Overall rating: Good**

**Safe**

**Rating: Requires Improvement**

The provider was rated as requires improvement for the provision of Safe services because:

- Processes were not in place to ensure that patients in receipt of high-risk drugs and other medicines had been monitored or reviewed in line with requirements.
- Processes had not been put in place to ensure that patient safety alerts and updates had been effectively assessed or actioned.
- Clinical tasks had not been actioned.
- Processes for ensuring vaccination of staff working in the practice were not in line with current guidance.

#### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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
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
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<p>The practice had policies and procedures in place to support staff to identify and respond to any safeguarding concerns. The policies clearly outlined the safeguarding leads for the practice, and provided contact details for external agencies for example, local safeguarding teams and social services.</p> <p>Clinical and non-clinical staff we spoke with and received feedback from knew who the safeguarding leads were. Staff had a good understanding of safeguarding processes, and were able to give examples of when safeguarding concerns had been identified and acted upon.</p> <p>We saw evidence of regular multidisciplinary team meetings where patients on the safeguarding register were discussed to ensure appropriate support was 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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>The provider did not have effective processes in place to assess the vaccination and immunisation status of staff. We saw that only some limited checks had been undertaken.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30/06/2022	Yes
There was a fire procedure. Date of fire risk assessment: 18/05/2022	Yes
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had arrangements in place to ensure appropriate risk assessments and checks were carried out. We reviewed a range of risk assessments during our inspection, including:</p> <p>Fire risk assessment Health and safety risk assessment Legionella risk assessment</p> <p>The practice kept a log of all actions identified during the risk assessments with a record of action required and action taken. We saw that some actions were still outstanding for example, actions relating to modifications to the premises, where the provider had contacted the landlord, but these had not yet been resolved.</p> <p>We reviewed records of a fire drill which had been carried out in August 2022. The practice had recorded learning and improvements as a result of the drill. For example, a nominated member of staff to prevent patients re-entering the premises until it was safe to do so.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
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: 03/05/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice had an infection, prevention and control (IPC) policy in place and a IPC dedicated lead.  We saw that the IPC audit undertaken in May 2022 showed an overall compliance score of 94%. The practice had an action plan in place to address minor issues for action.  When we inspected the practice we found that the premises were clean and well maintained.	

## 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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours	Partial
Explanation of any answers and additional evidence:  At the time of our inspection the reception team was not operating at full capacity due to staff leaving the practice or being redeployed to other areas. This had been identified as a high risk on the provider risk register and plans were in place to recruit an additional member of staff to the team.  Staff we spoke with and feedback we received indicated that there were systems in place to manage staff absences and busy periods. However, as the reception team was not at full establishment, this had increased pressure on remaining staff members. The provider was taking steps to increase staffing levels on reception at the time of our inspection.	

## 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. <sup>1</sup>	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
Referrals to specialist services were documented, contained the required information 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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>As part of our clinical searches undertaken on 24 November 2022, we noted that pathology reports received by the practice were generally up to date and had been reviewed by a clinician. However, we saw that some had not been actioned. For example, one patient had a blood test carried out in October and required a repeat test which had not been actioned. One patient had abnormal results indicating a possible iron deficiency that had not been acted upon.</p> <p>During our clinical searches we saw that there were 640 open tasks on the clinical system, some of which dated back to 2020. We reviewed a sample of these and saw that many of these were for information purposes only and had not been closed appropriately following action taken. However, the number of tasks open could increase the risk of important information being overlooked. We discussed this with the practice during our inspection and were informed that this was an area identified by the secretarial team as a quality improvement project, and they were in the process of reviewing tasks and completing these as appropriate.</p> <p>We received an action plan from the provider following our inspection outlining steps they would take to address the issues identified.</p> <p>The practice had a system in place for processing incoming patient correspondence from other services, for example, discharge advice notes from hospital. A member of the administrative team would review the documentation and scan these onto the patient record. If any actions were required these would be escalated to a member of the clinical team. We discussed this with one of the GP partners during our inspection and were informed that random audits of clinical correspondence were carried out to ensure they had been managed appropriately.</p> <p>We reviewed 5 patient records and saw evidence of referrals being actioned in a timely manner, for example we reviewed an urgent cancer referral and saw evidence that the patient had been seen within the 2-week timeframe.</p>	

