

Care Quality Commission

Inspection Evidence Table

Maple Access Surgery (1-585078956)

Inspection date: 19th – 26th May 2021

Date of data download: 12 May 2021

Overall rating: **Good**

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

The practice was rated overall Inadequate following a comprehensive inspection in May 2019 and placed in special measures. At the follow up comprehensive inspection in December 2019 the practice was rated Requires Improvement overall. Although some improvements had been made, there was insufficient improvement for working age people and an Inadequate rating remained for this population group. The service therefore remained in special measures.

At this inspection, we have found the practice had made improvements in all areas of previous non-compliance. We have rated the practice as Good overall and Good in all population groups.

Safe **Rating:** **Good**

At the previous inspection the practice had been rated as Good for Safe and was rated Good at this inspection.

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 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

Safeguarding	Y/N/Partial
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> <ul style="list-style-type: none"> • Policies were kept under regular review and were last reviewed in March 2021. • Safeguarding meetings were held monthly at the practice and quarterly at the organisational level. Learning points were shared with the team during safeguarding meetings. We viewed meeting minutes for April 2021 to confirm this. • Information was shared appropriately with partner agencies including adult social care, Northampton police, Multi-agency Safeguarding Hub (MASH) team, health visitors, school visitors, Substance to Solution (S2S) and Northampton Borough Council outreach team. • Northamptonshire Healthcare Foundation Trust (NHFT) district nurses had access to the practice system and were able to raise screen alerts/messages directly with clinical staff. • Special patients notes (SPN) were emailed directly to the NHS 111 service. • All staff had completed relevant levels of safeguarding training. Records confirmed training had been completed in June 2021. • The practice confirmed they had a higher than average number of vulnerable patients and told us they worked hard to ensure safeguarding processes were in place. 	

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> <ul style="list-style-type: none"> • The required checks and documents were in place for all staff working at the practice including locums and agency staff. • Staff were responsible for maintaining their own registrations and revalidations. The practice manager had a system to monitor these to ensure registrations and revalidations were completed as required. • We saw that the practice used a consistent format for all staff files, with dedicated sections for specific documentation. • We reviewed two staff files on-site and saw that all required documentation was present. This included references, pre-recruitment checklists, photographic identification and proof of address, disclosure and barring service (DBS) checks, risk management forms (where applicable), vaccination records, and training logs. 	

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: 16 April 2021	Yes
There was a record of equipment calibration. Date of last calibration: 16 April 2021	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
A fire risk assessment had been completed. Date of completion: 18 March 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There were areas identified for improvement in the fire risk assessment (completed March 2021) which included installation of security devices linked to the fire alarm system where doors needed to be kept open. The devices would release upon actuation of the alarm and close the doors. This work was in progress and due for completion next month. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 01 March 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01 March 2021	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All risks had been assessed and action plans were in place to manage those risks. For example, continued education and training for staff was provided so that the safety and security of everyone using the premises was assured. 	

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: January 2021 with next audit scheduled for July 2021.	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> An external professional cleaning company was employed. The practice had confirmed that they followed the latest infection, prevention and control (IPC) national guidance, which included specific cleaning of areas with possible exposure to suspected Covid-19. The practice worked in conjunction with Northamptonshire clinical commissioning group (CCG), the Health Protection Agency and Public Health England in managing infection control. Clinical and non- clinical staff completed IPC training annually. Hand hygiene audits had been completed in June 2020 and repeated in December 2020. These showed that hand washing hygiene had significantly improved across both audits. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us they were able to recognise any changes in demeanour or appearance of patients they knew and looked for signs that indicated patients were unwell and needed a prompt response. In those instances, staff told us they would share any concerns, however slight, with the duty doctor. During the pandemic the lack of face to face contact had made observation more difficult to maintain especially with older patients or patients with complex needs. To address this the practice helped to establish a community network which provided an alternative way to support, maintain contact and minimise risks to patients. 	

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.	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.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the previous inspection we found that not all patient notes had been summarised. At this inspection evidence confirmed all records were up to date. A member of staff had been appointed with responsibility for summarising patient notes. 	

