

# Care Quality Commission

## Inspection Evidence Table

**Dr Rashid Akhtar (1-533212045)**

Inspection date: 17 January 2019

Date of data download: 7 January 2019

## Overall rating: Requires Improvement

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

### Safe

### Rating: Inadequate

We inspected the practice in October 2015 and rated the practice good for safe services. During this inspection we rated the practice as inadequate for providing safe services as not all risks had been assessed and managed, such as infection prevention and control and the absence of emergency medicine and equipment. The practice did not have reliable systems in place for the appropriate and safe use of medicines. Staff did not always have the information they needed to deliver safe care and treatment.

#### 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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies 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).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
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
Explanation of any answers and additional evidence: There was evidence of regular multi-disciplinary team meetings with the community matron which provided the opportunity to discuss and share concerns relating to vulnerable adults. There were no formal documented meetings with the Health Visitor however, the Health Visitor attended the practice every two weeks to discuss any issues and there was a communication book for sharing information.	

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.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence:	

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: 26.10.2018	Y
There was a record of equipment calibration. Date of last calibration: 20.4.2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 7.6.2018	Y
There was a log of fire drills. Date of last drill: 27.4.2018	Y
There was a record of fire alarm checks. Date of last check: 14.1.2019	Y
There was a record of fire training for staff.	Y

Date of last training: April/March 2017	
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 9.2.2018	Y
Actions from fire risk assessment were identified and completed. No actions identified	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Fire training updates training for staff was booked for February 2019.</p> <p>There were challenges associated with the layout of the premises for example, the corridors were narrow. The fire risk assessment had not considered these risks and any potential impact when evacuating patients with a physical disability and who required the use of a wheelchair.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 6.4.2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 6.4.2018	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider had completed an Equality Access Audit (26.2.18) to establish how accessible the premises were for a wide range of potential users including people with a physical disability. However, we saw potential challenges for patients with a physical disability accessing the premise which had not been identified as a result of the audit. For example, the doors to the entrance of the building were not automatic, patients in a wheelchair would require assistance to enter the premises and there was no system in place for patients to alert staff for assistance. Following the inspection the practice manager confirmed they had installed a call bell so that patients could alert staff should assistance be required, a sign was also displayed informing patients.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 31.12.2018	Y
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The infection prevention and control audit had not identified potential risks such as reducing the risk of cross contamination and the absence of a legionella risk assessment which was last carried out in 2004 (Legionella is a term for a bacterium which can contaminate water systems in buildings). However, we saw that the practice had obtained a quote from an external company and was awaiting a confirmation</p>	

date for the legionella risk assessment to be undertaken. Following the inspection the practice manager confirmed that a legionella risk assessment had been completed by an external contractor.

We saw that clinical waste was stored securely however, clinical waste bags awaiting collection had not been correctly labelled in line with legal requirements. The practice manager told us that they would address this with relevant staff. Following the inspection the practice manager confirmed they had taken action to ensure clinical waste was labelled correctly.

## 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 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
Explanation of any answers and additional evidence:	

## Information to deliver safe care and treatment

**Staff did not always have the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the	Y

summarising of new patient notes.	
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
Explanation of any answers and additional evidence: The records of patients on high risk medicines did not always clearly demonstrate that the patient had received appropriate monitoring of their health. The practice manager told us that some of these patients had received monitoring in secondary care services and they kept a list of patients on high risk medicines to ensure appropriate monitoring. However, we saw the list was not up to date and there were gaps in the information recorded such as the date the patient was called and re called for their test and the results of the test. We saw that patient electronic records did not always demonstrate why a patient did not have a test or investigations as appropriate codes were not always used.	

