

Care Quality Commission

Inspection Evidence Table

Dr Gangadhar Duddukuri (1-514852405)

Inspection date: 18 December 2018

Date of data download: 04 December 2018

Overall rating: Requires Improvement

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

Safe

Rating: Requires improvement

Safety systems and processes

The practice generally 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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	N
There was active and appropriate engagement in local safeguarding processes.	Y
Systems were in place to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>We saw the practice identified and placed alerts on the records of patients they had identified as vulnerable because of specific health and/or social care needs and the practice was able to identify these patients. However, there were no patients on the practice registered list who had been identified as at risk of requiring safeguarding. Staff told us recent conversations with the health visitor had confirmed there were no children identified as at risk at the time of our inspection. Policies we saw confirmed patients at risk would be coded appropriately on the patient clinical record system when necessary.</p> <p>At our previous inspection, not all staff who acted as chaperones had received a DBS check. At this inspection, we saw all staff had been checked appropriately.</p> <p>Records of safeguarding training were not held comprehensively; there was no overall summary of staff safeguarding training. Records were generally held in individual staff files however, there was no record on the day of inspection for the new practice nurse safeguarding children training and the practice was unable to supply us with this following our inspection.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Staff who required medical indemnity insurance had it in place.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in June 2018 we found recruitment processes had been lacking. At this inspection, we looked at the file for a newly-recruited member of staff and found these processes had improved. We found all processes had been undertaken appropriately although the practice had not used a confidential health questionnaire to ensure working conditions were suitable.</p> <p>We were told records of staff vaccination were recorded in individual staff files for clinical staff, however, there was no evidence of this in staff files and managers did not have oversight of staff vaccination status.</p> <p>There was no system in place to ensure managers were assured of clinical staff appropriate registration with professional bodies.</p> <p>At this inspection we saw the medical indemnity insurance for the regular locum GP recorded in that GP's file was out of date. We were sent evidence of current, valid insurance following the inspection.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 23 March 2018	Y
There was a record of equipment calibration. Date of last calibration: 23 March 2018	Y
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check: August 2018	Y
There was a log of fire drills. Date of last drill: June 2018	Y
There was a record of fire alarm checks. Date of last check: 18 December 2018	Y
There was a record of fire training for staff.	N
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion: 24 March 2017	Y
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection we saw records of fire marshal training for the designated member of staff to allow for the role to be carried out effectively. We viewed staff records of training and were unable to see any records of staff training in fire safety. We were told staff were to complete this training online annually but records did not confirm this. Staff we spoke with were able to confirm they were aware of evacuation procedures and they had participated in regular fire drills arranged for the building. Staff told us they had trained previously in fire safety.</p> <p>The majority of the risk assessments for the premises were carried out by the community services in the building on behalf of the practice. We viewed records of fire, electrical, gas and legionella safety checks which were complete and in date. Managers knew these were held by community services although they had not assured themselves they were managed appropriately. We saw there were risks identified by a previous fire risk assessment in August 2015 and March 2017 that had not been addressed. The action plans from the latest fire risk assessments had indicated those actions to be undertaken by the tenants of the building and those for which NHS property services (NHS PS) were responsible. Those risks identified for the tenants to action had been completed. We saw there was one action by NHS PS which had been indicated as the highest priority; to build an external waste compound to store the waste carts away from the building. This had been identified in both the 2015 and 2017 assessments and had not been done. The timescale for this had been given in the last assessment as to be completed by 1 December 2017. The practice was not aware of this risk and had not followed up the fact it was outstanding.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: November 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2018	Y
Explanation of any answers and additional evidence: We saw a premises and security risk assessment had identified areas for improvement and these had been addressed appropriately or were in the process of being addressed. This included a repair to uneven flooring and the covering of electrical cables.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
An infection risk assessment and policy were in place.	Y
Staff had received effective training on infection prevention and control (IPC).	N
An infection prevention and control audit had been carried out. Date of last infection prevention and control audit: Decontamination of equipment 19/11/2018 and Weekly cleanliness check 6/12/2018. Full infection prevention and control audit November 2016.	N
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: We saw minutes of meetings that confirmed staff had been trained in handwashing techniques. We were also told that when the new practice nurse had started at the practice in July 2018, the lead nurse for infection prevention and control for the local area had attended the practice and had spent considerable time with the nurse to ensure all areas of IPC were identified and reviewed. The new practice nurse had been designated as the practice IPC lead. We were told all staff would complete IPC training online each year but there were limited records for this. We saw records of staff training for maintaining the cold chain for refrigerated vaccines but no records of general IPC training except for the healthcare assistant. We also saw two audits related to IPC that covered equipment decontamination and general cleanliness, however there had been no audit of all areas of IPC such as sharps disposal, clinical waste, aseptic technique or hand washing. We had identified the lack of a full IPC audit at our last inspection in June 2018.	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in June 2018 we identified staff had not been trained to recognise the symptoms of sepsis and equipment to assess the condition was not available. At this inspection, we saw this situation had been comprehensively addressed. Staff had all received training in sepsis awareness and there were posters for patients and staff regarding the symptoms of sepsis. A new file of information for staff on dealing with unwell patients who may have sepsis had been introduced in the reception office as well as an emergency folder for managing all patients experiencing various medical emergencies such as stroke or chest pain. Staff we spoke with were knowledgeable about the symptoms of sepsis and dealing with medical emergencies. There was suitable equipment available for the assessment of sepsis.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in June 2018, we found there were no minutes of meetings with other health and social care professionals to discuss vulnerable patients and no records of these discussions made on patient records. Also, there was no documented protocol for the management of patient test results.</p> <p>At this inspection, we saw these areas had been addressed. We saw minutes of meetings and entries made on patient records as a result of these meetings. There was a new documented protocol that allowed for the timely management of patient test results.</p> <p>Patient referrals to urgent two-week-wait services were managed well. The practice aimed wherever possible to ensure patients had an allocated appointment with secondary care before leaving the practice. For those patients where this was not possible, staff followed up the referral to ensure a timely appointment was given.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - (NHSBSA)	0.90	0.85	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	8.0%	9.8%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process in place for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures in place for the safe ordering, receipt, storage, administration, balance	N/A

