

# Care Quality Commission

## Inspection Evidence Table

### Forest End Medical Centre (1-572215550)

Inspection date: 1 May 2019

Date of data download: 29 April 2019

## Overall rating: Requires Improvement

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

### Safe

### Rating: Requires Improvement

#### Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, safety training requirements required a review and there was no oversight of health and safety information for one of the branch sites.

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 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).	Partial (a)
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
<p>(a) All staff had received initial training in adult and child safeguarding. Most staff had also received regular updates. The training matrix showed one GP, two nurses and three administration/reception staff were overdue for their safeguarding updates (for one or both adult and child).</p> <p>The training matrix did not identify which level of training for safeguarding each staff member had undertaken. We asked to see copies of training certificates and found not all the nurses or GPs had been trained to level three safeguarding children as recommended by the intercollegiate guidance for child safeguarding published in January 2019. It was also unclear if the non-clinical staff had undertaken level two safeguarding children training, where appropriate. The practice policy did not identify the levels of required training and stated staff training would follow local guidance.</p> <p>All the staff we spoke with on the day of the inspection had suitable knowledge of safeguarding and how to raise a concern. They were all aware of the safeguarding lead and who to go to if they had a concern.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y (b)
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N (c)
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
<p>Explanation of any answers and additional evidence:</p> <p>(b) We looked at ten staff recruitment files (five clinical, five non-clinical) and found they all contained Disclosure and Barring Service (DBS) checks (or risk assessments where appropriate), proof of identity and references. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).</p> <p>One staff file did not contain any interview notes and none of the staff files contained evidence of health status checks. (Staff health status checks identify if there are any physical or mental health conditions that may require reasonable adjustments to ensure their wellbeing and safety at work).</p> <p>(c) We found evidence of staff immunisation status in five of the ten staff files (all clinical). There was no established protocol or system to request the immunisation status of all staff in line with guidance. (Knowing the immunisation status of staff ensures both patient and staff safety when dealing with potential infectious diseases or exposure to these, such as measles or chicken pox).</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: April 2019 (all sites)	Y
There was a record of equipment calibration. Date of last calibration: March 2019 (all sites)	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: January 2019 (Forest End site) December 2018 (Boundary House site) Not seen (Skimped Hill site)	Partial (d)
There was a log of fire drills. Date of last drill: February 2019 (Forest End site) January 2019 (Boundary House site) 2019 (uncertain of month) (Skimped Hill site)	Y
There was a record of fire alarm checks. Date of last check: April 2019 (weekly checks at Forest End and Boundary House sites) No evidence seen at Skimped Hill site	Partial (d)
There was a record of fire training for staff. Date of last training: Various dates	Partial (e)
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2019 (Forest End site) April 2019 (Boundary House site) Not seen (Skimped Hill site)	Partial (d)
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(d) The premises at Skimped Hill was utilised under a tenancy arrangement and the provider did not have oversight of their fire safety risk assessments or equipment checks.</p> <p>The provider reviewed this arrangement on the day of the inspection and showed us an action plan to ask for the necessary risk assessments and safety checks for the Skimped Hill facility from the site manager of the property. They also told us they would schedule regular updates with the site</p>	

manager.

- (e) The training matrix and training certificates we saw demonstrated various dates for online and face-to-face training for most staff. We found two clinical and three non-clinical staff were overdue their updates for fire safety training.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: March 2019 (all sites)	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2019 (all sites)	Partial (f)
Explanation of any answers and additional evidence:	
<p>(f) The provider had carried out legionella testing of their water supplies at two practice sites. (Legionella is a bacterium that affects water supplies). The Forest End site had undertaken a legionella risk assessment in April 2015 and had a sample of water tested in March 2019. We noted there was no regular flushing of less used taps or water temperature testing being carried out at the Forest End site.</p> <p>At the Boundary House site a legionella water sample had been undertaken in January 2019, but they could not show us a legionella risk assessment. There was also no evidence of water flushing or temperature checking being carried out.</p> <p>The provider did not have oversight of the legionella status or risk assessment of the Skimped Hill site.</p> <p>The provider reviewed this arrangement on the day of the inspection and showed us an action plan to implement regular temperature checking. They also told us they would contact an external company to request a new legionella risk assessment which they planned to have by the end of June 2019. In addition, they told us they would seek the legionella status information from the facilities team at the Skimped Hill site.</p>	

