

# Care Quality Commission

## Inspection Evidence Table

### Fleet Medical Centre (1-541156705)

Inspection date: 13 December 2018

Date of data download: 11 December 2018

## Overall rating: Good

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

### Safe

Rating: Good

#### 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
Policies were in place covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
Systems were in place to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	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

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>The training requirements for staff in relation to safeguarding children or adults were not included in the practice's safeguarding policies. The practice's training policy stated that all staff should receive safeguarding training within three months of commencing employment. However, we found that one member of staff had not received training on safeguarding adults and children within this timeframe. Staff we spoke to during inspection demonstrated full understanding of the practice's safeguarding procedures.</p> <p>Since inspection, the practice provided an updated copy of its Safeguarding Adults policy which included a section on training. This section declared staff will receive safeguarding adults and children training within three months of starting employment at the practice. It also described how a risk assessment could be created if safeguarding training could not be completed within that time-frame. However, the training section did not include the frequency nor the level of safeguarding training staff should receive relevant to their role, in line with the Intercollegiate guidance document on safeguarding.</p> <p>When needed staff had a Disclosure and Barring Service (DBS) check undertaken. For staff who did not have a DBS a risk assessment was in place demonstrating why one had not been carried out.</p> <p>The practice held regular quality meetings with health visitors, community nurses, and palliative care nurses. The meetings were held to discuss patients who required additional support or were of a concern to professionals. These quality meetings were held two monthly at the practice and minutes from the meetings were shared with clinicians accordingly.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who required medical indemnity insurance had it in place.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Prior to the inspection, the practice reported that the professional registration status of one of its clinical members of staff had expired, and this had not been identified for five months. The affected member of staff confirmed they were not undertaking any clinical duties until their registration had been reinstated. The practice had declared this incident as a significant event and had also informed the appropriate professional bodies of this incident.</p> <p>Actions taken as a result of this incident included documentation of clinical staff members' registration renewal dates on the practice's central calendar. The calendar was checked monthly and reminder emails were sent to relevant staff for them to confirm when their registration renewal had been completed.</p> <p>Since inspection, the practice has confirmed all patients seen by this member of staff have been contacted to inform them of the situation. The practice reported they had received messages of support for the member of staff from patients.</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: 10 February 2018	Yes
There was a record of equipment calibration. Date of last calibration: 21 August 2018	Yes
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure in place.	Yes
There was a record of fire extinguisher checks. Date of last check: August 2018	Yes
There was a log of fire drills. Date of last drill: Not recorded by inspection	Yes
There was a record of fire alarm checks. Date of last check: Not recorded by inspection team	Yes
There was a record of fire training for staff. Date of last training: 2018	Yes
There were fire marshals in place.	Yes
A fire risk assessment had been completed. Date of completion: 27 September 2018	Yes
Actions from fire risk assessment were identified and completed.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>All fire test points, fire extinguishers, emergency lighting and all fire doors within the practice were inspected weekly and any issues were logged and reported and acted upon.</p> <p>Five members of staff had been identified as fire marshals and had received specific training off-site with an external fire protection company to undertake this role.</p> <p>The annual fire risk assessment, completed 27 September 2018, identified no follow up actions were required.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: April 2018	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 2 October 2018	Yes
<p>Explanation of any answers and additional evidence:</p> <p>A Legionella risk assessment was completed on 8 October 2018. A quarterly inspection of the practice's water system and water tank was undertaken.</p>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met but infection prevention and control measures not yet fully embedded at the practice.**

	Y/N/Partial
An infection risk assessment and policy were in place.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit: 11 November 2018	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice's most recent infection prevention and control (IP&C) audit was undertaken on 11 November 2018 by the infection prevention and control lead from the local clinical commissioning group. The external IP&C audit scores were: <ul style="list-style-type: none"><li>• Clinical infection prevention and control: 71%</li><li>• Waste management: 86%</li><li>• Sharps handling and disposal: 92%</li><li>• Vaccines: 88%</li><li>• Hand hygiene and Personal Protective Equipment: 80%</li><li>• Domestic cleaning: 71%</li><li>• Antimicrobial stewardship: 50%.</li></ul> In total there were 24 areas which required improvement to be compliant with local guidelines. The practice provided an update on how they were progressing with the actions identified in the recent IP&C audit. The update demonstrated 17 of these actions had been addressed by the time of our inspection. The remaining actions either had no update documented or had been referred to external parties, such as the practice's cleaning company, for completion. Clinical waste was stored in a secure external compound within the grounds of the practice premises.	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes

Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
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.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

### 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
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
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
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There were 10 test results waiting to be actioned on the day of inspection. This was deemed appropriate by the inspection team's specialist advisor, based on the size of the practice population.</p> <p>The administrative team were responsible for processing two-week wait referrals. (Two-week wait referrals are intended for patients that are suspected to have symptoms of cancer and require urgent review by an appropriate hospital consultant). An appointment would be made for the patient and a letter with the appointment details would sent direct to the patient. A log of all the appointments for two-week wait referrals was maintained and monitored.</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)	0.81	0.91	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)	9.2%	8.9%	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.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations in place 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 in place 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 in place for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A

Medicines management	Y/N/Partial
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 in place 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
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems were in place 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
<p>Explanation of any answers and additional evidence:</p> <p>Clinicians we spoke to during the inspection confirmed that due to the personalised lists they maintained, they could monitor their patients who were receiving high-risk medicines appropriately.</p> <p>The practice performed an in-house INR near patient testing service to support the monitoring of patients receiving blood thinning medicines. (INR stands for International Normalized ratio and is used to monitor how well a blood-thinning medicine is working).</p> <p>The practice told us they were following new local guidance from 2018 regarding antimicrobial use to optimise patient outcomes.</p> <p>The practice had three medical oxygen cylinders. They were all stored together in an unlocked storage cupboard in a large treatment room. The practice confirmed that should emergency equipment be required from the cupboard while the treatment room was in use, they had installed privacy curtains that could be quickly drawn to protect a patient's dignity and privacy. We saw these curtains in place.</p> <p>The practice reported a significant event when it was identified a fridge containing travel vaccines had been turned off. As a result of this incident actions included new plug covers to be installed on all fridges containing vaccines, which we saw were in place. The practice also recorded fridge temperatures twice a day, rather than one recording per day.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes



Number of events recorded in last 12 months:	11
Number of events that required action:	11

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

Event	Specific action taken
Abusive behaviour towards reception staff from a patient.	The practice invoked their zero-tolerance policy with regards to abusive behaviour towards their staff. The practice contacted and met with the patient and advised that appropriate action would be taken if a repeat of this behaviour was seen again.
Vaccine administered twice.	The practice said that the affected patient had confirmed no previous vaccine had been received at the time of administration. On review of patient's record, a previous vaccine record was found. Actions taken included contacting the vaccine manufacturer to check for potential side-effects of administering the vaccine twice. Informing the patient affected to explain the what had occurred and an apology given. Additional questions had been added to pre-vaccine checklists to ensure all previous vaccines were included. The practice said they were considering having a second nurse or healthcare assistant at all vaccine clinics, not just for children's clinics.
Different instructions regarding a prescribed medicine had been given by the practice and a specialist team.	The practice communicated with the specialist team and had improved communication following a multi-disciplinary quality meeting.

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



## Effective

**Rating: Good**

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
Appropriate referral pathways were in place 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

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)	0.59	0.85	0.81	No statistical variation

## Older people

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>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.</li> <li>The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks were offered to patients over 75 years of age.</li> </ul>

## People with long-term conditions

**Population group rating: Good**

## 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.
- 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)	80.8%	80.7%	78.8%	No statistical variation
Exception rate (number of exceptions).	12.6% (72)	9.2%	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)	77.8%	79.1%	77.7%	No statistical variation
Exception rate (number of exceptions).	14.2% (81)	7.8%	9.8%	N/A
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)	83.5%	83.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.2% (87)	10.8%	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,	70.1%	73.1%	76.0%	No statistical variation

NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	5.5% (41)	3.9%	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)	88.9%	92.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	16.6% (25)	10.1%	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)	78.6%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.5% (69)	3.1%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	92.4%	93.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.3% (16)	6.1%	6.7%	N/A

## Families, children and young people

**Population group rating: Good**

### Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- 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)	129	136	94.9%	Met 90% minimum (no variation)
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)	135	148	91.2%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	135	148	91.2%	Met 90% minimum (no variation)
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)	135	148	91.2%	Met 90% minimum (no variation)

## 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 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,	75.5%	74.9%	72.1%	No statistical variation

and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	77.4%	72.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	66.9%	61.5%	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)	75.8%	78.8%	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)	42.9%	45.0%	51.6%	No statistical variation