## Appropriate and safe use of medicines

### The practice did not have 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)	1.02	0.98	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)	7.0%	5.6%	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 to administer medicines (including Patient Group	N

Medicines management	Y/N/Partial
Directions or Patient Specific Directions).	
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.	Y
There was a process 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.	Partial
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.	N
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 for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols 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.	Partial
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 to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We saw a Patient Group Direction (PGD) had been signed and dated. We saw Patient Specific Directions (PSD's) that were signed by the authorising manager but did not have individual patient names and were not dated, the GP and practice manager told us they had written them in preparation for future use. However, this did not provide assurance that the patient had been assessed by the prescriber on an individual basis before being administered the PSD.</p> <p>The practice had a process for the management of information about changes to a patient's medicines including changes made by other services. All correspondences were sent to a GP for review and coding. However, we saw there were gaps in the information relating to patients on high risk medicines,</p>	

Medicines management	Y/N/Partial
<p>it was not always clear from their medical records if and when a blood test had taken place to ensure prescribing was safe prior to issuing a repeat prescription.</p> <p>The records of patients on high risk medicines did not always demonstrate that the patient had received appropriate monitoring of their health. The 13 patient records we viewed did not demonstrate that appropriate monitoring had taken place prior to a prescription being issued.</p> <p>The emergency medicines held by the practice did not include a medicine that could be used to treat a person with low blood glucose level or a person suffering a seizure. There were no risk assessments in place that provided a clear rationale for the decision to not stock these medicines.</p> <p>There was evidence that the medical oxygen was checked regularly. Staff told us that the defibrillator was also checked regularly. However, the provider was unable to demonstrate this took place as there were no written records to confirm that the defibrillator was being checked regularly to ensure it remained in working order. Following the inspection the practice manager confirmed that a written log was now in place to record the checks completed on the defibrillator.</p> <p>There were two fridges to store vaccines both had a built-in thermometer, although no second thermometer or data logger was used, we saw the fridges had been calibrated regularly to provide some assurance of the accuracy of the temperature readings. Following the inspection the practice manager confirmed that a second thermometer was purchased for both of the fridges.</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.	Partial
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:	Five
Number of events that required action:	Zero
<p>Explanation of any answers and additional evidence:</p> <p>The significant events that had occurred were all positive events, there was no evidence that significant events were not reported or recorded. However, we discussed with the lead GP the threshold for reporting to ensure all types of relevant events were captured.</p>	

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

Event	Specific action taken
Cancer diagnosis	No action required, reinforced general awareness of signs and symptoms

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
Explanation of any answers and additional evidence: Patient safety alerts such as information from the Medicines and Healthcare Regulatory Agency (MHRA) were received by the practice manager and then sent to clinical staff by email to ensure any actions were completed. Any relevant learning was shared with staff during practice meetings.	



## Effective

## Rating: Good

During this inspection the overall rating for this practice is requires improvement due to concerns in providing safe and well-led services. However, we have rated the practice good for providing effective services overall and across all of the population groups. We rated the practice good for effective services because patients were able to access timely and effective care and treatment.

### 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.	Partial
There were 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: Not all patients prescribed high risk medicines had received appropriate monitoring.	

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)	1.11	0.74	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> </ul>

- 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.
- Multi-disciplinary team meetings took place to ensure important information was shared about vulnerable patients including those receiving end of life care.

## People with long-term conditions

## Population group rating: Good

### Findings

- Most 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. However, some patients on high risk medicines were not reviewed and did not have appropriate monitoring in place.
- 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 a long-term condition.
- 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)	74.9%	79.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	3.5% (7)	11.2%	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)	84.4%	78.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	3.0% (6)	8.8%	9.8%	N/A

	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)	70.8%	78.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.2% (30)	11.4%	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)	84.1%	77.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.7% (3)	4.5%	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)	95.7%	90.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	16.1% (9)	12.7%	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)	82.0%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.8% (10)	4.3%	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)	95.2%	90.9%	90.0%	No statistical variation

Exception rate (number of exceptions).	1.2% (1)	5.4%	6.7%	N/A
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### Any additional evidence or comments

The practices QOF achievement for patients 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 was comparable to the local and national averages and QOF achievement for patients with Chronic Obstructive Pulmonary Disease (COPD) who had had a review with a health care professional was also comparable to local and national averages. However, the exception reporting rate was higher than the local and national averages. 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. We saw evidence that the practice exception reported patients appropriately.

The combined overall exception reporting in the following QOF (2017/2018) clinical domains were also above local and national averages.

Heart failure 13.3% (local 9.4%, national 8.5%)

Coronary heart disease 12.6% (local 10%, national 8.7%)

Osteoporosis 21.4% (local 12.1%, national 17.5%)

We looked at the reason for the exception reporting and saw that patients had been exception reported appropriately for example they had declined or did not attend.