## Appropriate and safe use of medicines

### The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	1.16	0.91	0.82	Tending towards variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) (NHSBSA)	5.5%	5.4%	8.5%	Tending towards variation (positive)
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 (01/01/2022 to 30/06/2022) (NHSBSA)	4.59	4.70	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	238.7‰	121.2‰	128.0‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.72	0.41	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.4‰	7.2‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

#### Explanation of any answers and additional evidence:

The discussed the prescribing issues identified above with the provider as part of inspection and were advised that:

- The practice has a significantly older patient population, with higher than average neurology and rheumatology patients who have gabapentinoid prescriptions issued and reviewed.
- High number of patients using multicompartiment compliance aids with weekly prescriptions which contribute to the prescribing figures.
- The practice had plans in place to refer patients to a recovery co-ordinator in order to support with medication reduction and stopping plans for specific patients.

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 effective medicines reviews for patients on repeat medicines. <sup>1</sup>	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. <sup>2</sup>	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 and Improvement 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 UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>There was informal clinical supervision and support of non-medical prescribers. However, this had not been developed into a formalised process. When we spoke with staff who were non-medical prescribers, they told us that they felt well supported by the practice, and that they were able to access advice when required.</p>	



Medicines management	Y/N/Partial
<p>The practice was supported by a dedicated Pharmacy Team which operated over all Affinity Care locations. This specialist team covered two main areas of activity:</p> <ul style="list-style-type: none"> <li>• Prescribing management - delivered by practice medicines coordinators, practice medicines technicians, and practice pharmacists. Duties included handling repeat prescription requests, and the identification and organisation of medicines reviews. Processes were in place for necessary oversight of this work.</li> <li>• Clinical Pharmacist services – delivered by clinical pharmacists who undertook reviews of patients with long-term conditions. Patients were booked into reviews by in-house care coordinators who identified patients and who organised monitoring such as blood samples and blood pressure readings prior to booking in the patients for a review with a clinical pharmacist.</li> </ul> <p>This service was led by a chief pharmacist who sat as a member of the Affinity Care Board of Directors.</p> <p>Medicine reviews – We examined 5 recent medication reviews undertaken for patients at the practice. We found in all 5 cases that whilst the record showed that a review had been undertaken, we found that these reviews either:</p> <ul style="list-style-type: none"> <li>• Lacked detail in relation to decisions and outcomes.</li> <li>• Did not check and review that required monitoring had been undertaken.</li> </ul> <p>In response to these findings the provider informed us that patients on high risk or multiple medication would be identified and invited for a structured medication review.</p> <p>High Risk Medicines and Disease-modifying anti-rheumatic drugs (DMARDs) – The provider showed mixed performance in respect of high-risk medicines management. We found that DMARD patient monitoring was in place. However, 7 out of a total of 125 patients in receipt of direct oral anticoagulants (DOACs – used to treat certain blood vessel and heart and lung conditions, such as atrial fibrillation) had not had the required monitoring. In the 5 records we checked in detail, we found that none of these patients had had their creatinine clearance calculated (this test provided information about how well the kidneys were working), and there was no evidence that the prescriber had checked that monitoring was up to date prior to issuing a prescription.</p> <p>In response to these findings the provider informed us that new DOAC patients would be identified for necessary monitoring, and that the patients identified by our searches would be reviewed by the pharmacy team.</p> <p>Medicines usage – our clinical searches indicated that 69 patients identified as having been prescribed gabapentinoids (used to treat epilepsy and also certain types of nerve pain) had potentially not received a review in the previous 12 months. We reviewed 5 records in detail, 1 patient had been reviewed and referred appropriately, however in 4 cases we saw that reviews had not been undertaken at the required frequency. We saw no evidence that advice regarding risks to women of childbearing age taking this medication had been undertaken.</p> <p>In response to these findings we were told by the provider that a review and monitoring programme was in place and that patients at risk had been sent a letter which informed them of risks associated with the medication. We were also told that the provider intended to examine deprescribing such medication, and that patients would be linked to alternative support.</p>	