### Any additional evidence or comments

The practice was aware their uptake for cervical screening was below the national target of 80% and said they were taking the following actions to improve the uptake:

- All clinicians were encouraged to opportunistically remind eligible patients of their cervical screen with reminders on the patient's record.
- The practice ran a search on all eligible patients who had not attended in the previous three to five-year period and wrote to each patient inviting them to attend for screening. The practice said that there had been a positive response using this method, but specific figures were not made available.
- The practice held a cervical screening clinic on a Tuesday designed for eligible patients who may also be 'commuters'. This clinic was run during the practice's extended opening hours on a Tuesday, until 8.30pm.
- Appointments for cervical screening were available during the practice's extended opening hours on a Saturday morning.
- The practice was in the process of training a fourth clinician in performing cervical screening procedures, to increase the availability of appointments further.

### People whose circumstances make them vulnerable

**Population group rating: Good**

### 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.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

## 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.
- 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.

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)	91.0%	91.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	11.9% (12)	10.6%	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)	77.8%	89.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.9% (11)	8.8%	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)	86.8%	84.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.4% (6)	4.9%	6.6%	N/A

### Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	551.68	-	537.5
Overall QOF exception reporting (all domains)	5.1%	4.4%	5.8%

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

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

<ul style="list-style-type: none"> <li>The practice provided evidence of their improved treatment of diabetic patients under the age of 55 years in line with the National Institute for Health and Clinical Excellence (NICE) targets. For example, in November 2016 patients under 55 years with Type 1 Diabetes, it was identified that approximately 30% were receiving appropriate treatment in line with NICE targets. In September 2018 the practice had increased the number of patients receiving diabetic treatment to NICE targets to approximately 40%.</li> <li>The practice streamlined the workflow processes for letters, documents and other correspondence received by the practice. This was done to reduce duplication of work for all staff involved.</li> <li>We saw evidence of a two-cycle minor surgery service audit. In 2016-17, the practice performed 77 procedures, which had an approximate 1% complication rate. In 2017-18, the practice performed 41 procedures, which had an approximate 2% complication rate, and a further eight joint injection procedures which had no complications. The practice said waiting times for minor surgery had been an issue previously but one of the clinicians had recently changed their arrangements for performing minor surgery procedures to reduce the possibility of needing to cancel any sessions.</li> <li>The practice provided evidence of an audit on its two-week wait referral process, which demonstrated 17 referrals were made using the process between June and December 2017. Of those 17 referrals, eight were for dermatological reasons. Since referring, all referrals were being monitored by the dermatology team based at the local hospital. The audit also identified the practice had achieved a 'pick up' rate of approximately 6%, with the target pick up rate being 4-6%.</li> <li>Further audits seen or discussed during inspection including an audit on the recommended needle length used by patients with diabetes; an audit regarding the use of e-Consult; an audit covering the cervical smear results obtained by one clinician at the practice; and an audit regarding the number of physiotherapy referrals to ensure they were necessary.</li> </ul>
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Any additional evidence or comments
The practice was one of the first local practices to pilot e-consult. (e-consult allows patients to consult online with their own GP as well as seek self-help advice and be signposted to other health services).

## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, the recording or completion of recommended training was not fully embedded.**



	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an Urgent Care Team, which consisted of an advanced nurse practitioner, paramedics and a daily duty GP, who received clinical supervision with a practice GP. We saw evidence of a recent clinical session covering dermatology undertaken by the advanced nurse practitioner and the paramedics with one of the practice's GPs. The session included information on the symptoms of different skin conditions and how to treat them.</p> <p>The training log maintained by the practice showed that not all staff were consistently up to date with all the practice's recommended training modules:</p> <ul style="list-style-type: none"> <li>• One member of staff had no record of completing any training. This was raised during inspection and the practice confirmed the individual was to complete all recommended training modules once the practice transferred to Bluestream Academy for their training package in January 2019. However, as the staff member had been employed at the practice since July 2018, this delay in completing the recommended training was outside of the practice's own guidance for all training to be completed within three months of commencing employment at the practice.</li> <li>• Since inspection, the practice has provided evidence of a risk assessment that confirmed the practice had extended the member of staff's training period following feedback from a member of staff. This risk assessment was dated 1 June 2018.</li> <li>• Since inspection, the practice has provided evidence to show the member of staff had completed eight of the ten recommended training modules. These training modules had been completed between 27 December 2018 and 21 January 2019. The remaining two modules were confirmed as being booked for January and February 2019.</li> <li>• Out of a total of 42 staff members, one additional staff member did not have a record of Basic Life Support training from the previous 12 months. This staff member was spoken to on the day of inspection and they confirmed this training had actually been completed in May 2018.</li> </ul>	