## Families, children and young people

## Population group rating: Good

### Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets, except the percentage of children aged 2 who had received immunisation for measles, mumps and rubella which was slightly below the national coverage rate.
- 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. The Health visitor attended the practice regularly and there were systems in place to share information.

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)	29	30	96.7%	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)	31	34	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)	31	34	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)	30	34	88.2%	Below 90% minimum (variation negative)

#### Any additional evidence or comments

The practice was slightly below the target range of 90% for the percentage of children aged 2 who had received immunisation for measles, mumps and rubella. We discussed this with the lead GP who told us that this was due to some parents preferring the vaccines to be administered separately.

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

Population group rating: **GOOD**

### Findings

- 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.
- The practice's uptake for cervical screening was similar to the local and national averages however, below the 80% coverage target for the national screening programme.

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) (01/04/2017 to 31/03/2018) (Public Health England)	67.3%	65.8%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	79.7%	64.2%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	57.7%	42.1%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	92.9%	65.7%	70.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	71.4%	50.1%	51.9%	No statistical variation

### Any additional evidence or comments

The practice's uptake for cervical screening was similar to the local and national averages however, below the 80% coverage target for the national screening programme. The practice followed up women who did not attend and the clinician undertaking the screening monitored their results. However, at the time of the inspection due to unforeseen circumstances the female practice nurse who undertook this role

was no longer in post. A female locum GP was currently carrying out the screening and patients were also able to attend a local clinic for screening however, we did not see any information promoting this arrangement. The practice manager told us they would ensure the service was promoted. The practice was looking to recruit a practice nurse.

## 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 or experiencing poor mental health.
- 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)

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.
- 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)	100.0%	91.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	14.3% (2)	13.5%	12.7%	N/A
The percentage of patients with	100.0%	93.1%	90.0%	No statistical



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)				variation
Exception rate (number of exceptions).	7.1% (1)	10.9%	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)	100.0%	83.7%	83.0%	Variation (positive)
Exception rate (number of exceptions).	11.8% (2)	6.8%	6.6%	N/A

#### Any additional evidence or comments

The combined overall exception reporting for the QOF (2017/2018) clinical domain for depression was 40% this was higher than the local average of 26.5% and national average of 22.7%. The practice provided more current unverified QOF data (end of year) which showed 97 patients had been exception reported as their diagnosis was over 15 months and therefore did not meet the criteria for the QOF indicator.

#### Monitoring care and treatment

**The practice had a 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)	545.2	538.0	537.5
Overall QOF exception reporting (all domains)	4.3%	6.2%	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.	Y

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

<p>The practice had completed 15 audits in the last 12 months, these included.</p> <ul style="list-style-type: none"> <li>An audit focusing on best practice guidance for prescribing a specific antibiotic. The initial audit was completed in March 2017. Patients on this antibiotic were identified, reviewed and an appropriate alternative prescribed. The aim was to maintain non-prescribing of this antibiotic. A re-audit was undertaken in April 2018, which showed no patients were prescribed this antibiotic since the initial audit and demonstrated best practice guidelines were maintained.</li> </ul>
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- An audit on repeat prescribing in March 2018, this was initiated by the Clinical Commissioning Group (CCG), the practice scored well in all areas of repeat prescribing that were assessed.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Partial
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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was no formal programme of learning and development however, the practice had a small number of staff and the practice manager had a system in place to monitor training and development for staff.</p> <p>We saw a detailed induction programme for a newly appointed Health Care Assistant which included assessment and training of core clinical competencies. However, the document was not fully completed and it was difficult to establish what areas had been assessed, the practice manager told us this was in progress.</p> <p>The practice had recently employed a Health Care Assistant, they were due to start the Care Certificate standards for Health Care Assistants in February 2019.</p>	

## 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:	

## 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:	

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	96.8%	95.8%	95.1%	No statistical variation

other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0.1% (1)	0.7%	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.	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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Discussion with clinical staff showed that verbal consent was always obtained before care and treatment and where relevant written consent for example, for certain treatments. Written consent forms were scanned directly on to the patient's records and verbal consent was recorded in the patient's notes. Clinical staff spoken with were aware of the importance of consent and showed understanding of areas such as best interest and Gillick competency.</p>	

# Caring

**Rating: Good**

During this inspection the overall rating for this practice is requires improvement due to concerns in providing safe and well-led services. However, we have rated the practice good for providing caring services. The practice was rated as good for caring because the feedback from patients demonstrated that staff were kind, caring and helpful and patients were treated with dignity and respect.