## 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.	Partial (g)
Date of last infection prevention and control audit: Forest End site: 25 April 2019 Boundary House site: 29 April 2019 Skimped Hill site: 27 June 2018	Y
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 (h)
Explanation of any answers and additional evidence:	
(g) The practice showed us their training matrix and we viewed a selection of training certificates. We	

found one clinical and seven non-clinical staff had not received up to date training in infection control. The lead nurse for infection control did not maintain oversight of staff infection control training.

(h) We were told staff had received in-house training for handling specimens, but not all the non-clinical staff we spoke with could confirm this.

There was differing information from staff at the three practice sites as to who the infection control lead was. The role had recently been designated to one of the practice nurses, but this information had not been passed to all staff.

## 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.	Partial (i)
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:	
(i) Non-clinical staff we spoke with on the day of the inspection could demonstrate they could identify symptoms of serious illness such as sepsis, however, we noted that not all the reception staff had received training on sepsis.	

## 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 in place for the appropriate and safe use of medicines, including medicines optimisation. However, non-medical prescriber's clinical supervision and emergency medicines required reviewing.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.62	0.88	0.91	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). (01/01/2018 to 31/12/2018) (NHSBSA)	9.0%	9.1%	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 (01/07/2018 to 31/12/2018) (NHSBSA)	5.73	5.70	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	2.19	1.81	2.13	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 Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N (j)
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

Medicines management	Y/N/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.	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
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
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 (k)
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.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(j) We saw prescribing audits undertaken by the clinical commissioning group which demonstrated positive outcomes for prescribing (as a generic audit of data). However, we were not shown any examples of clinical supervision or audit for the non-medical prescribers and staff told us they were not formally supervised. We were satisfied that prescribing competence had been established for these staff as part of their recruitment and induction processes.</p> <p>(k) The practice did not stock an antibiotic used for the initial emergency treatment of infection, such as sepsis, at any of the three practice sites. They had not undertaken a risk assessment for this. They told us they would review this after the inspection.</p>	



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

**The practice learned and made improvements when things went wrong. However, not all staff were aware of the process for identifying and escalating an incident or concern.**

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.	N (I)
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.	N (I)
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	19
Number of events that required action:	19
Explanation of any answers and additional evidence: (I) There was a lack of awareness amongst the non-clinical staff we spoke with, of what would constitute a significant event and how they should be raised. There was confusion over who the lead was for significant events and where the reporting forms were located. GPs and management staff told us all staff had received training on significant events and were unaware of the lack of understanding. They told us they would revisit the training after the inspection.	

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

Event	Specific action taken
A fire alarm triggered an evacuation of the building (not a test).	Learning actions identified a lack of trained fire wardens across all sites. Training was sought and initiated.
Information regarding a patient had been submitted to a generic email address and was not actioned in a timely manner.	All staff given access to NHS mail and staff reminded to check the generic email frequently throughout the working day.
An emergency button was activated but did not work.	Staff were reminded there is an emergency call system on the computer system. The practice initiated a checking system for emergency buttons.

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: Requires improvement

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed. 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.	N (m)
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
<p>Explanation of any answers and additional evidence:</p> <p>(m) The practice operated a "sit and wait" appointment system for patients who required a same day appointment when there were no appointments left for that day. The reception team asked patients if their need was urgent and advised to arrive at the practice at a specific time to sit and wait. When patients arrived they were given a numbered ticket indicating where they were in the sit and wait queue. There was no assessment of patient needs or to determine if there were any priorities. We were told patients could be waiting up to 1.5 hours to be seen.</p> <p>Some members of the reception team had been trained to recognise signs of serious illness and staff we spoke with on the day of the inspection told us they would escalate any concerns to the duty GP. There was a risk that a patient may wait to be seen when their care should be prioritised, as there was no assessment or triage when they arrived to attend the sit and wait service.</p> <p>We did note that both waiting areas at the Forest End site and Boundary House site had open waiting areas that were in full view of the reception staff and patients could be observed whilst they waited to be seen.</p>	