## 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.	Partial
Number of events recorded in last 12 months:	25
Number of events that required action:	25
Explanation of any answers and additional evidence:	
<p>The provider had renamed significant incident reports as learning events. They felt that this promoted a service improvement and learning ethos across the organisation. Staff we spoke with told us that they were aware of reporting procedures and had confidence that issues raised would be dealt with. They felt incidents were handled within a blame-free culture.</p> <p>Some incidents resulted in organisational wide learning, and we saw evidence how this had changed provider practices. For example, the practice had implemented new procedures in relation to the monitoring of vaccine storage across all locations following an isolated incident at one site. We saw that there were dissemination routes for learning to be shared with staff members such as via meetings. However, some staff reported that they did not receive feedback as a result of learning events.</p> <p>All the staff we spoke with and received feedback from knew how to report an incident and felt comfortable to do so. We reviewed a summary of incidents recorded by the practice and found that these contained details of immediate action taken. However, we saw limited evidence of identified learning or changes to processes to reduce the risk of reoccurrence.</p> <p>In addition, there were no systems in place to share learning from significant events and incidents with the wider practice team.</p>	

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

Event	Specific action taken
Issues with identification of samples from care home patients.	<ul style="list-style-type: none"> <li>- Requested that care home staff record full patient details on sample pots.</li> <li>- Reminded reception staff to check patient details when sample pots are delivered to practice.</li> </ul>
New cancer diagnosis added to wrong patient record.	<ul style="list-style-type: none"> <li>- Reiterated to all staff to check three types of identification when communicating or processing information for patients.</li> <li>- Discussed at multi-disciplinary meeting.</li> </ul>



Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Partial
Staff understood how to deal with alerts.	Partial
<p data-bbox="57 338 810 371">Explanation of any answers and additional evidence:</p> <p data-bbox="57 412 1513 490">The provider was unable to demonstrate that all relevant safety alerts had been responded to. For example:</p> <ul data-bbox="108 530 1513 759" style="list-style-type: none"> <li>• Pregabalin (a medicine used to treat epilepsy, anxiety and some nerve pain) – A safety alert from April 2022 advised that patients of childbearing age prescribed pregabalin should be made aware of the risks of congenital malformations to the unborn baby in pregnancy, and the need to use effective contraception. We reviewed the records of 5 female patients of childbearing age and found no clear documentation in the records that patients had been advised of the specific risks of pregabalin in pregnancy.</li> </ul>	

## Effective

## Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

### 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.	Partial
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 prioritised care for their most clinically vulnerable patients.	Yes

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>Complex care health teams had been established, these teams supported housebound and/or otherwise vulnerable patients such as palliative care patients, those approaching end of life, or patients accommodated in residential care settings. This service was also available to those who were temporarily housebound and required home visits. The service supported the delivery of both acute and planned care and included long-term condition reviews, ongoing monitoring, and wellbeing and health promotion. The service was delivered by a combination of staff who included advanced nurse practitioners, physician associates and GPs, supplemented by GP registrars and Foundation Year 2 doctors. The teams were supported by care coordinators who reviewed patient needs, organised monitoring, and who also contacted new housebound patients and those who had been recently discharged to offer proactive support. In addition, the in-house pharmacy team supported this work.</li></ul>

Of necessity the teams worked and liaised closely with partners who included local voluntary and community sector (VCS) social prescribing providers, community matrons and the local palliative care team.

- Care coordinators who supported the needs of patients with long-term conditions. They worked and liaised with patients regarding their care needs and identified patients when monitoring and reviews were required.
- Each location had a duty doctor available to increase capacity when needed, and to act as a point of support and advice for other staff.

The practice identified older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.

Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

All patients with a learning disability were offered an annual health check. The practice had 53 patients on their learning disability register, and all had received a health check in the previous 12 months.

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.

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.

Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

Our reviews of clinical records showed that patients with long-term conditions had generally been managed appropriately, with recalls and reviews in place. However, our searches of patient records showed some areas of concern:

- Potential missed diagnosis of Chronic Kidney Disease (CKD) stage 3, 4 or 5  
We identified 55 patients with a potential missed diagnosis of Chronic Kidney Disease stage 3, 4 or 5. We reviewed 5 patient records and found that all patients had renal function blood tests within the last 12 months. However, this had not been appropriately coded on the patient record. We received confirmation from the provider following our inspection that a plan was in place to review this. The provider had developed a template with a diagnosis letter to ensure information was appropriately recorded.

- Patients with CKD stage 4 or 5 who have not had a urea and electrolytes (U&E) test in the last 18 months. A U&E test checks for electrolytes in the blood. If levels are too high or too low, this can cause abnormal heart rhythms.