## 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:	

CQC comments cards	
Total comments cards received.	21
Number of CQC comments received which were positive about the service.	18
Number of comments cards received which were mixed about the service.	Three
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards	There were 18 positive comment cards and this included comments about staff who were helpful and caring.
Patient interviews	We spoke with three patients including one member of the Patient Participation Group (PPG). Positive comments included staff being respectful, polite and caring.

## 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
3073	253	103	41%	3.35%

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)	94.8%	83.5%	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)	92.5%	81.4%	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)	99.0%	93.0%	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)	91.5%	75.6%	83.8%	No statistical variation

### Any additional evidence or comments

The practice was above local and national averages for a number of questions in the 2018 GP Survey and this was aligned with the patient feedback we received on the day of the inspection.

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

### Any additional evidence

The practice had gathered feedback from patients through the patient participation group (PPG), national surveys and comments and complaints received. The provider told us they had reviewed the results of the

most recent national GP survey and were happy with the results as the results showed that the practice scored higher than the local average in every question. In some questions the practice score was also higher than the national average. There were no areas where the practice was below local or national averages. However, the provider acknowledged ongoing work was required to sustain positive feedback and ensure ongoing monitoring of the quality of the service. There were plans for a patient survey to be conducted via an external agency.

## 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:	

Source	Feedback
CQC comment cards	There were 18 positive comment cards and these included comments about being listened to and having needs met.
Patient interviews	We spoke with three patients including one member of the Patient Participation Group (PPG). The feedback was overall positive, patients described staff as helpful and their care and treatment was explained to them. Only one patient commented they felt the clinician did not give sufficient time for explanation and discussion during a consultation.

## 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)	94.1%	89.4%	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	Y

told patients how to access support groups and organisations.	
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: Information leaflets in other languages and in easy read format were not readily available in the practice but could be ordered on request.	

Carers	Narrative
Percentage and number of carers identified.	68 (2.2% of the practice list size).
How the practice supported carers.	The practice had identified more than 2% of its practice population as carers. A member of staff had the lead role for carers. The practice had carers register to ensure all carers were easily identified and could be offered annual health assessment, the flu vaccination and support and advice. Information was displayed in the patient waiting area sign posting carers to support groups and encouraging carers to identify themselves to staff so support could be offered.
How the practice supported recently bereaved patients.	The practice had bereavement support information displayed in the patient waiting area. The practice also referred patients to support services and bereavement counselling.

## 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
Explanation of any answers and additional evidence: A notice was displayed informing patients that a private room was available should they wish to speak in confidence away from the waiting room and reminding patients to stand back when in the queue to respect the privacy of those speaking with staff at the desk.	

## Responsive

**Rating: Good**

During this inspection the overall rating for this practice is requires improvement due to concerns in providing safe and well-led services. However, we have rated the practice good for providing responsive services overall and across all of the population groups except for vulnerable people because patients were able to access the service in a timely manner and complaints were listened to and acted on. We rated the population group people whose circumstances make them vulnerable requires improvement as we saw potential challenges for patients with a physical disability or who require the use of a wheelchair accessing the premises.

### 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.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
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 provider had completed an Equality Access Audit to establish how accessible the premises were for a wide range of potential users including people with a physical disability. However, we saw potential challenges for patients with a physical disability or who require the use of a wheelchair. For example, the doors to the entrance of the building were not automatic, patients in a wheelchair would require assistance to enter the premises and there was no system in place for patients to alert staff for assistance. There was no emergency call system in the toilets should assistance be required. Following the inspection the practice manager confirmed they had installed a call bell so that patients could alert staff should assistance be required, a sign was also displayed informing patients.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 8pm *6.30pm to 8pm Extended hours service
Tuesday	8.30am to 8pm *6.30pm to 8pm Extended hours service
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 1.30pm
Friday	8.30am to 6.30pm



Appointments available:	
Monday	8.30am to 8pm *6.30pm to 8pm Extended hours service
Tuesday	8.30am to 8pm* *6.30pm to 8pm Extended hours service
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 1.30pm *Between 1.30pm and 6.30pm patients can access GP services at a local Hub practice
Friday	8.30am to 6.30pm
Saturday & Sunday	9am to 12pm *Extended hours service, alternated across the three Hub practices

#### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3073	253	103	41%	3.35%

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)	94.8%	92.5%	94.8%	No statistical variation

### Older people

### Population group rating: Good

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- There was a medicines delivery service for housebound patients. The practice worked with local pharmacies to coordinate the service.
- 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.