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) (01/01/2018 to 31/12/2018) <small>(NHSBSA)</small>	0.47	0.70	0.79	No statistical variation

**Findings**

We have rated the practice as requires improvement for providing safe, effective and well led services. These areas impacted all population groups and so we have rated all population groups as requires improvement. However, we did see areas of good practice;

- 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 carried out weekly ward rounds at a local residential and care home for patients registered with Forest End Health Group.
- 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.
- The practice had access to a paramedic practitioner who could undertake home visits to assess the needs of older, vulnerable patients. The paramedic was recruited by the federation of Bracknell and Ascot GPs.

## Findings

We have rated the practice as requires improvement for providing safe, effective and well led services. These areas impacted all population groups and so we have rated all population groups as requires improvement. However, we did see areas of good practice;

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice had initiated a monitoring function on their computer system to determine if patients were overdue any testing or other intervention for their long term condition. Staff could access this by pressing the F12 key to bring up a window on the screen. Information within the window indicated what medical conditions were added to the patient record and what follow up and testing they may require as part of their ongoing monitoring. This was currently only available for a few high risk medicines and the practice had plans to expand to other conditions requiring regular review and monitoring.
- The practice had been allocated a clinical pharmacist who had been recruited by the federation of Bracknell and Ascot GPs. They were still defining their role to include reviewing patients on long-term medications and dealing with minor ailments.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	80.5%	78.6%	78.8%	No statistical variation
Exception rate (number of exceptions).	23.2% (119)	14.1%	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>	72.0%	82.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	14.6% (75)	7.7%	9.8%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	81.3%	79.8%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.7% (91)	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) <small>(QOF)</small>	77.9%	76.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	5.0% (35)	3.2%	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) <small>(QOF)</small>	90.6%	92.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	11.5% (18)	7.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.1%	83.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.6% (80)	3.6%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.6%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.6% (3)	6.2%	6.7%	N/A

#### Any additional evidence or comments

The practice showed us their unverified data for the Quality and Outcomes Framework (QOF) 2018/19:

- The percentage of patients on the diabetes register who had attained a blood sugar level of 64mmols or less in the preceding 12 months was 80% (similar to the previous QOF year) and exceptions had stayed at 24%.
- The percentage of patients on the diabetes register who had a recorded blood pressure of 140/80 or below in the preceding 12 months was 73% (an increase of 1% from the previous QOF year) and exceptions had reduced to 8%.
- The percentage of patients on the diabetes register who had attained a cholesterol blood level of 5mmols or less was 78% (similar to the previous QOF year) and exceptions had risen to 18%.

The practice told us they regularly reviewed their QOF achievement and exceptions throughout the year and actively encouraged patients to attend for reviews. We were told all patient records were reviewed by a GP before applying exception criteria.

## Findings

We have rated the practice as requires improvement for providing safe, effective and well led services. These areas impacted all population groups and so we have rated all population groups as requires improvement. However, we did see areas of good practice;

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

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) (i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	168	173	97.1%	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)	147	155	94.8%	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)	147	155	94.8%	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)	147	155	94.8%	Met 90% minimum (no variation)

### Any additional evidence or comments

The nursing team had proactively followed up parents of children requiring immunisations to ensure attendance. There was a text messaging system for reminders of appointments which had contributed to the uptake of immunisations for young patients.

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

### Population group rating: Requires improvement

#### Findings

We have rated the practice as requires improvement for providing safe, effective and well led services. These areas impacted all population groups and so we have rated all population groups as requires improvement. However, we did see areas of good practice;

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	75.2%	71.1%	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)	68.7%	70.3%	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)	50.0%	50.9%	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)	70.8%	79.8%	70.2%	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)	54.5%	48.3%	51.9%	No statistical variation



### Any additional evidence or comments

The practice showed us their unverified data for cervical screening for the year 2018/19. This demonstrated an 81% achievement which was in line with the NHS England target of 80%.