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) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.68	0.84	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2020 to 31/12/2020) (NHSBSA)	7.8%	8.6%	9.5%	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 (01/07/2020 to 31/12/2020) (NHSBSA)	4.87	5.16	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	287.7‰	129.8‰	127.1‰	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	3.15	0.69	0.67	Significant Variation (negative)

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

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
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.	Yes
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.	Yes
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.	Yes
Explanation of any answers and additional evidence:	

- The practice regularly reviewed its prescribing data in conjunction with the clinical commissioning group (CCG) prescribing team and pharmacists within the practice.
- The practice used clinical audit, sharing, learning and reflection at clinical meetings as an integral part of the management of medicines. A range of audits were used to monitor the appropriate management of medicines. For example, a trimethoprim antibiotic audit second cycle completed in April 2021 found that of 11 prescriptions issued, three were deemed inappropriate. This was an improvement on the six found to be inappropriate at the previous audit. This audit remained ongoing, with monthly searches carried out to support this process. Learning from the findings was discussed and minuted in clinical meetings.
- Monitoring of patients prescribed high risk medicines was undertaken every two weeks to highlight where monitoring was overdue. Reminder and recall letters were sent to patients and scanned into their notes. The flow chart for this system included an escalation process which was applied according to the number of days monitoring was overdue.

As part of this inspection we carried out searches and reviewed patient records to check national guidance was being followed for high risk medicines.

- 399 patients were prescribed ACE inhibitors (heart medicines). Monitoring had not been completed for 82 of those patients. Records showed that reminder letters had been sent for follow up appointments or that blood monitoring by secondary care had been carried out for these patients. Following the inspection, the practice provided us with evidence that showed hospital blood test results had been added to patient records. The practice confirmed that part of the delay was due to the COVID-19 pandemic.
- Seven patients had been prescribed a mood stabilising medicine and alerts had been applied to all patient records to ensure monitoring was maintained. We saw that routine checks had been completed for three patients and evidence showed that follow up contact had been attempted for the remaining four patients on a number of occasions, with dates recorded.
- 16 patients were prescribed methotrexate (medicine for arthritis). The records showed that two patients were monitored by secondary care.
- Four patients were prescribed valproate and records confirmed that all patients had been informed of the risks where applicable.

Clinical staff and evidence confirmed that controlled drugs were managed safely and in line with national guidance.

- Staff told us that they kept minimum stocks of controlled drugs on site and these were limited for patients with complex needs.
- During the on-site visit we saw that medicines were stored appropriately and securely, including those requiring refrigeration. Emergency medicines were stored suitably.
- The practice had appropriate systems for monitoring and recording medicine stock levels and checking equipment, including using dedicated checklists. We saw that these were up to date.
- We viewed copies of Patient Group Directions (PGDs) to ensure staff had the appropriate authorisations to administer medicines. Those we saw were signed and in date.

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:	22
Number of events that required action:	22
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff completed incident forms when incidents occurred and notified their line manager. All incidents were discussed in weekly multidisciplinary team meetings to determine what had happened, how and why it happened and what steps were needed to deal with any preventable factors. An action plan was implemented with arrangements for follow up and review, to include a patient response and an apology. Set agendas for team meetings ensured that a clear audit trail was available for all incidents and events. All events were acted upon and reviewed to ensure that learning was captured, and that changes were implemented and monitored regularly. 	

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

Event	Specific action taken
<ul style="list-style-type: none"> Photos of a child's health problem emailed to practice without name or date of birth of the child. Information was added to the mother's record and consultations took place on the mother's record rather than the child's. 	<ul style="list-style-type: none"> Clinicians to ensure they are reminding patients to include identifiers (name, date of birth) in subject line and body of email. Checks to be made when uploading patient information to ensure that the patient had been asked to send in photos.
<ul style="list-style-type: none"> Flu vaccine delivery left in room, not refrigerated. 	<ul style="list-style-type: none"> Clinical and non-clinical deliveries flow chart and protocol were created. Staff were sent a reminder about the location of the protocol on the shared drive. The practice manager carried out regular checks to make sure that all staff followed the protocol.
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
Explanation of any answers and additional evidence:	

- The practice had an electronic system for MHRA alerts. All alerts received into the practice were reviewed routinely at 10am and 3pm daily and there was a clear process for all staff to follow to ensure that all appropriate action was taken. All alerts were discussed and minuted at weekly clinical meetings and provided an audit trail of all action taken.

Effective

Rating:

Good

At the last inspection the practice was rated as Requires Improvement for providing effective services in patient care and treatment, and staff training. Improvement was also needed across all population groups as exception reporting (now referred to as personalised care adjustment (PCA)) were higher than national averages while cervical screening and child immunisation uptakes were below national averages.