Medicines management	Y/N/Partial
checks and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols in place for verifying patient identity.	Y
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.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our previous inspection, we found there was no patient specific directive (PSD) in place for the administration of vitamin B12 injections by the healthcare assistant and there were concerns with the storage of refrigerated vaccines. At this inspection, we found these areas had been comprehensively addressed.</p> <p>We saw all expected PSDs were in place, including one for vitamin B12. The practice had raised the breach of the cold chain identified at our last inspection with Public Health England (PHE) and all appropriate processes and procedures had been carried out. There was a significant event audit in place to identify and share learning points and all staff had trained in maintaining the cold chain for refrigerated vaccines. A new digital thermometer had been installed and a back-up thermometer purchased as a spare.</p> <p>The practice had started a new prescription service for patients on 1 October 2018; they had joined the local prescription ordering direct (POD) service offered by the clinical commissioning group (CCG). A medicines optimisation support manager employed by the CCG had joined the practice team and managed a team of medicines co-ordinators to handle all patient requests for medication made to the practice. There was a dedicated telephone line for patients from 8.30am to 5pm Monday to Friday for patients to request medicines and raise queries. Services were offered in line with a memorandum of understanding with the practice and standard operating procedures. The service was relatively new to the area, but in its work previously with other practices, the POD had been effective in reducing inappropriate patient prescribing and medicines wastage. The medicines optimisation support manager reviewed and managed patient prescribing for high risk medicines to ensure all monitoring was done appropriately for these patients. They had also completed a large piece of work to ensure all patient medicines were able to be viewed at one time to ensure prescribing was as effective as possible.</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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <p>We found at our last inspection in June 2018, the recording of significant events was not comprehensive and lacked reference to and documentation of discussion in practice meetings. At this inspection we saw this situation had improved although there was still some need for improvement. On the day of inspection, we were given evidence of four significant events for the last year. However, we saw references in meeting minutes to one other significant event in respect of a flu invitation being sent to a deceased patient, and we were also told of two further clinical incidents which had been raised as significant events. Documentation for these three events was not available on the day of our inspection and was sent to us in the following days. We noted at our last inspection there was no management oversight of significant event, this remained the case at this inspection.</p>	

