

Care Quality Commission

Inspection Evidence Table

Lavender Hill Group Practice (1-569303018)

Inspection date: 26 February 2019

Date of data download: 20 February 2019

Overall rating: add overall rating here

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

Safe

Rating: Requires improvement

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse but they were not always embedded.

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.	Y
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
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:	

Safeguarding	Y/N/Partial
The practice did not have effective oversight of staff training. We reviewed staff training records and found that not all staff had received safeguarding training in line with practice policy and national guidelines. Following inspection, the practice sent us confirmation that staff had completed safeguarding training, however we found that two practice nurses were not working towards the appropriate competency as set out in the intercollegiate guidance 2018.	

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

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: July 2018	Y
There was a record of equipment calibration. Date of last calibration: June 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: November 2018	Y
There was a log of fire drills. Date of last drill: November 2018	Y
There was a record of fire alarm checks. Date of last check: 25 February 2019	Y
There was a record of fire training for staff.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: February 2018	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: On inspection, the practice was unable to evidence that all staff had completed fire safety training. We reviewed staff training records and found that two members of staff had not completed fire safety	

training. Following inspection, the practice sent us confirmation that all staff had completed the required training.

We reviewed the practice's fire risk assessment and found that the practice had not monitored if recommended actions had been completed. Following inspection, the practice sent us confirmation that they had completed the recommended actions to mitigate risk. However, the practice had not addressed each area identified on the risk assessment. Their action plan had identified 12 points which required action whereas the fire risk assessment had identified 14 points which required action. The practice did not have oversight of this.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 19 February 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30 January 2018	Y
Explanation of any answers and additional evidence: We reviewed the practice's health and safety risk assessment and found that they did not have effective oversight of required actions as they did not record if actions needed had been completed to minimise risk. Following inspection, the practice sent us evidence to show that some actions were completed as required, however we found that not all items identified as requiring action on the risk assessment had been identified on the practice's action plan. For example, it was identified that risk assessment should be reviewed and re-signed on an annual basis however the practice was unable to evidence that this was actioned.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were 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:	September 2018
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: We reviewed the practice's infection prevention and control (IPC) audit and found that they did not record if actions needed had been completed to minimise risk. Following inspection, the practice sent us evidence to show that actions had been completed or were in the process of completion, as required.	

Risks to patients

There were adequate in systems to assess, monitor and manage risks to patient safety but they were not always embedded.

	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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice's process to monitor and mitigate risks relating to Legionella did not keep patients safe. A Legionella risk assessment had been conducted for the practice December 2017 however no actions had been recorded as completed on the risk assessment. The practice evidenced that they had been recording the water outlet temperatures, however the temperatures recorded were not within a safe range and no actions had been identified to mitigate this risk. Out of range water temperatures were identified on the risk assessment as a high priority and that an investigation should be conducted, and an action plan created to combat any faults identified. The risk assessment identified that this action should be completed within three months of the assessment date. The practice could not evidence that this had been done.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y

There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation but these were not always embedded.

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)	0.51	0.72	0.94	Significant Variation (positive)
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)	9.0%	10.5%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	5.58	5.81	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	1.18	1.28	2.22	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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures 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.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems 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>The practice demonstrated that they kept a log of blank prescription stationery when these were delivered to the practice, however they did not keep a log of blank prescription stationery held in clinician's rooms.</p> <p>The practice's process to ensure medicines were in date and safe to use was not embedded. On inspection we were told that daily checks were conducted of the medicine fridges and a monthly stock check was conducted. However, on inspection we found three Hepatitis B vaccines dated December 2018, which were out of date. We raised this with the practice and they were removed by the end of the day.</p> <p>The practice's process to ensure medical equipment was in date and safe to use was not embedded. On inspection, we were told that the nurses had responsibility to conduct stock checks in their designated treatment rooms however no record was kept to ensure this was actioned and we found a tray of blood collection pots which had expired in October and December 2018. We raised this with the practice and they were removed by the end of the 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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7

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

Event	Specific action taken
A significant event was raised when a patient with a complex medical history presented with increased breathlessness. The practice carried out multiple investigations but no cause was found. It was later identified that a chest x-ray had been conducted 18 months previously and not repeated. The patient was later diagnosed with lung cancer.	This was discussed at a significant event meeting and the practice created a new prompt and template for patients presenting with similar symptoms in order to prevent this from happening again.

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

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial

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

The practice developed their own in-house diabetic clinic after it was identified that patients did not have consistent access to a community diabetic nurse. The clinics were run by two GPs and one nurse who had received further training in this area so that they could conduct more detailed reviews of their diabetic patients. Patients who did not have their blood sugar levels within a safe range would either receive a phone call or would be asked to attend the practice. They would then have a review conducted by either a nurse or a GP to find a way to bring their blood sugar levels under control. The practice told us that this intervention had increased the number of patients whose blood sugar levels were within a safe range from 81% to 90%.