### People whose circumstances make them vulnerable

### Population group rating: Requires improvement

#### Findings

We have rated the practice as requires improvement for providing safe, effective and well led services. These areas impacted all population groups and so we have rated all population groups as requires improvement. However, we did see areas of good practice;

- 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.
- 58% of patients with a learning disability had received a health check in the preceding 12 months. The practice had a plan to increase the uptake of these.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

### People experiencing poor mental health (including people with dementia)

### Population group rating: Requires improvement

#### Findings

We have rated the practice as requires improvement for providing safe, effective and well led services. These areas impacted all population groups and so we have rated all population groups as requires improvement. However, we did see areas of good practice;

- 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)	97.1%	93.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	13.9% (11)	8.1%	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)	93.3%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.1% (4)	6.5%	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)	76.2%	83.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	8.7% (6)	4.9%	6.6%	N/A

#### Any additional evidence or comments

The practice showed us their unverified data for the Quality and Outcome Framework (QOF) 2018/19:

- The percentage of dementia patients who had received a review of their care plan in the preceding 12 months had risen to 85% and the total number of exceptions had reduced to 6%.

## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	551.9	549.4	537.5
Overall QOF exception reporting (all domains)	6.5%	5.5%	5.8%

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

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

### Monitoring of thyroid stimulating hormone (TSH) in patients (July 2018)

One of the GPs undertook an audit of patients receiving medication to control thyroid levels. The audit was initiated to ensure patients were monitored appropriately. (Guidance from the national institute for clinical excellence (NICE) suggests a minimum of annual blood test monitoring for stable patients).

From the first audit, 78 patients were identified who had not received a blood test for monitoring in the preceding 15 months. The practice contacted these patients and arranged for testing. An alert was added to the patient records and GPs were reminded of the guidance.

The second audit, six months later, identified there were 22 patients that still required their blood test monitoring. This demonstrated that 56 patients had been monitored for their thyroid levels and annual reminders were in place.

### Adherence to anti-epileptic medication (February 2018)

This audit reviewed patient compliance with taking anti-convulsant medication by reviewing prescription issues on repeat and identifying any that had not been collected.

Of the total number of patients on the epilepsy register, 11% of patients had not collected their regular prescription. These patients were contacted, and the GP discussed the importance of compliance with medication use for each patient. Patients were also offered an educational leaflet.

At the end of the audit process all patients had been contacted and reviewed.

The practice had not repeated the audit since the merger.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial (n)
The learning and development needs of staff were assessed.	Partial (n)
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
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.	N (o)
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>(n) We were shown the practice staff training matrix and asked to see a selection of staff training certificates. We noted a number of gaps in staff training records including safeguarding children and adults, fire safety and infection control. Staff we spoke with had suitable knowledge of these areas.</p> <p>(o) Staff appraisals had not been regularly carried out for most staff. All but two appraisals had not been undertaken in the preceding 12 months. Ten staff were overdue their appraisal by one month.</p> <p>The practice had an action plan to address this in the next few months. The action plan included offering training to staff in lead roles to undertake appraisal training.</p> <p>(o) We also noted that non-medical prescribers, such as members of the nursing team with a prescribing qualification, did not receive any ongoing clinical supervision or oversight. The practice policy for clinical supervision outlined the supervision for new staff, trainees and staff working a probation period (such as a newly qualified prescriber). It did not outline any continuing or ongoing clinical supervision.</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.	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 (p)
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: (p) The practice had actively promoted cancer screening services and patient uptake of these was in line with national uptake rates.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	95.1%	95.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.8% (18)	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

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

CQC comments cards	
Total comments cards received.	48
Number of CQC comments received which were positive about the service.	37
Number of comments cards received which were mixed about the service.	10
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Comment cards	We received one overall negative comment regarding staff attitude.
Comment cards	We received two mixed comments relating to differences in care and treatment between the Forest End and Boundary House Practice sites.
Comment cards	There were eight further mixed comments received across the two sites. The negative comments related to appointment availability, access to the practice by phone and waiting times. The positive comments related to caring and professional staff and receiving a good service. There were also comments around the practices being clean and staff being helpful.
Comment cards	There were 37 positive comment cards received. Most of them praised staff and told us they were caring and considerate to their needs. Some stated they were able to get appointments when they needed them including having the sit and wait system which guaranteed they were seen. There were also comments relating to professionalism and helpfulness of staff.