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

Event	Specific action taken
A patient reported a problem with ordering prescriptions online on several occasions which the practice had not resolved.	The practice contacted the IT supplier who resolved the problem after six days. Staff were informed of the reason for the issue and how to resolve it should it re-occur. Staff were reminded of keeping the patient informed of what was happening and actions being taken.
It appeared that refrigerated vaccines had not been kept at appropriate temperatures for a period of time. The practice had not investigated this issue.	Staff contacted Public Health England who assisted the practice in investigating the incident. It appeared that the fault lay in the resetting of fridge temperatures following longer periods of opening the fridge door when accessing vaccines. Staff were retrained in how to reset the fridge thermometer and a new digital thermometer was installed so that actual fridge temperatures could be checked if the manual thermometer was not reset. Staff also trained in the management of refrigerated vaccines.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in June 2018, we found there was no system in place for the monitoring and management of patient safety alerts although a system was introduced within 24 hours of the inspection.</p> <p>At this inspection, another more comprehensive system had been put in place using the new CCG POD medicines optimisation manager. They managed all patient medicines safety alerts to ensure they were actioned safely and appropriately. These were comprehensively documented and shared with staff although records of discussion of these were not kept.</p>	

Effective

Rating: Requires improvement

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: Clinicians had access to NICE guidelines online and were knowledgeable about guideline changes. We were told changes to best practice were discussed at clinical meetings although these discussions were not always documented.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.93	0.65	0.81	No statistical variation
Additional comments: The CCG medicines optimisation support manager working with the practice told us they were working to review patients taking hypnotic medicines. The number of these medicines was being slowly reduced in consultation with patients. The next stage of the work was planned for the new year for a clinical pharmacist to review patients face to face to further reduce prescribing.				

Older people

Population group rating: requires improvement

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or

severe frailty. Those identified received a full assessment of their physical, mental and social needs. Care plans were produced for patients with severe frailty.

- The practice followed up on older, vulnerable patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The medicines optimisation support manager was responsible for the review of their medicines with the approval of the GP.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

People with long-term conditions Population group rating: Requires improvement

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The practice worked to streamline patient appointments for those with more than one chronic health condition.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	82.5%	78.4%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.7% (22)	8.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.0%	81.4%	77.7%	No statistical variation

Exception rate (number of exceptions).	4.3% (8)	6.1%	9.8%	N/A
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	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	74.9%	79.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	9.0% (17)	11.5%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	72.7%	78.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	15.4% (30)	3.7%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	85.7%	92.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	27.3% (21)	6.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.3%	84.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.3% (7)	2.6%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	76.9%	86.2%	90.0%	No statistical variation

Exception rate (number of exceptions).	5.8% (4)	6.5%	6.7%	N/A
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Any additional evidence or comments

The exception reporting rates for patients with asthma and/or chronic obstructive pulmonary disease (COPD) was high. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Staff felt this was due to a poor response in these patients to invitations to attend for reviews and partly to a historical lack of clinical staffing resources. The medicines optimisation support manager was planning to work with patients suffering from respiratory problems, in particular to demonstrate inhaler techniques.

Families, children and young people improvement

Population group rating: Requires

Findings

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) targets with 100% achieved for all three indicators for two-year olds.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018))(NHS England)	20	21	95.2%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	20	20	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their immunisation for Haemophilus	20	20	100.0%	Met 95% WHO based target (significant

influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)				variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	20	20	100.0%	Met 95% WHO based target (significant variation positive)

Working age people (including those recently retired and students) improvement

Population group rating: Requires

Findings
<ul style="list-style-type: none"> The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	71.2%	74.6%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (PHE)	71.6%	72.5%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)(PHE)	55.1%	57.0%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	80.0%	74.5%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	35.3%	42.8%	51.6%	No statistical variation

Any additional evidence or comments

The practice's uptake for cervical screening was 71.2%, which was below the 80% coverage target for the national screening programme but in line with the local and national averages. Staff contacted patients who did not attend for screening to encourage them to attend.