We looked at 1 patient record and found the last blood pressure reading undertaken by the practice was high. However, we saw no evidence that this had been followed up. We discussed this with the provider as part of our inspection and received confirmation that appropriate action had been taken to support this patient.

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. For example, the provider had an in-house respiratory specialist, and other staff had received training to deliver higher levels of care. For example, they operated an advanced level 2 diabetes services for patients from the practice.

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 asthma were offered an asthma management plan.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	75	76	98.7%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	60	98.3%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	60	98.3%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	60	98.3%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	60	61	98.4%	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>

#### Any additional evidence or comments

The practice had systems in place to promote uptake of childhood immunisations. If a child was not taken to an appointment parents or guardians were contacted to check why the appointment was missed and to rebook the child. This work was undertaken by a care coordinator who worked closely with the nursing team. Continued failures to attend were escalated to the safeguarding lead.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	75.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	60.8%	52.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	64.9%	58.5%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	68.4%	62.7%	55.4%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments
<p>The practice told us that they had recognised cervical screening performance required improvement. In response to this the practice had put in place measures to improve uptake. Actions included:</p> <ul style="list-style-type: none"> <li>Members of the practice care coordination team contacted patients to proactively promote uptake, and also rebooked patients into new cervical screening appointments if a previous appointment had been missed. Staff also discussed screening opportunistically if they recognised a patient was overdue their screening.</li> <li>Patients were able to access screening via an extended hours service delivered at the practice.</li> </ul>

## 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.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	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

<p>SABA (short-acting beta agonists) inhalers prescribing audit – to assess possible overprescribing (6 or more inhalers per year). This audit had been undertaken over a number of years and showed levels of overprescribing to have fallen.</p> <p>27/11/2018 – 41 patients  31/03/2019 – 34 patients  31/03/2020 – 33 patients  31/03/2022 – 32 patients</p> <p>This showed an overall fall in prescribing between 2018 to 2022 of 22%. Actions to achieve this result included increasing the issue duration of inhalers on repeat prescription, and increasing patient reviews.</p>
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## 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.	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
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	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>We saw that there was an induction programme for new staff. However, we reviewed two staff files and were unable to see evidence of a completed induction checklist.</p> <p>Staff told us that the practice had supported their training and development. The majority of training records we reviewed showed that staff training was up to date.</p> <p>We were informed by the provider that staff appraisals had been undertaken in the past. However, these had recently lapsed due to changes within the management team and the additional pressures during the COVID-19 pandemic. The provider was in the process of re-establishing the appraisal process.</p>	

There were systems in place for clinical supervision and support of non-medical prescribers. However, this had not been developed into a formalised process. All the staff we spoke with and received feedback from felt well supported by the practice, and that they were able to access advice when required.

## Coordinating care and treatment

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

Indicator	Y/N/Partial
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

## 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 and tackling obesity.	Yes
Explanation of any answers and additional evidence:  Staff had been trained in care navigation and were able to signpost patients to other services and support when this was appropriate.  NHS health checks were available to patients.  We saw that information was available for patients in the waiting area. For example, mental health, alcohol and healthy living advice.	

### Any additional evidence or comments

The provider worked closely with HALE (Health Action Local Engagement – a local community and voluntary sector provider based in Bradford). Practices within the Affinity Care Partnership hosted HALE Community Connectors who delivered social prescribing services for all patients registered with Affinity Care Partnership practices.

In addition, the provider funded a dedicated engagement team at HALE to improve patient engagement and involvement in decision making throughout Affinity Care Services. The engagement team worked with all practices in the Affinity Care Partnership to ensure patients are well-informed regarding self-care, well-being campaigns and focus groups to discuss how the services could best support long-term health conditions.

Data from HALE showed that from July to September 2022 they had supported 7 patients from Haigh Hall Medical Centre.