- Two staff members were overdue their annual update for Infection Prevention and Control training.
- All remaining staff members had completed a one-off training module regarding the Mental Capacity Act 2005.
- All remaining staff members had completed relevant training modules in both Safeguarding Adults and Safeguarding Children appropriate to their role at the practice.
- Four staff members were overdue their annual fire safety training update.
- Two staff members had no record of completing moving and handling training.
- Two staff members had no record of completing Equality and Diversity training.
- One staff member had no record of completing Health and Safety training.
- Two staff members had no record of completing Conflict Resolution training, which was expected to be completed every three years.
- One staff member had no record of completing training on the new General Data Protection Regulations 2018.

Despite these gaps in training, staff we spoke to during the inspection could demonstrate the appropriate knowledge, awareness and skills to undertake the roles they had been employed to do at the practice, and we found no evidence of harm to patients.

Since inspection, the practice has provided evidence to show that staff had completed the recommended training modules in 2018. However, this evidence did not include an update for the two staff members who were identified as overdue their annual infection prevention and control update.

The practice confirmed they were a training practice for GP registrars and medical students. At the time of inspection, there was one GP registrar attached to the practice.

The practice considered training and career development was important for all staff. For example, three members of non-clinical staff had attended management courses appropriate to their role. The practice had employed two apprentice receptionists in the previous 12 months. A newly recruited practice nurse was in the process of completing her practice nurse qualification and the healthcare assistant had completed a City & Guild Level 2 qualification.

The practice confirmed both paramedics had been booked to undertake a prescribing course in 2019 to become non-medical prescribers.

## 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)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or	Yes

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had provided a self-service blood pressure in the waiting area for patients to access so they could monitor their own blood pressure as required.</p> <p>The practice confirmed approximately 36 women were now using the new Sayana Press self-inject contraceptive following appropriate training by a healthcare professional at the practice. (Sayana Press is a long-term contraceptive hormone injection).</p>	

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)	92.0%	94.4%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (5)	0.5%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes

## Caring

**Rating: Good**

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	18
Number of CQC comments received which were positive about the service.	15
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comments cards	Patients who completed positive comment cards said that all staff at the practice were professional, friendly, kind, respectful. Patients reported they felt looked after. Cards which contained mixed comments reported no issues with how patients were treated at the practice.
NHS UK website	The practice had an overall rating of three stars out of five on the NHS UK website, based on 17 ratings, dating back to April 2017. Comments made by patients stated clinicians were kind, attentive and professional but members of the reception staff had been rude towards patients.

## 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
14,544	241	107	44.4%	0.74%

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)	90.6%	90.0%	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)	84.6%	89.4%	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)	97.2%	96.9%	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)	75.9%	86.7%	83.8%	No statistical variation

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

### Any additional evidence

The practice provided evidence of a patient survey undertaken in June 2018. Themes from the patient survey and associated information were published in the practice's patient newsletter in October 2018. Themes that had been identified by patients for improvement included:

- Car parking
- Quicker and easier telephone access to reception
- Website layout

- Wi-Fi
- Phlebotomy
- Walk in service
- Access and signage
- Clinical staffing
- Waiting room
- More services to be provided by the practice

The practice was providing updates on actions taken to address these areas via a newsletter.

## 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: The reception team had all received training in care navigation. (Care navigation training was intended to give receptionists the ability to support patients in accessing the most appropriate source of help or advice, not just within the practice but in the local community too).	

## 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)	96.2%	95.0%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: There were several members of staff who spoke additional languages and acted as translators for patients. Patients were asked at the point of booking an appointment if they would like a translator to be	

present. If required, appropriate arrangements for the specific member of staff to be available were made. The practice offered on-site translators for patients who spoke Portuguese, Nepali, French, Hindi, Mandarin, Urdu and Arabic. However, during conversations with clinicians at the practice, the availability of staff who acted as translators did not appear to be widely known.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 174 patients that were also carers. This represented approximately 1% of the practice patient's population.
How the practice supported carers.	The practice offered carers a seasonal flu vaccine. The practice also provided carers with a letter and leaflets about local support available to them. We also saw evidence of posters in the waiting area which had information about local support for carers and a carers cafe.
How the practice supported recently bereaved patients.	The practice said that a bereaved patient would be contacted, either by telephone or letter, by their named GP to offer support and information.

