

Care Quality Commission

Inspection Evidence Table

Spring Street Surgery (1-548937393)

Inspection date: 30 April 2019

Date of data download: 18 March 2019

Overall rating: Good

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

Safe

Rating: Requires Improvement

At our previous inspection in July 2018 we rated the practice as inadequate for providing safe service because systems for reporting and recording significant events was not always effective and because the practice did not always have clear systems to manage risk, including safeguarding, recruitment, PGDs, and safety alerts. At this inspection the practice has been rated as requires improvement as although the practice had shown great improvement some systems and process needed to be further embedded. For example, the recording of actions from significant events and safety alerts, checking of required documents for the locums and ensuring the cold chain for fridges were maintained.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that the practice did not have clear policies and procedures including those for safeguarding. Staff had not received the appropriate safeguarding training or knew who the safeguarding leads were. Staff who acted as chaperones had not been DBS checked. Policies we reviewed did not always contain relevant and up to date information.</p> <p>At this inspection, we found the practice had reviewed and updated all policies and these were easily available for staff to access. We saw there was a policy spreadsheet that highlighted dates for policies to be reviewed by. Vulnerable adult and children's safeguarding policies had been reviewed and updated (vulnerable adult policies and procedures December 2018 and child safeguarding policies and procedures February 2019). Both contained safeguarding team contact details and up to date relevant information. Safeguarding team contact details were also readily available to all staff via a link on their computers.</p> <p>All staff had completed the relevant safeguarding training. Staff spoken with were aware of how to raise a safeguarding concern and felt able to approach and discuss safeguarding concerns with the appropriate safeguarding lead GPs. We also saw that staff had completed a safeguarding quiz to further embed their training.</p> <p>The practice had a system to identify vulnerable patients. Patients and their families were read coded and were identified with pop up flags on the IT system. The practice held a list of vulnerable patients. The practice had made reports regarding vulnerable adults and children to social services and the health visitor service.</p> <p>Staff had been DBS checked. The practice had decided to re-new DBS checks every three years. This was reviewed for non-clinical staff during appraisals and for GPs the practice had agreed that all would be done this year.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P
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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that the practice did not have all of the information required for recruitment files. At this inspection we found the practice had reviewed their records and now had the required information.</p> <p>The majority of staff were long term and had been at the practice a number of years. We reviewed the recruitment files for three members of staff including one new starter and found the relevant information included in the files.</p> <p>Previously, the practice manager had told us that training certificates for locum staff were not</p>	

requested. At this inspection we reviewed the locum check list and saw that training certificates for safeguarding and basic life support (BLS) were now requested. However, we reviewed the files for one locum and found that the training for safeguarding and BLS had not been recorded.

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: 29/01/2019	Y
There was a record of equipment calibration. Date of last calibration: 05/02/2019	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: October 2018	Y
There was a log of fire drills. Date of last drill: 27/09/2018	Y
There was a record of fire alarm checks. Date of last check: Checked weekly	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: 06/03/2019	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The building was owned and maintained by NHS Property Services. Health and safety assessments including fire risk assessments, legionella and electrical fixed wire risk assessment, were completed by NHS Property Services. The practice was made aware of the results of these assessments and any action required.</p> <p>At our inspection in July 2018, we noted that the last fire drill had taken place in 2016. Since that inspection the practice had completed their own fire drills. Staff we spoke with told us about an unscheduled fire drill due to work taking place in a separate part of the building. The evacuation was successful, and the practice was able to reflect on what happened. The practice had given additional training to staff named as fire wardens.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 03/04/2019	Y

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:	April 2019
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: A practice nurse was the practice infection control lead and had received appropriate training and regular updates. All staff had received annual infection control training and up to date information was available on the practice intranet.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: Information on recognising and dealing with sepsis was displayed in clinical rooms. All staff had received training in sepsis awareness. We also saw an "urgent conditions" list that was available for staff, this helped them to escalate any concerns to the GPs for immediate attention. Staff were able to tell us where emergency equipment was kept and what action to take in an emergency.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We noted that a significant event had been raised in relation to a two week wait referral which had been delayed. The practice had investigated the event and reviewed their procedures. This now included giving the patient a print out of what should happen within two weeks and who to contact if they had not received an appointment. The secretary also held a log of referrals made and completed a check to ensure patients had been offered an appointment within the required timescale.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.98	0.89	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	10.0%	9.3%	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	5.22	6.13	5.64	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) <small>(NHSBSA)</small>				
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) <small>(NHSBSA)</small>	1.86	1.45	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/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