The practice participated in a federation led Putting All Care Together (PACT) programme which led them to identify vulnerable patients to offer appropriate support. A PACT register was maintained by the practice This included patients who had learning difficulties, were housebound or had complex medical conditions. The patients identified would then be invited in for a longer appointment at the practice or would receive a home visit in which they would be involved in formulating a personalised care plan. The patients would then receive ongoing monitoring by the practice which enabled GPs to have contact with them on a continuing basis rather than just when they were acutely unwell.

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) <small>(NHSBSA)</small>	0.65	0.77	0.81	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicine 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.
- 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) <small>(QOF)</small>	83.1%	73.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	16.8% (56)	8.1%	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) <small>(QOF)</small>	72.2%	72.1%	77.7%	No statistical variation
Exception rate (number of exceptions).	13.8% (46)	6.9%	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) <small>(QOF)</small>	81.3%	76.4%	80.1%	No statistical variation
Exception rate (number of exceptions).	13.5% (45)	7.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
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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)	73.7%	76.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.1% (11)	2.1%	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)	96.2%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	10.2% (12)	7.3%	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)	80.6%	80.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.3% (58)	2.8%	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)	92.5%	87.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.5% (7)	6.3%	6.7%	N/A

Any additional evidence or comments

On inspection, we discussed the higher than average exception reporting figures for diabetic indicators with the practice. The practice told us that they were aware that the practice's figure was higher than local and national averages and that they were working to reduce it. It was felt that the introduction of the diabetic clinic held at the practice would contribute to the reduction in exceptions. We reviewed two records where a patient had been excepted and found that this had been carried out appropriately in line with best practice guidance.

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 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)	151	165	91.5%	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)	131	142	92.3%	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)	128	142	90.1%	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)	129	142	90.8%	Met 90% minimum (no variation)

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 medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
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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)	68.4%	66.4%	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)	66.3%	64.4%	70.5%	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)	51.7%	48.2%	55.1%	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)	75.0%	77.3%	70.5%	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)	50.0%	48.1%	51.9%	No statistical variation

Any additional evidence or comments

The practice was aware that their cervical screening uptake figures were below national targets of 80%. In order to improve on this, they had assigned a nurse and administration lead to contact non-responders by telephone. They also worked with a community links organisation to promote uptake of screening. At the time of inspection, the practice was unable to demonstrate the impact these changes had made.

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 homeless people, travellers and those with a learning disability.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for

physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

- 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)	92.9%	92.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	10.9% (12)	7.1%	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)	97.0%	92.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.1% (10)	6.0%	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)	88.9%	85.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.6% (1)	5.7%	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)	542.4	537.7	537.5
Overall QOF exception reporting (all domains)	4.8%	4.3%	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

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

<p>The practice carried out a two-cycle audit to assess whether they were requesting a specific blood test, which assists in diagnosing a rare autoimmune disease, appropriately.</p> <p>The first cycle covered the period 1 October 2016 to 31 March 2017. A total of 25 blood tests had been carried out between this period. Of these only five tests were carried out in line with best practice guidelines where the autoimmune disease was suspected. None of the patients were diagnosed with the auto immune disease that was a potential diagnosis. As a result, the practice re-circulated the guidance to clinicians and recommended blood tests should only be carried out where there was more than one clinical feature of the autoimmune disease.</p> <p>The second cycle of the audit covered the period 1 April 2017 to 23 February 2018.</p> <ul style="list-style-type: none"> • A total of 25 blood tests were carried out. • Of these 13 were deemed to have been appropriately carried out and one of the patients was diagnosed with the auto immune disease. • The practice determined that there had been some improvement, but would reiterate with clinicians the guidance and monitor future blood test results.

Effective staffing

The practice was able 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.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	n/a

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
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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.	Y

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

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	96.8%	94.7%	95.1%	No statistical variation

(01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0.1% (1)	0.6%	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

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive.

	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

CQC comments cards

Total comments cards received.	20
Number of CQC comments received which were positive about the service.	19
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	1

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
13055	407	126	31%	0.97%

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)	90.0%	90.4%	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)	93.2%	88.0%	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)	98.3%	96.2%	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)	92.1%	87.3%	83.8%	No statistical variation

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

Any additional evidence
With the assistance of the patient participation group (PPG) the practice had conducted surveys for patients with particular conditions to determine if they were satisfied with level of care they had received and any areas for improvement. For example, they had conducted surveys for patients with diabetes and for patients who were hard of hearing. The results were then discussed at a focus group meeting with those patients and actions identified were passed to the practice. For example, it was identified that patients who attended a flu clinic might benefit from a hearing test. The practice contacted Action on Hearing Loss who ran a clinic alongside the flu clinic in October 2018.