## 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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Yes
<p>Explanation of any answers and additional evidence</p> <p>As part of our inspection, we reviewed a sample of DNACPR decisions made within the last 12 months. We saw that detailed and comprehensive records had been maintained. These contained information regarding the patients capacity to consent to a DNACPR decision and a record of other services involved in the patients care.</p>	

## 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

Patient feedback	
Source	Feedback
NHS Friends and Family Test	Results for August 2022 showed that from 96 responses: <ul style="list-style-type: none"><li>• 81 patients (84%) would be extremely likely or likely to recommend the practice to others.</li><li>• 12 patients (13%) would be neither likely or unlikely to recommend the practice to others.</li><li>• 3 patients (3%) would be unlikely or extremely unlikely to recommend the practice.</li></ul>
NHS Friend and Family Test	Comments from August 2022 included word such as welcoming, friendly, supportive and helpful.

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	90.1%	80.1%	84.7%	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 (01/01/2022 to 30/04/2022)	84.9%	78.5%	83.5%	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 (01/01/2022 to 30/04/2022)	93.7%	89.8%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	75.7%	65.5%	72.4%	No statistical variation

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

Any additional evidence
<p>The practice had undertaken a number of surveys to better understand their patient population. These included:</p> <ul style="list-style-type: none"> <li>Young people's survey (2021) which sought feedback on the in-house young people's service. Of 20 responses received 18 (90%) felt that the service was either really useful or quite useful. In addition, all 20 respondents would recommend the service to a friend.</li> <li>In 2021 the provider undertook an LGBT+ (lesbian, gay, bisexual, transgender, and people with gender expressions outside traditional norms) survey across all of the practices operated by Affinity Care. Results showed high levels of patient confidence in the practice for issues relating to sexual or gender identity. For example, only 12% of respondents avoided being open and about identifying themselves or took steps to avoid identifying themselves as being a member of the LGBTQ+ community. 71% of respondents said they felt respected when they accessed the surgery.</li> </ul>



## 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

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	93.9%	86.5%	89.9%	No statistical variation

	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.	339 (5%)
How the practice supported carers (including young carers).	Carers had access to flu vaccinations and were signposted to local support services when this was identified.  We saw information to support those acting in the role of carer available in the practice waiting room.
How the practice supported recently bereaved patients.	Condolence packs were sent to recently bereaved patients, this contained a sympathy card and offer of support from the practice.  The practice also signposted patients to bereavement support groups.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
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:  The reception area at Haigh Hall Medical Practice was large enough to ensure that patient seating was located a good distance from the reception desk.  Incoming calls were answered by reception staff in a room located away from the reception desk.  Patients had access to chaperones should these be needed. We saw information displayed throughout the practice to advise patients of this service.	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>All of the clinical rooms were located on the ground floor of the practice to ensure patients requiring wheelchair access were not restricted.</p> <p>The practice had access to a telephone translation service to support patients whose first language was not English.</p> <p>The premises had been updated to ensure a dementia friendly design to support patients (and their carers) when attending the practice for an appointment.</p> <p>The provider had undertaken a survey of patients in respect to access and used this to inform decisions about the delivery of patient care.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am until 6pm
Tuesday	8am until 6pm
Wednesday	8am until 6pm
Thursday	8am until 6pm
Friday	8am until 6pm
<p>In addition, the practice offered an in-house extended access service from 6.30pm until 8pm each weekday. A range of appointments were available between these hours.</p>	

Further information about how the practice is responding to the needs of their population
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 provider had developed a segmented model of care which included two complex health care teams who undertook the management of care for some of the most vulnerable and/or housebound members of the practice population. Activities of these teams included home visits, and visits to residential care facilities, as well as coordinating care with other stakeholders. Teams were supported by dedicated care coordinators who worked closely with patients, families and partner organisations to deliver care appropriate to need.

The provider had developed a number of services to meet the specific needs of members of the local community. These included:

- Women's Health Service – this included general women's health advice, menopause advice including hormone replacement therapy, cervical screening, contraceptive implants and removals, and contraceptive pill reviews and prescribing (undertaken by the Pharmacy Team). The service used a mixture of pre-bookable appointments both telephone and face to face, and e-consultations. Services were delivered by clinicians who had a special interest in women's health issues.
- Young Person's Contact Service – used to support referred young patients aged 11 to 18 (up to 25 for those patients with a learning difficulty). It was delivered using a multi-disciplinary team approach and utilised the services of a specialist nurse, and youth worker, and had the additional support of counselling, drug and alcohol and sexual health workers. The service was offered across Affinity Care practices. It delivered care via face to face clinics and drop-in sessions. Conditions and issues supported included anger management, behavioural issues, anxiety and low self-esteem, as well as physical health. At the time of inspection, the north locality which included Haigh Hall Medical Centre supported 27 young patients. The service was also able to refer young people for additional support to their VCS partner Hale (Health Action Local Engagement). We saw feedback from young people who had used the service who stated how beneficial the support they had received had been.