At this inspection we have rated the practice as Good for providing effective services because although we found the uptake of childhood immunisations and cervical screening rates were still below the national average, we were assured that the practice had taken action to improve these areas.

Improvements in PCA reporting had been made, although some areas remained higher than local and national averages. The practice assured us that they kept the data under review but recognised most of the PCA was associated with the complexities of their patient population demographics.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Long-term chronic disease clinics were arranged according to patient birth months so that annual reviews of their conditions and medicines limited the number of visits and contact the patient needed. 	

- The practice worked with community teams to provide appropriate care to their patients, particularly vulnerable and palliative care patients.
- From patient records we viewed as part of the inspection, it was evident that all relevant guidance was being followed.
- The practice kept patient registers including those for patients needing palliative care, carers and vulnerable patients. This enabled regular reviews to be carried out. The practice had a large cohort of vulnerable patients and managed the Northamptonshire Violent Patients' Scheme. Evidence showed how patient needs and wishes were considered on care planning in areas such as dementia and mental health.

Increased review and monitoring of patients care plans had seen a reduction in some areas of personalised care adjustment (PCA), although the practice told us their patient demography was a contributory factor in higher rates of adjustments.

- The practice had provided a breakdown of their population groups which showed a high percentage of patients who returned to their home country for screening. For example, Eastern European patients registered with the practice was 47.86%. Patients were encouraged to provide confirmation of home country screening but responses from patients continued to be low.
- An analysis of patients who were hard to reach was provided to us by the practice. For example, 48% of those patients registered with them had no telephone or permanent address.

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Older patients discharged from hospital were followed up by the practice and ensured that care plans and prescriptions were updated to reflect any extra or changed needs.
- Structured annual medicines reviews were carried out 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.
- Vaccinations were routinely provided for housebound patients and those living in a local care home.

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, usually through face to face reviews.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Other community teams included district nurses, palliative nurses, health visitors, midwives, substance to solution addiction rehabilitation service and mental health teams.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Patients were reviewed following any hospital admission due to a long-term condition, such as asthma flare-up.

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)	86.7%	77.7%	76.6%	Tending towards variation (positive)
PCA* rate (number of PCAs).	42.9% (175)	13.0%	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)	91.7%	88.7%	89.4%	No statistical variation
PCA rate (number of PCAs).	54.5% (72)	14.8%	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) (QOF)	91.4%	81.5%	82.0%	Tending towards variation (positive)
PCA rate (number of PCAs).	32.5% (39)	5.8%	5.2%	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) (QOF)	73.4%	69.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	39.5% (135)	20.1%	15.3%	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) (QOF)	76.0%	74.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	46.3% (335)	8.4%	7.1%	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>	96.4%	94.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	6.7% (2)	3.9%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	70.5%	76.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	43.6% (149)	12.5%	10.4%	N/A

Any additional evidence or comments

The practice acknowledged that PCA rates were above local and national averages. Reasons for this included:

- Limited understanding of English, misinformed cultural health beliefs, lack of awareness and education relating to the health system in the UK were potential challenges faced by the diversity of the population served by the practice.
- Regular annual reviews and preventative care was not a concept that many patients, predominantly those born outside the UK were familiar with.
- Additional patients in Northamptonshire were directed to Maple Access Surgery from local services such as the Emergency Department, Outreach Mental Health, crisis mental health, homeless services both state and charities, East Midlands Ambulance service, GP practices in the local area who were unable to manage the patient needs, Substance to Solution agency, the Probation service and the local police.
- The practice's patient population was very transient; with have many young adults who arrived for periods of work and study and then moved out of the local area. Patients originally from outside the UK stayed for prolonged periods outside the UK without contact with the practice and spent limited time in Northampton.
- Vulnerable patients including patients with no fixed abode who were homeless would also move in and out of the area. Regular reviews or monitoring were difficult due to lack of patient engagement. The practice attempted to overcome this by completing opportunistic reviews when a patient presented with an acute problem. The flexibility of their appointment system also encouraged patients to book for future reviews.
- Patients within the above groups tended to seek medical support and input when an acute medical or social need arose. The practice told us that treatment was not refused, or patients removed from their patient list due to the lack of engagement, or for not having all the correct documents at registration. This was confirmed by staff we spoke with.
- The practice confirmed that there were higher numbers of patients from their ethnically diverse and socially deprived cohort on their patient list who smoked either tobacco or other substances, notably cannabis and crack cocaine. These patients did not engage routinely for care reviews of their chronic conditions. Ongoing support and attempts were made by the practice to encourage patient participation in their care reviews.