**People whose circumstances make them vulnerable
improvement**

Population group rating: Requires

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. These patients were discussed regularly with other health and social care services to ensure care was co-ordinated.
- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

**People experiencing poor mental health
(including people with dementia)
improvement**

Population group rating: Requires

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.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Staff had trained in recognising the signs of dementia.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.0%	94.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	23.1% (3)	5.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.9%	95.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	15.4% (2)	4.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	85.7%	84.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (4)	4.3%	6.6%	N/A

Any additional evidence or comments

The exception reporting rates for patients with poor mental health and dementia were higher than average, however, the number of patients excepted was low. Staff told us how they always sent at least three letters to patients to invite them to attend and clinical staff were able to offer home visits for health screening.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.23	550.61	537.5
Overall QOF exception reporting (all domains)	4.9%	4.5%	5.8%

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

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

- An audit was carried out on patients taking certain injectable contraceptive medicines from July to September 2017. The audit resulted in the review of eight patients in the practice and the referral of two patients for a bone density scan. The audit also indicated it was to be repeated on a six-monthly interval; this had not happened.
- The medicines optimisation support manager carried out medicines audits related to local prescribing initiatives, patient safety alerts and practice needs. They acted on results to improve prescribing practice.

Any additional evidence or comments

We saw little evidence of reflective practice or quality improvement work by clinicians apart from the above audit activity. There were no two-cycle audits available for us to view except for medicines searches done by the CCG medicines optimisation support manager.

Effective staffing

The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
Management overview of staff training was lacking. Certificates of completed training were kept in staff	

files and some were documented in a summary spreadsheet of training. By reviewing personnel files for the practice nurse and healthcare assistant, we were assured they were generally appropriately trained for the role. However, records of safeguarding training for the practice nurse were not available.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence: We saw evidence of comprehensive referrals to other services and good systems in place to ensure these referrals resulted in patient appointments. There was good communication with the out of hours service and palliative and secondary care.	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: Staff referred patients to local health and social care services such as the Lancashire wellbeing service, exercise management and weight reduction programmes.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QoF)	95.9%	96.8%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (2)	0.5%	0.8%	N/A

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	N
<p>Explanation of any answers and additional evidence:</p> <p>Clinicians had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Clinical staff told us how they would seek and record consent appropriately. Staff were trained and had a good understanding of consent issues. However, we saw no evidence of any audit or monitoring of the consent process, including for minor surgery.</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.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Staff told us, as a small practice, they knew their patients well and understood their needs. They were aware of patients who might need reminding of appointments and often contacted them beforehand.	

CQC comments cards	
Total comments cards received.	49
Number of CQC comments received which were positive about the service.	38
Number of comments cards received which were mixed about the service.	11
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comments cards	Many cards praised the helpful, caring attitude of staff and GPs. Patients commented staff were respectful, understanding and sympathetic and always did their best for patients. They said staff were friendly and efficient and they were treated with dignity and respect. The mixed comments received from patients generally related to having to wait sometimes in the surgery after the appointment time. However, patients commented the GP always took time to listen to patients and did not rush.
Patient interviews	The four patients we spoke with told us they found staff caring and helpful. They said staff went out of their way to help. GPs were always good at listening to patients and never rushed them during appointments. They said the service offered generally by the practice was excellent and they were lucky to be with the practice.

National GP Survey results

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2769	237	104	43.9%	3.76%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	89.0%	88.2%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	90.0%	86.6%	87.4%	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 (01/01/2018 to 31/03/2018)	95.3%	95.9%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	91.3%	81.4%	83.8%	No statistical variation

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

Any additional evidence
The practice carried out an annual patient survey every January. This survey generally was designed to assess patient understanding and awareness of practice services, such as online access and extended hours opening.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Staff used a telephone translation service when needed and some staff were able to speak other languages. An easy-read health check preparation questionnaire was sent to patients with learning difficulties before appointments for completing with carers.	