## 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
19931	306	107	35%	0.54%

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)	92.4%	86.5%	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)	88.9%	85.2%	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%	94.9%	95.6%	Tending towards variation (positive)
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)	85.1%	80.7%	83.8%	No statistical variation

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

Any additional evidence
<p>The practice had carried out patient surveys in conjunction with the patient participation group in the past, with the last survey being in 2017. There had been no patient surveys undertaken since the merger of Forest End Medical Centre with Boundary House Surgery.</p> <p>The practice was aware of the national patient survey results and data from the friends and family test which demonstrated positive outcomes for caring.</p>



## 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.	Partial (q)
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: (q) Not all staff were aware of the accessible information standard and how to access communication support for patients.	

Source	Feedback
Comment cards	We received a number of positive comments stating patients felt they received explanations about their care and were offered appropriate advice.

## 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)	91.7%	92.8%	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.	The practice had identified 139 patients as a carer. This was less than 1% of their patient list.
How the practice supported carers.	The practice signposted carers to a local support organisation and they were offered an annual flu vaccine.
How the practice supported recently bereaved patients.	The practice contacted bereaved patients to offer their condolences and signposted patients to further support.

## 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.

	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

Practice Opening Times	
Day	Time
<b>Opening times (all sites)</b>	
Monday to Friday	8am to 6.30pm
<b>Appointments available in core hours (across sites)</b>	
Monday to Friday	Morning: 8.10am to 11.10am
	Afternoon: 2pm to 5.40pm
<b>Extended Hours</b>	
The practice offered extended hours clinics on weekday mornings and Monday evenings. They also encouraged patients to attend the extended hours service which was provided by the federation of Bracknell and Ascot GPs. The service had a high uptake of use from patients registered with Forest End Medical Centre. When patients used the extended hours service their records were accessed by the federation and could be updated in real time, so GPs could review patient care.	

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
19931	306	107	35%	0.54%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	97.3%	94.1%	94.8%	No statistical variation

### Older people

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>All patients had a named GP who supported them in whatever setting they lived.</li> <li>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.</li> <li>The practice had access to social prescribers who could assess social needs of older patients and offer support and signposting to organisations.</li> <li>Patients who were housebound were offered the flu vaccination and this was administered in their place of residence.</li> </ul>

### People with long-term conditions

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>Most patients with multiple conditions had their needs reviewed in one appointment.</li> <li>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.</li> <li>Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.</li> <li>The practice facilitated a health coach to discuss coping strategies with patients diagnosed with a long term health condition. The health coach was employed by an external health organisation.</li> </ul>

## Families, children and young people

Population group rating: Good

### Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice had considered the needs of young patients, who identified with characteristics of the autism spectrum, in the waiting room at the Forest End site and had decorated in colours that were known to offer a calming environment.

## 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 had promoted online access to patients to enable them to book appointments and request medications without contacting the surgery. They showed us evidence that 56% of their patient list had registered for this service.
- The practice had introduced a messaging system via the practice website for patients to request non-urgent contact, such as fit notes or to leave a message for a doctor or nurse.
- The practice offered early morning clinics Monday to Friday and a late evening clinic on Monday evenings, for patients who could not attend during core opening hours. If patients were unable to gain an appointment, staff encouraged them to attend the extended hours service provided by the federation of Bracknell and Ascot GPs. Pre-bookable appointments were available during the evenings Monday to Friday as well as on Saturdays and Sundays, when required.

## 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. For example, health checks and reviews were organised on quiet days and a longer time for the appointment was made.
- The practice had access to social prescribers who could assess social needs of vulnerable patients and offer support and signposting to organisations.

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

**Population group rating: Good**

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice had been one of the pilot sites for facilitating a talking therapies service for patients experiencing mental health conditions such as depression or anxiety.