The practice offered a number of in-house clinics including:

- Diabetes
- Specialist respiratory
- Childhood immunisations

Working with other local partner organisations the provider worked to raise community awareness of diabetes. At three events using this partnership approach they had undertaken 120 health checks and contacted over 200 individuals.

In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

Additional extended service appointments were available at the practice from 6.30pm to 8pm Monday to Friday.

All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. For example, longer appointments were available, and these could be delivered at quieter, less busy periods.

The practice supported 1 patient in a residential care home setting.

The provider was Veteran Friendly accredited. The provider had developed materials and processes to recognise and promote actions to better support military veterans and their families.

The provider had been given the Pride in Practice Award in 2022 in recognition for the work they had undertaken to deliver fully inclusive healthcare services to LGBTQ+ patients. Actions taken by the provider to qualify for the award included training staff and developing supportive policies such as a Trans Equality Policy. The provider had also taken other steps which included improved engagement with service LGBTQ+ patients, and the development of an online repository of resources.

The provider worked closely with established community partnerships in the Bradford area (community partnerships act to ensure that health, care and wellbeing services are focused on the needs of the community). The provider had also developed their own Affinity Care Community Partnership with other stakeholders. In 2021/22 activities had included funding:

- A living well champion – work included promoting the uptake of immunisations, smoking cessation and children's exercise.
- A volunteer coordinator – a role which supported local volunteer run groups and health interventions.
- A dementia worker – used to support wider dementia care including reviews, and the organisation of monthly clinics with an external partner which supported patients and families who had dementia and memory concerns.

Other activities have included funding a garden project, and a project which provided public benches and through this sought to encourage people to take exercise.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes

Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider recognised that capacity and demand was a significant challenge. To meet this they had developed a delivery and appointment model which they felt was flexible and met the needs of the majority of their patient population. This included:</p> <ul style="list-style-type: none"> <li>• Provision of a duty doctor who during operating hours offered additional capacity when required and who was available to deal with specific support requests in relation to patient care.</li> <li>• Urgent and on the day appointments for GPs. This was felt to improve capacity, meet urgent demand and reduced the impact of patients who did not attend for pre-bookable appointments.</li> <li>• Pre-bookable appointments were available with members of the nursing team.</li> <li>• Flexible access via face to face, telephone and remote/e-consultation.</li> <li>• The development of specialist services and clinics such as the complex health care teams, women's health service, and young people's service.</li> </ul> <p>The provider was committed to ensuring services were delivered in a way which meet the needs of the local population and at the time of our inspection had decided to reduce the amount of duty doctor time each day and increase the number of face to face appointments at Haigh Hall Medical Centre.</p>	

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	60.4%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	61.9%	49.7%	56.2%	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 (01/01/2022 to 30/04/2022)	50.1%	50.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	81.1%	69.2%	71.9%	No statistical variation



## 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.	9
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	1
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>The practice had a complaints policy in place and all staff we received feedback from were aware of how to support patients to make a complaint.</p> <p>We found in some cases the complaints process had not always been followed. For example, acknowledgement letters not always sent within timescales. However, this was an area the provider was addressing.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy with lack of appointments for blood tests.	Apology was given to the patient with an explanation that the practice was currently in the process of reviewing the appointment system to increase face to face appointments. Also recruiting a new practice nurse.

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	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:	
The provider had a good understanding of the challenges they faced. For example, they had recognised that recruitment and retention of staff was a particular issue in certain practices across Affinity Care. They had therefore planned a number of actions to tackle this. This included: <ul style="list-style-type: none"><li>• Ongoing staff recruitment.</li><li>• Examining reasons why people had left the organisation and putting in place measures to reduce these. The provider had recognised that some staff had quickly left the organisation due to having unrealistic expectations as to what their role entailed. This included the receipt of abuse and aggression from patients.</li><li>• Developing staff within the organisation to take on other roles.</li></ul>	
However, some of the staff we spoke with and received feedback from indicated that leaders were not always visible following the practice merge into Affinity Care.	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
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