Source	Feedback
Interviews with patients	Patients told us they felt involved in decision-making. They said they were given choices when appropriate and options were well-described.
Comments cards	Patients commented staff and GPs listened and always answered any questions. They said they felt involved in their care and their opinions were valued.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	96.9%	94.3%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in June 2018, we saw no evidence of information leaflets available in other languages or easy read format. At this inspection, we saw examples of leaflets that could be requested and information on the practice website that could be provided in other languages. Staff told us information could be printed in large print if necessary.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 49 patients as carers, (1.77% of the practice population). This was an improvement on the number of carers identified at our last inspection which had been 27 (0.97% of the practice population).
How the practice supported carers.	All carers were offered a flu vaccination, offered health reviews and given information about local support organisations. There was a carers' folder in the reception waiting area that detailed support services for patients who were carers and information on the practice website.
How the practice supported recently bereaved patients.	The practice provided support to patients on an individual basis and this included a visit or telephone call if it was appropriate. They signposted patients to bereavement support services and sent a sympathy card to families.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw there was a suitable distance between the reception desk and the patient seating area to allow for quiet conversations not to be overheard. There was a poster telling patients to ask for privacy for sensitive conversations and an administration area away from the front desk for staff to make confidential telephone calls.</p>	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence: The practice had adjusted surgery times and times when services were available following patient feedback. They proactively identified vulnerable patients and produced care plans, for example for palliative care patients, which were shared with other services.	

Practice Opening Times	
Day	Time
Opening times:	
Monday to Friday	8am to 6.30pm
Appointments available:	
Monday	9am to 11.40am and 3.30pm to 4.50pm
Tuesday	9am to 11.40am and 3.30pm to 4.50pm
Wednesday	9am to 11.40am and 4pm to 5.20pm
Thursday	9am to 11.40am
Friday	9am to 11.40am and 3.30pm to 4.50pm
Extended hours appointments:	
Offered at the practice and two other sites in West Lancashire	
Saturday	9am to 6pm
Sunday	9am to 6pm
Weekdays	6.30pm to 9.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2769	237	104	43.9%	3.76%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	97.1%	95.4%	94.8%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Good

Findings

- All patients had a named GP, the principal GP, who supported them in whatever setting they lived. This provided good continuity of care for patients.
- 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.
- Patients in this age group told us they never felt hurried during their appointments and all complex needs were met at one appointment even if this meant taking more than the allotted time.
- Ophthalmology services were available to patients in the building.
- Older patients had expressed difficulties attending the practice for early morning blood test appointments. The practice only had one arranged collection time of 11.30am for blood samples to go to the pathology laboratory for testing, so the practice healthcare assistant offered a service to take later samples to the laboratory at the end of the day. This enabled blood tests to be booked at any time during the day.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Podiatry services were available in the building.
- Care and treatment for people with long-term conditions approaching the end of life was

coordinated with other services.

- The CCG medicines optimisation support manager worked to review the medicines for people with long-term conditions. They ensured all medicines could be viewed on one page to aid treatment decisions, for example for patients taking blood-thinning medicines.
- Appointments with the community heart failure nurse were available at the practice.

Families, children and young people

Population group rating: Good

Findings

- Appointments were available outside school hours with the nurse for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- There was a comprehensive flowchart of questions available for staff to assess whether a child or baby was possibly suffering the symptoms of sepsis.

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.
- Pre-bookable appointments were available to all patients at the practice and two additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday.
- The practice had adjusted the afternoon surgery on Wednesdays to offer later appointments until 5.30pm.
- Telephone appointments with the principal GP were available.

People whose circumstances make them vulnerable **group rating: Good**

Population

Findings

- People in vulnerable circumstances were easily able to register with the practice, including

those with no fixed abode. Patients living on boats which moved frequently were offered full registration with the practice.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Pre-health check questionnaires were used to prepare for appointments and longer appointments were offered.
- Staff from the Lancashire wellbeing service held regular clinics at the practice to discuss patient social needs.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

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

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: The practice had a policy for dealing with patient requests for home visits. Staff were aware of this policy and recorded all requests with as much detail as possible so the GP could assess the level of need before the visit. Staff were aware of patient symptoms that required immediate attention and would interrupt the GP if necessary to pass on information. There was a comprehensive folder describing possible patient emergency situations for staff in reception and staff were knowledgeable about dealing with patient emergencies.	