Action taken by the practice included:

- Providing education to their patients to increase awareness of the services attempting to address cultural health beliefs, misinformation, and the benefits and value of regular reviews of their care and treatment. Information was available in leaflets, on their website, through community engagement as well as opportunistic engagement with individuals.
- Invitation letters for care reviews had been translated into other languages.
- A member of staff had been appointed with expert QoF knowledge and worked with the practice to improve their QoF results. The practice also carried out QoF work opportunistically when patients presented, due to the complexity of their patient cohort and needs. This approach also helped to reduce PCA rates.
- The practice's recall system had been developed, improved and implemented to encourage increased uptake. This included the use of a tracker to invite patients in their month of birth when medicine reviews were completed.

Evidence provided included:

- Reviews of patients with long-term conditions had continued to be carried out according to their birth month. For example, 35 care reviews for patients with asthma had been completed by June 2021. The practice had identified 62 patients with COPD had not attended for annual review in April and May 2021. The practice's efforts to contact these patients was ongoing.
- The practice had purchased 15 blood pressure monitors to loan to patients for recording their blood pressure readings for routine monitoring or when concerns were raised about their blood pressure.
- Unverified data provided by the practice showed that 45.7% of patients achieved monitoring blood pressure readings to June 2021.
- A self-service blood pressure monitoring cabin had been planned for the reception area of the surgery where patients would be able to get their blood pressure monitored without needing to attend for an appointment. Due to COVID-19 restrictions they were not able to go ahead with the project. It was anticipated this would be established as soon as COVID-19 restrictions were lifted.
- Follow up telephone call invitations had been more productive than letters to encourage patients to attend for medicine reviews. The practice had seen an increase in attendance which would see a reduction of their PCA rate. Reviews and monitoring of prescribed medicines continued to be carried out where patients had not attended.

Families, children and young people

Population group rating: Good

Findings

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had not met the minimum 90% for childhood immunisation uptake indicators or the WHO based national target of 95% (the recommended standard for achieving herd immunity). The practice was aware that their performance was less than the WHO target. Their patient population was more deprived than the national average and this accounted for some of the poor uptake. The practice acknowledged that continued efforts were needed to improve uptake and drive improvements in this area.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- Arrangements were in place to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	169	205	82.4%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	152	192	79.2%	Below 80% uptake
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) (01/04/2019 to 31/03/2020) (NHS England)	154	192	80.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	156	192	81.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	97	150	64.7%	Below 80% uptake

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

At the last inspection we saw:

- The practice was aware that their performance was less than the WHO target. Their patient population was more deprived than the national average and this accounted for some of the poor uptake. However, they acknowledged that there was still work to be done to improve uptake and drive improvements in this area.

During this inspection we found:

- Reports were regularly produced so that children with overdue immunisations could be contacted in a variety of ways, including follow up contact by nurses at the practice.
- The practice was aware of the challenges of their population and discussed immunisations opportunistically with parents.
- The patient population included a high number of patients from different cultural backgrounds. Cultural factors impacted on patient health beliefs which affected immunisation uptake. The

practice was actively communicating with local community groups to educate and encourage patients to take their children for vaccinations.

- Flexible appointment times were offered to parents.
- A range of information was available for patients. Educational materials and posters were displayed in the surgery and information was available on the practice website.

The practice told us:

- Their patient population was very transient; with many young families who arrived for a short period of time, then moved out of the local area, such as travelling families. Patients originally from outside the UK stayed for prolonged periods outside the UK without contact with the practice, and spent less time in Northampton which meant the immunisation schedule was more complex than the traditional GP practice which data was compared with.
- Evidence was provided to show that immunisation had been completed in the period January to June 2021 for all overdue children. For example, 97 children were due to be immunised in January 2021 and all had received their vaccinations by June 2021.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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 medicines 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: 31/12/2020) <small>(Public Health England)</small>	40.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	45.3%	74.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) <small>(PHE)</small>	37%	N/A	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	100.0%	94.4%	92.7%	N/A

occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	66.7%	52.9%	54.2%	No statistical variation

Any additional evidence or comments

During the last inspection we found:

- The practice uptake for cervical screening was significantly below target. The practice confirmed that it was challenging getting patients to attend for this screening.