**Timely access to the service**

**People were able to access care and treatment in a timely way, although initial care needs were not always assessed.**

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Partial (r)
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
<p>Explanation of any answers and additional evidence:</p> <p>(r) The practice operated a daily sit and wait appointment system with no triage or assessment of needs. This was offered to patients who had requested a same day appointment and had suggested their need was urgent. If no bookable appointments were available, the patient was advised to attend the sit and wait option. Patients were informed they would receive a five minute appointment with the duty GP and were allocated a number upon arrival at the practice. Prioritisation was based on first come, first served. We were advised the wait for this service could be up to 1.5 hours.</p> <p>Most reception staff had received training in recognition of the signs of sepsis and serious illness and told us they would escalate any concerns about patients, if required.</p> <p>We received two comments from patients via the comment cards, which stated they had a positive experience of the sit and wait system and found it quick and easy to access.</p>	

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)	74.2%	N/A	70.3%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)	63.4%	63.1%	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)	56.5%	61.6%	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)	70.9%	71.0%	74.4%	No statistical variation

#### Any additional evidence or comments

The practice was aware of the national patient survey results and had reviewed them from an individual site basis and as merged practices.

Overall there was high satisfaction with how patients were treated by the clinical staff, with the only aspect of care patients expressed dissatisfaction with was continuity of GP care.

Satisfaction with appointment times was below local and national averages and the practice had upgraded their telephone systems in July 2018 to increase outgoing lines (to minimise disruption to incoming calls), and had initiated cross-site call centre so calls could be answered from any site. They had also implemented a call monitoring system to analyse when the peaks of telephone access were and offer additional personnel to answer calls at these times.

Source	Feedback
Patient comment cards	<p>We received 48 comment cards from patients at the Forest End site (20) and the Boundary House site (28). Of these, 37 were positive about the care and treatment received, the professionalism of the teams and how well they have been looked after by the practice.</p> <p>There was one negative comment about staff attitude and ten mixed comments. The mixed comments included how there was a difference in the standard of care between the two sites and difficulty in getting a timely appointment. There was also one comment about preferring to be seen at one particular site, but being told to go to another site to see a GP.</p>
NHS website	<p>There had been five patient reviews left on the NHS website (formally NHS Choices) in the 12 months before the inspection. There were two 1-star reviews and three 5-star reviews.</p> <p>The 5-star reviews reflected positive experiences of the care and treatment received, staff helpfulness and able to get an appointment when needed, including a last minute appointment at the end of the working day.</p> <p>The 1-star reviews commented on the negative attitude of the reception staff, but praised clinical staff for their care and treatment. There was also concern over the merger and if this would actually improve the service provision.</p>

## 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.	17
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: We were shown the practice complaints log that included details of verbal and written complaints. We noted there was no indication of the practice learning actions on the log and complaints were not discussed at regular clinical or staff meetings. Staff we spoke with were aware of complaints that had directly affected them, but could not outline any themes or trends for the practice. We also reviewed four compliments received by the practice. One compliment praised all staff for their professional and reassuring response to a patients care.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A repeat prescription did not request enough supply for the patient's needs.	Clinicians reviewed the guidelines for prescribing specific medications to determine if safe to prescribe more than a one-month supply.
Staff attitude	Customer care and call handling skills training offered to non-clinical staff.



## Well-led

## Rating: Requires Improvement

### Leadership capacity and capability

**Leaders had the capacity and skills to deliver high quality sustainable care, but were not always visible and accessible to staff.**

	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.	Partial (s)
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: (s) Some staff told us the merger had been challenging and some systems and processes were not yet fully integrated or established. We were told leaders and managers were not visible across all the practice sites, although they were all approachable.	

### Vision and strategy

**The practice had a vision and strategy to provide high quality sustainable care. However, not all staff had been involved in developing the service.**

	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.	N (t)
Staff knew and understood the vision, values and strategy and their role in achieving them.	N (t)
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: (t) Some staff told us they had not been involved in discussions regarding the merger and could not describe the visions and values of the service.	