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

Source	Feedback
Interviews with patients.	Feedback from patients included that their privacy and dignity was respected by all staff and that they felt included in their care and treatment.

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)	94.9%	95.2%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	A total of 78 carers had been identified, this represented 0.6% of patient population.
How the practice supported carers.	The practice had a section on their website dedicated to patients who were carers and they had a carers board in the reception area. They included information such as what benefits are available to carers.

How the practice supported recently bereaved patients.	Patients who were recently bereaved would be contacted by their named GP.
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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

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence: The practice was part of a federation of local practices which offered extended access at a GP hub site for patients over the weekend. This gave patients access to pre-bookable appointments on Friday evenings and all day on Saturdays and Sundays.	

Practice Opening Times

Day	Time
Opening times:	
Monday	8:00am to 8:00pm

Tuesday	8:00am to 8:00pm
Wednesday	8:00am to 8:00pm
Thursday	8:00am to 8:00pm
Friday	8:00am to 6:30pm
Appointments available:	
Monday	8:20am to 11:00am to 2:00pm to 8:00pm
Tuesday	8:20am to 11:00am to 2:00pm to 8:00pm
Wednesday	8:20am to 11:00am to 2:00pm to 8:00pm
Thursday	8:20am to 11:00am to 2:00pm to 8:00pm
Friday	8:20am to 11:00am to 2:00pm to 6:00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
13055	407	126	31%	0.97%

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)	94.9%	94.3%	94.8%	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> We found there were systems to identify and follow up children living in disadvantaged

circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

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

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 ran a commuter clinic Monday to Thursday between 6.30pm and 8.00pm for working patients who could not easily attend appointments during the working day.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Longer appointments and evening appointments were available for patients if required.

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

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)	95.6%	N/A	70.3%	Significant Variation (positive)
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)	85.3%	74.2%	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)	80.3%	70.5%	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)	77.1%	74.8%	74.4%	No statistical variation

Source	Feedback
NHS Choices – Rated 4.5 stars out of 5	Feedback from patients included that they were happy with the choice of appointments available including evening and telephone appointments; and they were happy with the consistent care they had received; and they felt that the practice was efficient in setting up appointments and referrals.

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 since January 2018.	11
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	11
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	11

	Y/N/Partial
Information about how to complain was readily available.	partial
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Information on how to complain was available in reception and patients were given a complaints leaflet at the point of registration. Information on how to complain was also available on the practice's website, however patients were advised that should they choose to raise a formal complaint they should do so by sending in their concerns in writing and did not take account of patients who were unable to do this.	

Well-led

Rating: Requires improvement

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

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

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
CQC staff questionnaire	Feedback from staff included that they felt supported by the practice and that it was a great team environment.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	partial
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have proper oversight of staff training. We reviewed staff training records and the practice was unable to evidence that all staff had received appropriate training in line with practice policy. Following inspection, the practice sent us confirmation that staff had completed the training as required.</p> <p>The practice's process to ensure all medicines and medical equipment was in date was not fully effective. On inspection, we found three vaccines dated December 2018 and medical equipment dated October and December 2018.</p>	

Managing risks, issues and performance

There were clear and effective processes for managing issues and performance, however the process for managing risks was not embedded.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
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.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice's process to ensure actions identified from risk assessments were completed was not embedded. We found that the actions needed were not marked as completed on risk assessments and therefore the practice could not be assured that all potential risk had been mitigated. Following inspection, the practice sent us confirmation that actions identified on the risk assessments had been completed. However, these did not address all concerns raised in the risk assessments. Furthermore, no process had been put in place to address the concerns identified in the Legionella risk assessment and the water temperatures as logged by the practice, were not within a safe range.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

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: The practice received feedback from patients and staff that the toilet facilities were not appropriate for use. This was acted on and the toilets had been refurbished. The practice had also received feedback from their nursing team, that they felt a 10 minute appointment length was not sufficient. This was acted on and the practice introduced 15 minute appointments.	

Feedback from Patient Participation Group.

Feedback
On inspection we met with the chair of the patient participation group (PPG). They advised that the

practice were open to hearing suggestions on how they could improve services for patients. For example, the PPG raised the issue that access to the practice was difficult for wheelchair users as the front door was heavy and the reception desk was too high. As a result, the practice introduced an automatic door system and lowered part of the reception desk so that it was more accessible to wheelchair users.

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.	Y
Learning was shared effectively and used to make improvements.	Y

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.
- 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.