## 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 had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider had a strong education and training culture with some of its locations being accredited training practices hosting GP registrars, Foundation Year 2 doctors, medical students, nursing students, physicians assistant trainees and advanced care practitioner trainees. The provider also supported nursing associates and offered apprenticeships.</p> <p>At the time of our inspection the provider did not have arrangements in place for an independent Freedom to Speak Up Guardian. We discussed this during our inspection and were advised that this would be rectified.</p> <p>Staff told us that they felt confident to raise issues with the management team.</p>	

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

Source	Feedback
Staff Questionnaires	Many of the questionnaires we received made reference to leaders and managers not being visible as they were not based at the practice. However, all staff reported being able to contact them by telephone or email.
Staff Questionnaires	Some of the staff we spoke with and received feedback from commented on how the role had changed since merging with Affinity Care and they now had less variety during the working day.
Staff Questionnaires	All staff reported that they felt supported, were able to raise concerns and that these would be listened to.

## 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider had developed a governance structure to lead the organisation. Affinity Care as a provider operated its constituent practices as a Primary Care Network (a group of practices who work together to deliver enhanced services to meet the needs of their population). The governance was built on a defined structure:</p> <ul style="list-style-type: none"> <li>Affinity Care Partnership Board (the governing body) – whose role was to define strategy, shape culture and ensure accountability across the organisation. It had oversight of, and held the Board of Directors accountable for, delivery of key areas of work.</li> <li>Board of Directors – these included amongst others a clinical director, a medical director, a director of performance, a chief operating officer, and 3 locality directors (for the 3 geographical localities which comprised the Affinity Care operational area). Their role as a Board was to implement delivery and report on performance. They also sought assurance from other designated sub-groups for key work areas such as finance and access.</li> <li>In addition to working as individual practices within 1 of 3 localities, individual practices were supported by some specialist teams which worked across the Affinity Care area. As examples these included a central human resources function, a data and secretarial team, a dedicated nursing and care coordination team and a pharmacy team.</li> </ul>	

## 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 quality improvement programme in place.	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> <ul style="list-style-type: none"> <li>We saw that the provider had structures and processes in place to manage, report and review performance. For example, from a sample of Board minutes we saw that financial planning, performance, locality updates and issues in relation to safeguarding and access had been discussed.</li> <li>The provider had a risk register in place and used this to manage identified concerns and risks to the organisation.</li> </ul>	

- When issues and concerns had been recognised we saw that the provider had developed action plans to deal with these. For example, we saw measures had been put in place to improve complaints management processes.

## 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 monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence:	
We saw that the provider had a dedicated director of performance in post and had established governance and performance oversight processes.	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
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
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
Staff are supported to work remotely where applicable.	Yes

## Engagement with patients, the public, staff and external partners

**The practice involved 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>The provider had a background of patient and community engagement. Activities have included:</p> <ul style="list-style-type: none"> <li>Engaging with and developing services for the LGBTQ+ community.</li> <li>Developing a social media presence for sharing information and receiving key messages.</li> <li>Establishing and working with the Affinity Care Patient Council. The council acted as a voice for Affinity Care's registered patients, and also acted as a central reference group for the constituent Affinity Care Patient Participation Groups (PPGs). The Patient Council comprised of a chairperson, and representatives from Affinity Care PPGs, an Affinity Care clinician, the Director of Operations for Affinity Care, and 2 members of a local voluntary and community sector organisation (HALE).</li> </ul>	

Feedback from Patient Participation Group.

Feedback
Feedback from the Patient Council chairperson indicated that members of PPGs across Affinity Care felt confident in raising concerns with the provider, and had started to build rapport with the developing Affinity Care structures.

## Continuous improvement and innovation

**There was evidence of 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 had a programme of clinical audits and other quality improvement activity.	

We saw that the practice reviewed complaints and significant incidents/learning events, and used these to make improvements to services. However, we saw limited evidence of discussions and shared learning with the wider practice team.

The provider had a strong commitment to education and training. This included:

- Operating as a GP training practice at some locations within the Affinity Care partnerships, and supporting other associated health trainees within the workplace.
- Supporting the development of staff into new career roles, or by supporting them to gain further professional qualifications.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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 SICBL 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 SICBL 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.
- UKHSA:** UK Health and Security Agency.
- 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.
- %** = per thousand.