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The reception area and waiting room were separated by a corridor. All incoming calls to the practice were answered by a team of receptionists based in an office, away from patient areas and the main reception desk.</p> <p>There was a self-service blood pressure machine located behind a privacy screen near the reception desk.</p> <p>The practice had 'confidentiality cards' at the front desk. The practice said this card was intended for patients to hand to a receptionist on arrival at the practice, if they wished to speak in private. Reception would arrange for the patient to have access to a private room and to speak with an appropriate member of the practice staff.</p> <p>All consultation and treatment room doors were closed during consultations. However, whilst sitting in the waiting area, we observed that a consultation could be overheard.</p>	



# Responsive

Rating: Good

## Responding to and meeting people's needs

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

	Y/N/Partial
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
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.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
Explanation of any answers and additional evidence: The practice had recently replaced the flooring throughout the patient accessible areas. Prior to doing so, the practice had sought advice to ensure the most appropriate flooring was laid and in line with their Dementia Friendly accreditation. The practice had changed the signage throughout the practice to be in line with the practice's Dementia Friendly accreditation.	

Practice Opening Times	
Day	Time
Monday	8.00am-6.30pm
Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm
Extended hours available:	
Tuesday evenings	6.30pm-8.30pm
Every 4 <sup>th</sup> Saturday morning	8.00am-12noon

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14,544	241	107	44.4%	0.74%

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)	95.7%	96.4%	94.8%	No statistical variation

#### Any additional evidence or comments

## Older people

## Population group rating: Good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- Patients received a 'birthday card' from the practice on their 75<sup>th</sup> birthday, reminding them of their name GP and health information relevant to their current phase of life.
- 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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice had recently started a 'Postcards for Sunrise' scheme, whereby staff were encouraged to send postcards from their holidays to the local care home. The practice stated they were inspired by a recent article that described how care home residents recalled their own holiday memories or previous business trips, through receiving the postcards through the post.
- This scheme was described in the practice's newsletter to patients, encouraging patients to do the same. However, due to the recent implementation of the scheme, the practice did not have any evidence of the impact besides feedback from the care home stating residents and relatives appreciating the scheme.

## 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.
- The practice has created a diabetes service team within the practice which was led by a senior GP partner who attained the Warwick University Certificate of Diabetes Care in 2016. The GP was supported by practice nurses and the healthcare assistant. The service carried out annual diabetic reviews and held weekly meetings to discuss complex patients that required further support. The service also worked with a local Consultant Endocrinologist to support patients that were identified as not achieving good control of their diabetes. The practice said that this working relationship had helped to optimise treatment for patients on an individualised basis.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- Additional practice nurse appointments were available until 8.30pm on a Tuesday for school age children so that they could attend outside of school hours.
- 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.

## **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 8.30pm on a Tuesday evening. Appointments were also available every fourth Saturday morning from 8am until 12noon. This is advertised to patients on the practice website.

## **People whose circumstances make them vulnerable**

**Population group rating: Good**

### **Findings**

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice was in the process of gaining its Learning Disability Friendly accreditation.

## **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. The practice had created a specific protocol to support these patients, known as 'Code 300'.
- 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.
- All staff had received dementia training in the last 12 months in line with the practice achieving Dementia Friendly accreditation.

## Timely access to the service

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

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	71.9%	72.5%	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)	58.7%	70.2%	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)	61.7%	67.8%	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)	66.6%	76.1%	74.4%	No statistical variation

### Any additional evidence or comments

The practice was aware patients experienced difficulties in getting an appointment at the practice. To improve this, the practice had recently increased the number of clinicians in its Urgent Care Team made up of the Duty Doctor, an advanced nurse practitioner and two paramedics, who offered on-the-day urgent appointments as required.