### People with long-term conditions

### Population group rating: Good

#### Findings

- Patients with multiple conditions had their needs reviewed in one appointment. Longer appointments were offered to facilitate this.
- The practice liaised regularly with the local district nursing team and community matrons to discuss

and manage the needs of patients with complex medical issues.

- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

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

**Population group rating: Good**

### **Findings**

- The practice offered appointments that would benefit school age children and ensure they did not need to miss school. Appointments were available until 8pm on a Monday, Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP Hub. These appointments were available Saturday and Sunday 9am until 12pm.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child age 5 and under 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 offered appointments that would benefit working age people. Appointments were available until 8pm on a Monday and Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP Hub. These appointments were available Saturday and Sunday 9am until 12pm.

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

**Population group rating: Requires Improvement**

### **Findings**

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability or experiencing poor mental health.
- 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.

- We saw potential challenges for patients with a physical disability or who require the use of a wheelchair. The doors to the entrance of the building were not automatic and there was no system in place for patients to alert staff for assistance. There was no emergency call system in the toilets should assistance be required. Following the inspection the practice manager confirmed they had installed a call bell so that patients could alert staff should assistance be required, a sign was also displayed informing patients.

## 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 utilised a single point of access service for emergency referrals to the mental health team.
- Staff interviewed understood 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: Home visits were generally available for elderly or housebound patients. All requests for home visits were taken by reception staff and then forwarded to a GP to triage and assess. Staff spoke with were aware of when a home visit would not be appropriate as the patient required urgent medical attention.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP	81.3%	N/A	70.3%	No statistical

Indicator	Practice	CCG average	England average	England comparison
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)				variation
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)	78.3%	58.3%	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)	80.6%	62.0%	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)	85.2%	65.8%	74.4%	No statistical variation

#### Any additional evidence or comments

The results of the national GP survey showed that the practice scored higher than the local and national averages in every question relating to access and this was aligned with the feedback we received on the day of the inspection.

At our previous inspection in October 2015, we told the provider they should ensure patients were aware of the extended opening hours. During this inspection we saw no information in the patient waiting area. The practice leaflet made reference to extended opening however, there was no information on the appointment times. Staff told us they provided this information to patients verbally. The practice manager acknowledged this information should be readily available and would ensure the service was promoted effectively.

Source	Feedback
CQC comment cards	Patients were happy with the appointment system and said they could access appointments in a timely manner. There were no comments relating to difficulty accessing appointments.
Patient interviews	We spoke with three patients including one member of the Patient Participation Group (PPG). Only one patient commented that it was sometime difficult to get a routine appointment however, if the need was urgent they would be seen on the same day.

#### 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.	Three
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	None

	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>The practice had a small number of complaints, there was no evidence that the system for recording complaints was not effective. The feedback on the day and results from the national GP survey demonstrated that patients were overall happy with the service. Complaints were discussed with staff during team meetings to ensure learning and help improve the service.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient missed their appointment due to no fault of their own this was recorded as the patient did not attend	Error corrected, patient given an apology

## Well-led

## Rating: Requires Improvement

We inspected the practice in October 2015 and rated the practice good for well led services. During this inspection we rated the practice as requires improvement for providing well led services because the overall governance arrangements were ineffective. The practice did not have clear and effective processes for assessing and managing risks.

### 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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The long-term plan to ensure sustainability of the service was to merge with two other local practices and move to new purpose-built premises. The aim was to improve facilities for patients and enable the practice to expand services. The location for the new building was secured and plans for the new build were ongoing.	