During this inspection we saw that:

- The uptake for cervical screening was still below the target. During the pandemic cervical screening was paused from 25 March to 28 May 2020. The national recall for screening was halted from 8 April to June 2020.
- Once screening was reinstated all those patients with an outstanding screening had been recalled by the practice.
- The practice had worked to improve cervical screening uptake by sending out personal reminders following failed appointments. They told us it was difficult to obtain information from over half of their patients who were of East European origin, as they had annual screening in their home country.
- The practice had liaised with local groups and religious leaders to improve attendance for all the national screening levels.
- Opportunistic screening was used by the practice and they had flexible appointments available to help with these.
- Patients who did not attend for their screening appointments were contacted by a practice nurse by telephone. Patients who defaulted their initial screening invitation were also contacted by the administration team.
- The practice had displayed information in the surgery and on their website about screening to raise awareness to increase uptake.

Audits had been completed to understand why patients had not completed their screening or attended appointments. The practice looked to understand and change their approach where necessary, to encourage further patient participation. For example:

- A bowel screening audit was carried out in February 2021. Of the 265 patients eligible, 87 had agreed to participate in the survey. The findings showed that although some patients were unsure about having received test kits (24%), 68% of patients had received but not completed. Reasons for this were given as lack of interest, not necessary, fear and had completed in own country. Thirteen patients stated they would complete the test if they were offered again. The learning from the practice included recognition of language barriers, gaps in education and understanding of the purpose of the tests.
- A breast screening audit was carried out in March 2021. Of the 276 eligible patients, 171 agreed to participate in the survey. The findings showed that anxiety, misinformation and out of area (home countries) were the main reasons for lack of uptake. Learning for the practice included reluctance through cultural factors, and that contact by telephone or text was more effective than letters. The practice recognised that a system was also needed to identify when patients with limited contact details were no longer in the area.

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 considered 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.
- Same day and longer appointments were offered when required.
- There was a system to follow up patients who failed to attend for administration of long-term medicines.
- 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 awareness training within 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>	90.8%	87.5%	85.4%	No statistical variation
PCA rate (number of PCAs).	63.3% (112)	24.0%	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>	100.0%	82.0%	81.4%	Significant Variation (positive)

PCA rate (number of PCAs).	10.5% (6)	11.6%	8.0%	N/A
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Any additional evidence or comments
<ul style="list-style-type: none"> The practice had a dedicated mental health team consisting of two mental health nurse practitioners, GPs with mental health interests and a consultant psychiatrist. On-the-day crisis mental health team appointments were available if needed as well as routine mental health follow ups. The practice used various resources to identify patients at high risk. For example, staff including receptionists were trained to recognise unusual signs and symptoms in patients, over 75 health checks, which included a memory assessment, NHS health checks, letters and discharge summaries from secondary care, communications from safeguarding services, notifications from police, 111 reports, ambulance reports, calls from third parties, families, and next of kin. Local support groups included Crisis Café, Bridge, Mental health Hub Northampton and improving access to psychological therapies (IAPT). All staff had completed dementia training. Registers of all patient groups enabled regular reviews to be carried out. The practice had a large cohort of vulnerable patients and managed and ran the Northamptonshire Violent Patients' Scheme. Evidence was seen within the records on searches of how patient needs and wishes were considered on care planning in areas such as dementia and mental health.

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)	556.1	Not Available	533.9
Overall QOF score (as a percentage of maximum)	99.5%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	24.5%	Not Available	5.9%

	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

- The practice had an audit schedule. This schedule included regular reviews of cervical screening and a two-cycle prescribing of trimethoprim audit, which had shown reduced prescribing in keeping with guidance.
- The practice regularly reviewed its prescribing data in conjunction with the clinical commissioning group (CCG) prescribing team and pharmacists within the practice.
- Ongoing quality improvement projects were being undertaken and included breast screening, bowel screening and palliative care.
- Data quality was monitored via audits, QoF and trackers. All deaths, palliative care, cancer diagnosis, MHRA alerts and QoF work for example, was kept under review.