Source	Feedback
CQC Comment cards	Positive comments received from patients confirmed that patients could access the practice and appointments as required.  Cards that contained mixed comments reported that patients had experienced difficulty in getting a regular appointment, but others stated an emergency appointment was always available when required.
NHS UK website	Comments posted on NHS UK website by patients contained mixed comments regarding access to appointments. Some stated they had no issues with getting an appointment, sometimes at the last minute, while others stated a wait of four to five weeks was required. Comments also reported continuity of care was difficult to maintain due to the delay in waiting for appointment to be available.

### 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.	27
Number of complaints we examined.	10
Number of complaints we examined that were satisfactorily handled in a timely way.	10
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice confirmed that no complaint was addressed in the reception area. When a patient identified themselves as wishing to make a complaint, the business card for the practice manager was supplied. The business card contained the direct email address of the practice manager, and patients were encouraged to put their complaint in writing. The practice manager confirmed all complaints were acknowledged and then investigated in line with their complaints policy. Where appropriate, patients were invited to attend a meeting at the practice to discuss a complaint further, and for a resolution to be reached.</p> <p>The practice confirmed if patients did not wish to put a formal complaint in writing to the practice, alternative methods of communication to discuss any concerns or complaints could be arranged.</p>	

The practice said they had created a new protocol, named 'Code 300'. The protocol was designed for those patients experiencing 'exceptional concerns' due to a mental health crisis or shortfalls in providing palliative care. It was designed for short-term duration and was reviewed on a three-monthly basis. Upon calling the practice, the patient would simply need to identify themselves as a 'Code 300' and access to medical care would be prioritised without further questions. The patient's record would also contain an alert confirming their 'Code 300' status and the duration that it was required for. We were provided with evidence of this protocol which demonstrated how a patient would be eligible for this status as well as detailing who had the authorisation to confirm a 'Code 300' status.

The practice had received a complex complaint, which had been ongoing for several months. In managing the complaint, once the practice had utilised their own resources, they had contacted multiple external organisations for support and advice.

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding a relative's admission to hospital.	The practice contacted the patient and apologised to the patient and relative. A full clinical explanation was provided with a diary of events and all actions taken. The case was further reviewed with the nursing team and the practice's INR process was checked. No clinical errors were found.
Complaint regarding a delay to a referral to secondary care.	The practice contacted the patient and apologised to the patient. The practice investigated and found delay to the referral had been caused by changes made by the local hospital. The hospital had not communicated the changes to the affected patient appropriately. The practice supported the rebooking of a new appointment on behalf of the patient.

## Well-led

**Rating: Good**

### 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 in place, including a succession plan.	Yes

## 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 in place 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

## 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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Explanation of any answers and additional evidence: The practice gave 'Employee of the Month' awards to their staff to acknowledge positive feedback where it had been identified.	

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

Source	Feedback
Staff interviews	Staff confirmed they felt valued, and were supported to extend their roles to suit their own skill sets, as well as develop new ones. Staff stated managers and GPs operated an open-door policy and were available for support and advice as required.
Staff questionnaires	Staff reported the practice was friendly and an interesting place to work. Staff reported no two days were the same, and everyone worked as a team to meet the needs of the patients. Managers were described as approachable and colleagues were supportive.
Staff feedback received via CQC Comment cards	Staff confirmed the practice had supported them and encouraged them to develop and progress in their careers. Staff stated they felt looked after, managers, clinicians and colleagues alike were approachable and helpful for any issue. Staff



	felt proud to work at the practice. Staff reported there was a 'no blame' culture at the practice, only learning opportunities.
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## 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 in place which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We were provided with a schedule of various meetings that demonstrated the practice communicated with both its own staff and external parties on a regular basis. Meetings held included quality meetings to discuss significant events, complaints and patients who may be of concern to the multi-disciplinary team; Quality and Outcome Framework meetings, Finance meetings, Partners meetings, Nursing team meetings and Clinical Referral meetings. The practice confirmed the Clinical Referral meetings were arranged to include an external speaker to provide an update on appropriate referral methods.</p> <p>The training log maintained by the practice demonstrated that staff were not consistently completing their training modules as recommended by the practice. One member of staff had no record of completing any training despite being employed for more than three months. We discussed this with the practice who told us the staff member would be completing the recommended training modules when the practice moved to a new training provider in January 2019. However, this was not in line with the practice's own training policy for all staff to have completed recommended training modules within three months of starting employment at the practice.</p> <p>Since inspection, the practice has provided evidence of a risk assessment that confirmed the practice had extended the member of staff's training period following feedback from a member of staff. This risk assessment was dated 1 June 2018. The risk assessment stated training should be completed within six to 12 months of commencing employment. The practice has also provided evidence to demonstrate the staff member had completed eight of the 10 recommended training modules between 27 December 2018 and 21 January 2019. The remaining two modules have been documented as being booked for January and February 2019.</p>	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance but not in relation to the monitoring of staff training.**