### 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.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.	

## 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

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

Source	Feedback
Staff member	Staff commented that the practice manager was supportive and approachable and they felt confident to raise any issues.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems 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 were available in paper format and on an electronic system which were easily accessible to all staff. Discussion with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing. We looked at a sample of policies and saw they had been reviewed and were up to date such as the complaints, infection prevention and control and recruitment policy. There were regular staff meetings to share important information. The practice manager and lead GP had taken on some of the roles previously the responsibility of the practice nurse such as ordering of medicine stock and infection prevention and control, this had some impact on capacity. The practice manager and lead GP had regular informal discussions to ensure important information as discussed and shared. However, these meetings were not documented and there was no formal arrangement to assess and monitor the governance arrangements in place. We saw gaps and inconsistencies in systems and processes. For example, infection prevention and control procedures were not always followed, there were gaps in the management of medicines. Some policies lacked detail such as the recruitment policy. The business continuity plan was not comprehensive.

We saw that all of the significant events that had occurred were positive. We discussed with the lead GP the need to review the threshold for reporting significant events to ensure all learning opportunities are

maximised.

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>There was some evidence of quality assurance systems for example, a number of clinical and non-clinical audits had been completed. An audit on repeat prescribing in March 2018, showed the practice scored well in all areas of repeat prescribing. However, we saw gaps and inconsistencies in other areas such as the monitoring of patients on high risk medicines. Completed audits did not effectively identify areas for potential improvements for example, the infection prevention and control. The Equality Access Audit did not establish the potential challenges people with a physical disability may experience when entering the building which had no automatic doors or call bell system.</p> <p>At our previous inspection in October 2015, we identified that the business continuity plan (major incident plan) was not effective and should be improved. For example, the plan stated the practice had an arrangement to use the premises of two nearby GP practices but did not include the names of the practices or details of the arrangement. We saw the plan now stated the names of the practices. However, the arrangements remained unclear. The plan was not comprehensive as it did not cover a wide range of possible events such as a fire, flood or unexpected staff shortages.</p> <p>Staff had not received formal training in preparation for a major incident but had some understanding on how they would respond to a medical or fire emergency.</p>	



## Appropriate and accurate information

### The practice did not always act on appropriate and accurate information.

	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.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The practice was mostly comparable to local and national averages for QOF indicators. The practice's uptake for cervical screening was similar to the local and national averages however, below the 80% coverage target for the national screening programme. The practice was aware and taking action to address this.</p> <p>Not all information was accurate, reliable or timely. Patients electronic records did not always demonstrate why a patient did not have a test or investigations as appropriate codes were not used. The records of some patients on high risk medicines did not provide clear accurate information on last reviews and blood tests.</p> <p>The arrangements for identifying, managing and mitigating risks were not always effective in areas such as medicine management.</p>	

## 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:	
<p>The results of the most recent national GP survey showed that the practice scored higher than the local average in every question. In some questions the practice score was also higher than the national average. There were no areas where the practice was below local or national averages. However, the provider acknowledged ongoing work was required to sustain positive feedback and ensure ongoing monitoring of the quality of the service. The practice had gathered feedback from patients through the patient participation group (PPG), surveys and comments and complaints received. As a result of</p>	

feedback from patients and the PPG the practice had recruited a female locum GP. In order to continue improving access a health care assistant was recently recruited and there were plans to recruit a practice nurse. The practice had recently started extended opening hours every Tuesday evening and there was an extended hours service on weekends, this service was alternated across the practice and two other local Hub practices.

#### Feedback from Patient Participation Group.

Feedback
The practice had a patient participation group (PPG). We spoke with one member who told us there were approximately 20 members and they met once a month to discuss ideas and service improvements. They explained that although a in house survey had not been completed patients views and concerns were encouraged. There was a good relationship with the practice, the lead GP and practice manager attended all meetings, this ensured collaborative working.

Any additional evidence
There was a PPG poster in the patient waiting area however, there were no information to encourage new participants or details of meetings, the PPG member told us they would address this.

#### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
*Demonstrated by prescribing audits which showed improvements made during re audit.	

Examples of continuous learning and improvement
Learning and improvement was encouraged through staff appraisals and meetings. The practice made use of internal and external reviews of incidents and patient safety alerts and learning was shared and used to make improvements. A number of clinical audits were completed and provided the opportunity to learn and improve.
The practice worked collaboratively with two local practices to provide extended opening hours for patients. The future was to merge services and locate to a new purpose-built building to improve services and facilities for patients.

#### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the

practices performance is genuinely different from the average. It is important to note that 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.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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.