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.	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> <ul style="list-style-type: none"> • A review of prescribing was carried out every three months, including a sample of consultations. • All clinicians in the practice had a regular, three monthly peer reviews by their colleagues, which included of a sample of consultations. <p>At the last inspection we found that:</p> <ul style="list-style-type: none"> • There was no system to ensure oversight of staff training. • The practice was unable to evidence that basic life support (BLS) training had been completed. <p>At this inspection we found:</p> <ul style="list-style-type: none"> • There was a system overseen by the practice manager, to record all training scheduled and completed for all staff. • Evidence confirmed that all staff had completed all training that had been identified as required by the practice, including safeguarding and BLS. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice worked in a collaborative way with many teams in the community to provide appropriate care for their patients, particularly vulnerable and palliative care patients. Community teams included district nurses, palliative nurses, health visitors, midwives, substance to solution addiction rehabilitation service, and mental health teamsRegular case review multi-disciplinary (MDT) meetings were held. Minutes were seen to confirm this.Complex patients and palliative care patients were discussed, and care reviewed in weekly clinical meetings.	

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: <ul style="list-style-type: none">Detailed information for patients was displayed in the practice waiting areas, including those relating to the patient participation group (PPG).Educational materials were made available through links on the practice website.There was information available for staff on staff notice boards, including guidance on 'good practice culture' and information relating to support and wellbeing.Patients identified as smokers were sent smoking cessation advice.	

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 decide.	Yes
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice obtained consent to care and treatment in line with legislation and guidance. Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw examples of discussions with patients and families, and application of best interest decision making in patients with no capacity to consent to care and treatment. The practice had a highly vulnerable patient population with serious mental health concerns which required reviews of individuals' mental capacity. 	

Caring

Rating:

Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff described how they supported patients to access services. For example, they helped patients without mobile telephones, homeless patients and members of the travelling community to access appointments even where they were not registered with the practice. As part of our on-site visit we saw that staff treated patients with patience and respect. Practice staff demonstrated a supportive and caring approach to COVID-19 risk management, for example explaining risk management processes clearly and sensitively. 	

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)	82.4%	87.3%	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)	77.0%	85.7%	87.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	89.8%	94.9%	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)	72.5%	80.4%	81.8%	No statistical variation

Any additional evidence or comments

- The practice provided evidence of steps they had taken for continuous improvements in patient outcomes. For example, through analysis of patient surveys and feedback.

Question

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

Any additional evidence

- The practice sought patient feedback through friends and family.
- Patients were able to leave complaints and feedback via their website.
- The practice carried out regular internal patient surveys. A patient survey was carried out in April 2021 with questions in line with the national GP survey. For example, in relation to access 80 out of 98 patients surveyed were extremely satisfied or satisfied with their ability to get an appointment with the practice.
- The practice continued to review results from the national GP patient survey and continued to obtain feedback from patients who attended this service, however this had been limited due to COVID-19.

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: <ul style="list-style-type: none"> The practice had a high number of patients for whom English was not their first language. Processes and resources were in place to ensure these patients were able to communicate effectively and that information was provided to them in a way they could understand. This included access to information on their website, and information leaflets in alternative languages. 	

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)	83.4%	92.1%	93.0%	Variation (negative)

	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had communicated with community leaders to engage with communities and establish links and encourage involvement in the patient participation group (PPG). 	

Carers	Narrative
Percentage and number of carers identified.	134 carers which equates to 1.05% of the practice population.
How the practice supported carers (including young carers).	

	Patients were signposted to local services for support by the Carers Champion who worked at the practice. There was information in the waiting area of support which was available to patients.
How the practice supported recently bereaved patients.	Patients who had been bereaved were identified by the practice bereavement lead. They contacted bereaved patients/families and offered personalised support. This involved offering condolences on behalf of the practice, signposting, information on bereavement support and prioritisation of appointments.

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: <ul style="list-style-type: none"> Staff told us that private rooms were made available should these be required. During the on-site visit we observed that conversations held in consultation and treatment rooms and at the reception desk could not be overheard. 	

Responsive

Rating: Good

At the last inspection the practice was rated as Requires Improvement for responsive services in relation to the management of complaints. At this inspection, we found improvements had been made in the management of complaints, so the practice has been rated Good for providing responsive services.

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> <ul style="list-style-type: none"> • Staff had a system to support patients who arrived at the practice without appointments or warning, and for managing the Violent Patients Scheme. • Patients were encouraged to see the same GP or health care professional to ensure continuity of care for their complex health concerns. • The practice managed the care of homeless people in Northampton, who lived in two local hotels during the pandemic. • The practice had a lift on-site which was functioning and was regularly maintained. • A hearing loop and a language line for interpreters was available within the practice. 	