## 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.	Partial (u)
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
<p>Explanation of any answers and additional evidence:</p> <p>(u) Some staff from different practice sites told us they had not been offered the opportunity to meet staff from the merged practices and staff morale had been affected by the merger. Staff from the two main sites (Forest End and Boundary House) told us there were differing approaches to leadership and communication with staff.</p> <p>Staff also told us they felt they had positive relationships with managers and could discuss issues and concerns, although they tended to raise these with managers or GPs they had previously worked with (pre-merger).</p>	

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

Source	Feedback
Staff interviews	Merger has been challenging and difficult. Change was not managed well. Some disparity in working processes between sites.
Staff interviews	GPs are supportive. Practice manager does not visit other sites (Boundary House or Skimped Hill) often but can be contacted by telephone.
Staff interviews	Enjoy working for the practice and the team atmosphere.

## Governance arrangements

**The practice had identified lead responsibilities, staff roles and systems of accountability to support good governance and management, but these were ineffectively applied.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N (v)
Staff were clear about their roles and responsibilities.	N (w)
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(v) Governance arrangements had not identified gaps in staff essential training such as fire safety, infection control, serious illness/sepsis and safeguarding, or lack of knowledge of non-clinical staff on identifying and escalating significant events or incidents.</p> <p>(w) Staff were unclear of lead roles and who to approach if they needed to discuss any concerns. We were told communication with staff had reduced since the merger of the two practices. We saw staff meeting minutes where the lead roles had been disseminated, but not all staff were aware of these.</p> <p>We viewed a selection of practice policies which had been merged and reviewed. All staff knew how to access these on the practice shared drive, which was available across the three practice sites.</p>	

## 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.	N (x)
There were processes to manage performance.	N (y)
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N (x)
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(x) The practice did not have oversight of risk assessments for one of their branch sites (Skimped Hill) and had not considered accessing or undertaking these to ensure the premises were suitable and fit for use by staff and patients. There was no legionella risk assessment at Boundary House site and the practice had not acted on the recommendation of a legionella risk assessment, at the Forest End site, to undertake regular temperature checks and flushing of water outlets.</p> <p>There had been no risk assessment of the emergency medicines to determine which should be stocked</p>	

for use and any alternatives that could be used if a medicine was not available.  
 (y) Staff had not received regular appraisals to review performance and there was no system of clinical supervision for non-medical prescribers. In addition, reviews of staff health status had not been completed to ensure staff could receive reasonable adjustments to their work, if required.

**Appropriate and accurate information**

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

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

**Engagement with patients, the public, staff and external partners**

**The practice involved the public and external partners to sustain high quality and sustainable care. However, staff did not feel involved.**

	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.	N (z)
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:  (z) Some staff told us they had not felt involved in discussions or decisions about the merger and communication since the merger was not well managed. We were given an example of how there were two different processes for non-clinical staff for dealing with patients presenting with a possible urine infection. We were also told many decisions regarding merging processes had felt more like a takeover, with one practice site domineering the other.	

**Feedback from Patient Participation Group (PPG).**

Feedback
<p>We spoke with two members of the PPG who told us they had also merged the two practice PPGs as part of the merger. Both PPGs had discussed and agreed how they would work together and with the practice. They met every two months, ran patient education events and produced patient newsletters. They had also been involved in patient surveys in previous years, but they had not undertaken one in 2018 due to the merger.</p> <p>The patient education events had been very popular, and the PPG planned to continue with these annually. Previous topics included childhood illness, diabetes, dementia and arthritis. They were discussing which topics to include in the future to incorporate mental health and wellbeing.</p>

### Any additional evidence

One of the reception team had initiated a practice newsletter to help improve communication. There had been two newsletters produced in April 2019 and May 2019. The newsletters offered information on upcoming meetings and events and celebrated staff achievements outside of work.

### 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

### Examples of continuous learning and improvement

- The GPs had introduced peer reviews of all referrals, to identify any gaps in knowledge and to share learning.
- Three administration staff had been given clinical coding training and upskilled to view letters and documents coming into the practice, to reduce GP workload.
- The practice had introduced a messaging service accessible through the practice website. This enabled patients to leave requests for non-urgent issues and make appointments or request fit notes.

## 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 Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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