Indicator	Practice	CCG average	England average	England comparison
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Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	86.4%	69.5%	70.3%	N/A
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	78.6%	61.6%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	77.7%	62.4%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	78.8%	69.8%	74.4%	No statistical variation

Any additional evidence or comments

The practice demonstrated there were few problems for patients when accessing appointments at the practice; we saw appointments were available on the day of our inspection and on the following day. Staff told us they rarely had no appointments available to offer patients and appointments with clinicians were plentiful.

Source	Feedback
Comments cards	Three of the 49 patient comments cards indicated they sometimes found it difficult to get an appointment although eight others specifically commented they never had a problem. Many others praised the service overall and said it was excellent or first-class.
Interviews with patients	Patients told us they were always able to get an appointment when it was needed. They said they could sometimes wait a while in the practice to be seen but they felt this allowed for a thorough consultation process and appreciated they would not be rushed when they saw the GP.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	1
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.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they rarely received complaints from patients. Of the two complaints received by the practice, one was a clinical complaint that was still ongoing. The remaining complaint had been submitted to the practice via the practice website and staff had tried to contact the complainant to discuss the issues raised but had been unsuccessful. Documentation of this complaint was sparse although the practice had raised the complaint as a significant event and there was more detail recorded on the incident report. We saw evidence of discussion with staff in meeting minutes.</p> <p>Since our last inspection in June 2018, the practice had improved their complaints policy to include appropriate timeframes for dealing with complaints. There was an improved complaints leaflet for patients that also detailed these arrangements.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
The practice had planned for the new practice nurse to attend travel vaccination training. A patient requested an appointment for travel vaccinations and been told one would be available following this training. The patient handed in a travel questionnaire to the practice and waited for an appointment but this did not happen. When the patient contacted the practice, they were informed the nurse had been unable to attend the training and offered an alternative appointment at a local travel health clinic. The patient submitted a complaint to the practice.	The practice manager tried to contact the patient on the phone to discuss the situation and apologise but was unable to; a letter was also sent. Staff were reminded of the importance of giving accurate information to patients and a poster was put up in the patient waiting area to explain that travel vaccinations were temporarily not available at the practice. The practice website was updated with this information as was the patient call and display system in reception.

Well-led

Rating: Requires improvement

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	N
Explanation of any answers and additional evidence: We saw very little evidence of management discussion of service quality and sustainability; there was no business or succession plan in place in the practice. We saw little evidence of reflection by managers on the quality of care or service delivery and no documentation of discussion at manager level. Staff told us managers were supportive and would always listen and act positively when needed.	

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy in place to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: We were shown a document labelled electronically as "Business development and strategy plan" which, on opening, was entitled "Statement of purpose". This document set out the practice aims and objectives related to all areas of service delivery, described the services offered to patients and the terms under which these services were offered. However, it did not describe how the business planned to develop nor did it set out a strategy to achieve these objectives. The aims and objectives of the practice were comprehensive and set to provide a service based on best practice. Staff were aware of these aims and told us they would always strive to attain best practice at all times. The aims and objectives had been developed within the local group of practices to provide consistency in care and treatment.	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: Managers told us they operated an "open-door" policy to allow staff to speak to them at any time. They said they valued openness and transparency. They said they would support staff in difficult times.	

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

Source	Feedback
Interviews with staff	<p>Staff we spoke with told us they felt they were a good team that worked well together, helped each other and were supported by management. They said the GP and practice manager were approachable and helpful.</p> <p>Staff told us they felt comfortable raising any concerns and that managers were open to any suggestions for improvement. Staff were aware of management responsibilities; they knew who they could report problems to and how to take issues further if they were not resolved.</p> <p>Staff demonstrated a strong commitment to high-quality patient care.</p>