Practice Opening Times		
Day	Time	
Opening times:		
Monday	8am-6.30pm	
Tuesday	8am-6.30pm	
Wednesday	8am-8pm	
Thursday	8am-6.30pm	
Friday	8am-6.30pm	
Appointments available:		
Monday	8am -12.30pm	1.30pm-6.30pm
Tuesday	8am -12.30pm	1.30pm-6.30pm
Wednesday	8am -12.30pm	1.30pm-8pm
Thursday	8am -12.30pm	1.30pm-6.30pm
Friday	8am -12.30pm	1.30pm-6.30pm
Extended Hours	Extended hours nurse appointments were available from 6.30pm -9.30pm Monday to Friday, and over the weekend	
Virtual GP appointments	Virtual GP appointments through e-consult were available throughout the week with 24hour access.	

Older people

Population group rating: Good

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

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 teams to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching their end of life was coordinated with other services.
- Improvements made at the previous inspection in how the practice responded to patients with long-term conditions had continued to impact positively on the quality of their care. This was demonstrated in the data we reviewed.

Families, children and young people

Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open till 8pm on a Wednesday. Children had to access to these appointments so that they did not need to miss school.

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.
- The practice was open until 8pm on a Wednesday.
- Online services were available including online appointment booking, repeat medication requests and a full range of health promotion information.

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. They adjusted the delivery of its services to meet the needs of patients.
- People in vulnerable circumstances were easily able to register with the practice including those with no permanent address.
- Effective care coordination was provided to enable patients living in vulnerable circumstances to access appropriate services.
- The practice saw a higher than average number of people in vulnerable circumstances including patients who had been removed from other practice lists and some who were part of the Violent Patient Scheme.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- There was a specialist mental health team at the practice which offered on the day crisis appointments.
- 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.

Access to the service

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

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
There were systems in place to support patients who face communication barriers to access treatment.	Yes
Patients with urgent needs had their care prioritised.	Yes
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All patients, including children, were offered a same day appointment, and this continued throughout the pandemic. • The practice had a significant cohort of vulnerable patients due to very complex social issues, sex workers, vulnerable migrants, homelessness, mental ill health, poverty, illiteracy, and 	

substance misusers. The practice told us that despite advice and encouragement, many were unable to access healthcare remotely or digitally, so patients arrived at the surgery and an appointment was arranged.

- The practice had measures in place to help patients with distrust of systems and organisations. These included informal uniform at reception, a patient care manager, and a flexible appointment system.

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)	77.3%	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)	71.4%	63.4%	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)	59.6%	60.5%	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)	74.6%	72.2%	72.7%	No statistical variation

Source	Feedback
NHS Choices	Positive feedback from six patients regarding receipt of their Covid-19 vaccine. Staff were praised for being friendly, helpful, thorough and efficient.

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.	31
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
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
Explanation of any answers and additional evidence: At the last inspection we found that: <ul style="list-style-type: none"> The practice was unable to demonstrate a working system for managing and responding to complaints. At this inspection we found: <ul style="list-style-type: none"> Detailed records were maintained for all complaints and comments received including verbal and formal written complaints. Complaints were discussed and learning shared with the team where appropriate. A copy of the practice complaints procedure was displayed on the notice board in the reception area and the procedure was explained on the practice website. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient had requested urgent referral to gastroenterology but found that the practice had made a routine referral.	Learning: clinician to be clear to the patient whether they were requesting urgent or routine referrals and explain the reasons for this. Outcome: Partially upheld - letter written to expedite referral request.

Well-led

Rating: Good

At the last inspection the practice was rated Requires Improvement for providing Well-led services due to a lack of oversight in managing staff training, complaints and the authorisation of Patient Group Directions (PGDs). At this inspection we found that improvements had been made and leaders were able to demonstrate effective management in all areas. The practice has been rated as Good for providing Well-led services.

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:	

- Staff told us that an open-door policy operated at the practice and they felt they could approach anyone in the team at any time for support should they need to.
- We were told that staff welfare was a priority and that care and support for everyone in the team was always available.
- We found that leaders had the skills, knowledge and experience to manage the service.

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: <ul style="list-style-type: none"> • The practice had a clear vision to deliver high quality patient care whilst looking after the practice team. 	

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:	

At the last inspection we found that:

- The practice had failed to fully respond to complaints from patients and was unable to evidence that people received an apology when things went wrong.

At this inspection we found that:

- A system for managing complaints from receipt to conclusion had been established with guidance for all staff to follow. Evidence showed that where appropriate, apologies and information about actions taken had been given.
- Staff told us they were confident to raise concerns if needed and they knew that appropriate actions would be taken.
- Staff described an open culture, they felt supported and respected.
- Members of the team had been with the practice for many years and had been promoted through various roles and training during their employment.
- There was a culture of openness and learning and development within the practice.