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	Partial
There were processes in place to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes

There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The training log provided by the practice prior to inspection demonstrated gaps in the completion of staff training modules. This demonstrated that the practice had not assured themselves that staff were completing their recommended training as instructed by the practice's own policies.</p> <p>Since inspection, the practice has provided evidence to show that staff had completed the recommended training modules in 2018. However, this evidence did not include an update for the two staff members who were identified as overdue their annual infection prevention and control update.</p> <p>The practice told us they were aware of a staff member who had not completed their recommended training modules. However, we did not see any evidence which demonstrated how the practice had risk assessed this decision to ensure the staff member had the appropriate skills to perform the role they had been employed for.</p> <p>Since inspection, the practice has provided evidence of a risk assessment that confirmed the practice had extended the member of staff's training period following feedback from a member of staff. This risk assessment was dated 1 June 2018. The risk assessment stated training should be completed within six to 12 months of commencing employment.</p>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

### 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
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:	

The practice provided evidence of a staff survey completed in September 2017. The practice received feedback from the administrative and reception teams, the nursing team and the Urgent Care Team. The practice also provided evidence that demonstrated the staff feedback had been reviewed and themes had been identified for further discussion. For example, patient access, improved use of resources, staff well-being and improved communication.

The practice produced a series of practice newsletters for patients as well as another for staff which contained information relevant to the practice. For example, information about e-Consult, flu vaccine season and other seasonal promotions, staff changes, and patient survey results.

The practice had implemented a new protocol in direct response to complaints received from patients which had improved access to clinical care for those in a crisis situation.

Feedback from Patient Participation Group.

### Feedback

Members of the Patient Participation Group (PPG) gave us information about their working relationship with the practice via email. Various members of PPG reported they did not feel valued by the practice as a way of gathering patient feedback, they were instead treated more as a 'tick-box' exercise rather than supportive or informative resources.

The arrangements for PPG meetings were only during working hours and one member struggled to attend due to their own work commitments. Previous meetings had been cancelled at short notice but minutes would be shared and topics for discussion were invited prior to the meeting.

The PPG reported they were informed of non-clinical issues as complaints regarding receptionists' attitude or the practice's retainment of receptionists due to the demands and expectations of patients. However, the PPG reported they were not made aware of any clinical issues or complaints in order to provide a patient's perspective and support the practice in making appropriate improvements.

The PPG reported suggestions made by them were limited to housekeeping issues and if additional suggestions were made, for example, extending the hours of practice nurse availability or introducing a triage system, there could be a prolonged period before improvements were implemented. The PPG reported they usually found out about changes to the practice via the practice's newsletter to all other patients, rather than their meetings.

PPG members were reported to have offered to support the practice in analysing survey responses but the role of the PPG has been reduced significantly by the practice.

All members of the PPG were satisfied with the clinical care provided by the practice and felt the practice met the needs of its practice population. However, the PPG itself wished to contribute more to the practice to support them, but reportedly found their support unwanted.

### Any additional evidence or comments

Since inspection, the practice has told us they were aware of the frustrations felt by its patient participation group (PPG). They told us they were looking at ways to improve how the PPG engaged with the practice and valued their involvement, including inviting the local clinical commissioning group and the National Association of Patient Participation to PPG meetings. The practice confirmed they had had a PPG for nearly 10 years. As well as the active PPG, the practice also had a virtual PPG of over 8,000 members for the last three years, who have been emailed ideas on service improvement, practice news and changes regularly.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence from the practice's quality meetings that demonstrated the learning from complaints and significant events were discussed and shared with all appropriate staff at the practice.</p> <p>The practice arranged for 'away days' for each team of staff based within the practice, for example, the data and administration team, the reception team, the GP partners, and the Urgent Care and salaried GP team. We saw evidence of agendas for these away days which included team-building exercises, updates from the practice and identified team, and an opportunity for staff to provide feedback. We saw updated action plans that had been created from feedback received at these away days.</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 weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.