Governance arrangements

The overall governance arrangements were not always effective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: Policies and procedures were available to all staff on the practice shared computer drive. We viewed the practice policy for high risk drugs we had seen to be out of date at our last inspection in June 2018 and saw it had been reviewed. The policies we viewed at this inspection were updated regularly and in line with best practice. There was a meeting structure in place to aid discussion and share learning. This was within the	

practice, the multidisciplinary health and social care team, with the neighbouring practices and the CCG. However, for the whole team meetings, names of attendees were missing. Minutes of clinical meetings were very brief and did not record for example, discussion of patient safety alerts, guideline changes or any quality improvement work such as audit. There were no fixed agendas for meetings to ensure relevant topics were always considered, such as significant events and patient complaints. Minutes of meetings were shared with staff and available on the practice shared computer drive.

The practice used rotas to minimise the risk of understaffing and to provide opportunities to cover staff absence. The practice rarely used locum staff apart from the regular locum GP.

There was no management overview of clinical and non-clinical staff training and development. Training was encouraged and staff were given protected time for training, however, managers did not ensure necessary training was undertaken in a timely way. On the day of our inspection, managers had never accessed the facility in the online staff training software package to view completed training; they were unaware this could be done. Further training for staff was delivered internally at meetings and externally. Very little of this training had been recorded centrally, the majority of evidence for this was in meeting minutes or in individual staff files. We saw staff had not undertaken annual training according to best practice guidelines, such as fire training within the last year. Managers had not considered what training should be mandatory for staff to complete and the timescales for this.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N
There were processes in place to manage performance.	Y
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Managers had not assured themselves all risk assessments for the premises had been completed in a timely way and any actions identified carried out. The priority action relating to the storage of waste identified by the last fire risk assessment in 2017 and the previous assessment in 2015 had not been addressed. Managers had not assured themselves staff indemnity and membership of professional bodies was current and staff immunisation status was not recorded.</p> <p>Managers had carried out relevant practice premises risk assessments although a confidential health questionnaire for new staff was not used to assess working conditions were suitable.</p> <p>Systems to respond to significant incidents and complaints were established, action was taken to improve service delivery where necessary and learning was shared with staff. Formal reviews to establish the effectiveness of the action implemented in response to concerns were not undertaken and there was no ongoing summary of events to identify trends. Patient complaints were not well-documented.</p>	

We saw no evidence of ongoing and meaningful audit or quality improvement save for that carried out by the CCG medicines optimisation support manager. The one audit we saw which had been carried out in August 2017 had been recommended for repeating every six months and this had not happened. There was little evidence of reflection on the quality of service delivery apart from ongoing discussion of the QOF and review of patient feedback.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: All communications coming into the practice were seen by the GP. There was a comprehensive system in place to manage these communications in a timely way. The work of the medicines optimisation support manager and their team ensured a co-ordinated, safe and professional approach to patient prescribing.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: Managers used feedback from patients and staff to improve services such as patient complaints, the friends and family test and an annual patient survey. There was a local federation of practices to share service delivery and common processes and procedures; extended hours appointments were offered through this federation and the statement of purpose framework had been developed. Local challenges were discussed at federation meetings.	

Feedback from Patient Participation Group (PPG).

Feedback

The practice had formed a virtual PPG that could be contacted by email when the practice wanted to engage with patients. We spoke with two members of the group who told us they would be contacted by the practice from time to time. They had been consulted each year regarding the proposed patient survey and were informed about any service developments. They told us they found the process valuable and they felt they were able to raise any concerns or express opinions whenever they wanted to.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice significant event process had been improved and we saw learning from these was shared with staff and used to make improvements. We saw instances of where patient feedback had changed and improved service delivery. The practice had a contract with the local CCG and delivered services in line with this service contract.</p> <p>However, we saw little evidence from managers for a focus on continuous improvement. Managers had worked since our last inspection to improve systems, particularly in the areas of the management of patient safety alerts, recruitment processes, sepsis awareness, the documenting of palliative care meetings and subsequent entries into patient records, policy review and health and safety risk assessment but evidence for ongoing improvement was lacking save in the area of medicines management. Some areas of risk identified at our previous inspection had not been addressed, particularly in the area of infection prevention and control audit and the documentation of patient complaints.</p>	

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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weightings 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.