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

Source	Feedback
Staff	Staff we spoke with were clear about their role and responsibilities at the practice. Staff said the practice team were open, friendly and listened to them.
Meetings	Meeting minutes showed a range of meetings held which included business meetings and strategy meetings.

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:	
<p>At the last inspection we found that:</p> <ul style="list-style-type: none"> • Although some of the governance systems had improved there remained a lack of oversight in some areas of the practice, such as staff training, complaints and the Patient Group Directions (PGDs). <p>At this inspection we found that:</p> <ul style="list-style-type: none"> • Evidence that the management and implementation of staff training and complaints had improved and a system with a structured process of reviews was in place. • All PGDs we reviewed were up to date, dated and signed appropriately. A review programme was in place to make sure these were regularly monitored. • Regular team meetings were held across all departments. • Clinical meetings were carried out weekly and minutes were shared with staff. Previous minutes were discussed to ensure all actions had been completed. 	

- There was clear oversight of performance with different partners leading on different areas within the partnership.

Managing risks, issues and performance

There were 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
Explanation of any answers and additional evidence:	
<p>At the last inspection we found that:</p> <ul style="list-style-type: none"> • Further management oversight was needed across the practice to ensure risks were being identified effectively on an on-going basis. • Summarising of patient notes and the lack of evidence in relation to complaints indicated that on-going work was needed. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> • Systems had been established and embedded to identify and manage risks on an ongoing basis. All identified risks had been kept under regular review. • Evidence showed that summarising patient notes and complaints management had improved and was monitored and reviewed routinely. • There was an ongoing quality improvement programme in place which focussed on areas for improvement such as breast screening, bowel screening and palliative care. Projects were established to develop and improve areas identified. • Regular supervisions and appraisals were used to help identify and manage performance related issues. 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes

The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<ul style="list-style-type: none"> The practice contacted patients who needed to shield, due to risk from Covid-19, to assess any needs and try and address them. The practice told us they had been able to mitigate the risk to patients who were likely to be affected by the backlog of referrals to secondary care, through early strategic planning. The management team identified this potential problem early. They monitored on a regular basis any potential impact on patient care and resolved any potential issues before they arose. Managers kept in close contact with secondary care services and with the COVID update Hub on a daily basis to see which patients could potentially be affected by a potential reduction in secondary care services. The practice was able to avoid the need to delay referrals and patients were referred to the appropriate secondary care service within an appropriate timescale. 	

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
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:</p> <p>At the last inspection we found:</p> <ul style="list-style-type: none"> There was a coding issue at the practice which staff were working hard to resolve, however, this had been an issue in fully identifying vulnerable patients and this work was on-going. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> Evidence showed that coding for identifying vulnerable patients had improved and the management team continued to monitor this. Meeting notes were well documented, and the practice's computer system allowed all members of staff to view and action these. 	

- Each of the GP partners had lead roles and were accountable in these areas.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice promoted online and digital access to their services. • The practice had a significant cohort of vulnerable patients due to very complex social issues such as sex workers, vulnerable migrants, homelessness, mental ill health, poverty, illiteracy, and substance misusers. The practice told us that despite education and encouragement, they may still not be able to access healthcare remotely or digitally. To ensure patients had access to services patients were supported to attend the practice in person. 	

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 (PPG).	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:

- With the pandemic the PPG had not met as frequently as they used to, but they had remained in touch via zoom and email. We saw minutes of these meetings which confirmed this.
- PPG members confirmed they felt listened to and were able to make suggestions for improvements. For example, it was suggested that pictures of the staff were uploaded to the website so that patients could put a face to the name during telephone appointments. The practice confirmed that this had been completed.

Continuous improvement and innovation

There were 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:	
<ul style="list-style-type: none"> • A GP was the local Primary Care Network (PCN) Frailty lead and contributed to the PCN's Covid vaccination roll-out, particularly in relation to immunising the hard to reach patients within the practice's population. They were also helping to recruit a care home and discharge coordinator for the PCN. • The practice carried out regular audits to improve outcomes for patients. They discussed significant events and complaints regularly to share learning accordingly. • The practice service-wide action plan demonstrated that the provider was committed to continued improvement in the provision of services for all their patients. 	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that several 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 considered 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 considering the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- **%** = per thousand.