Medicines management	Y/N/Partial
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.	P
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that some of the Patient Group Directions (PGDs) were out of date and not signed. At this inspection we found PGDs were appropriately detailed, signed and in date.</p> <p>Previously the practice did not have a policy for what to do with paper repeat prescriptions that had not been collected. During this inspection we saw that a policy had been created and staff took the appropriate action.</p> <p>For vaccines and medicines that required refrigeration, there was a cold chain procedure in place. Fridge temperatures were monitored electronically and also checked manually on a daily basis. However, we noted recorded for December 2018 there were missing entries for fridge checks for all four fridges. Action had not been taken or been raised with the practice manager.</p> <p>Patients who received high risk medicines (for example Warfarin) received appropriate checks. The practice had a procedure in place for the management of prescriptions and repeat prescribing. A register to track blank prescription forms was in place with details of prescription numbers recorded.</p> <p>Stock levels and expiry dates of emergency medicines and medical gases were checked. All medicines were seen to be in date.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, the system needed to be embedded further and the outcomes of actions taken needed to be recorded in more detail.

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.	P
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:	11
Number of events that required action:	8
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that the practice did not keep a complete record of significant events or the action taken and so there was no central information recorded to refer to. At this inspection, we found the practice had improved their system for significant events and all staff were aware of the process. Significant events were stored in a central location. However, there was no overview holding all of the appropriate information. We noted that outcomes and the dates these were completed were not centrally recorded. We viewed the new significant event form and found this to be complicated for staff to use. The practice told us they would ensure the process was further embedded and review the form so that it was easier to use. We saw evidence of events discussed at team meetings and the actions taken as well as a review of significant events from 1 April 2018 to 31 March 2019.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Staff member who monitored flu vaccines levels was absent and the practice ran out of flu vaccine during a flu clinic	The task to monitor the levels of vaccines was given to a second member of staff who would be able to cover for any absences and ensure that the required number of vaccines was available.
The immunisation vaccine storage refrigerators were unplugged and the vaccines inside compromised.	Staff took appropriate action and raised the incident as a significant event. Stocks of unsafe vaccines were removed and arrangements made for their destruction. External staff were informed of the importance of not to disconnect plugs. Covers over plug sockets were now in use so they cannot be mistakenly turned off.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that the practice did not keep a complete record of safety alerts received and could not demonstrate if any required action had taken place. At this inspection, we found the practice had improved their system for receiving safety alerts. Safety alerts were stored centrally, dated and recorded any action taken. However, we found a safety alert that had required specific action to be taken which had not been recorded as having been completed. The practice assured us they would ensure the process was fully embedded.</p>	

Effective

Rating: Good

Effective needs assessment, care and treatment

At our previous inspection in July 2018, we rated the practice as inadequate for providing effective services because some data relating to the management of long-term conditions was significantly lower than clinical commissioning group (CCG) and England averages. We also noted that in some areas there was a higher number of patients who were exception reported. Staff had not completed all of their mandatory training and non-clinical staff had not received an appraisal. At this inspection, we found significant improvements had been made and so were rated as good. The practice had reviewed all QoF data and had improved the care for patients. All staff had completed their mandatory training and had received an appraisal.

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
Explanation of any answers and additional evidence: At our previous inspection in July 2018, we found that the practice had not examined why some of their QOF scores were lower than national and England averages and where in a few areas their exception reporting was above average. At this inspection, we found the practice had taken a systematic approach to patient care and had conducted monthly QOF searches to ensure that care was being provided effectively for patients. We saw that in all areas the practices QOF scores had improved and that exception reporting had reduced and not just those areas highlighted from our previous inspection. Leaders within the practice had agreed that patients could only be exception reported on agreement by the GP who would first review the patient details. The practice was also able to use social prescribing for their patients and could signpost patients and carers to various support groups.	

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) (NHSBSA)	1.62	1.05	0.79	Tending towards variation (negative)

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.

The practices' clinical pharmacist conducted medicines reconciliation for patients (Medicines reconciliation is the process of ensuring that a patient's medication list is up-to-date).

People with long-term conditions

Population group rating: Good

Findings

Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Adults with newly diagnosed cardio-vascular disease were offered statins.

Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	79.0%	83.4%	78.8%	No statistical variation
Exception rate (number of exceptions).	3.8% (13)	10.2%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	52.6%	77.9%	77.7%	Significant Variation (negative)
Exception rate (number of exceptions).	6.1% (21)	10.0%	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>	72.8%	81.4%	80.1%	No statistical variation
Exception rate (number of exceptions).	12.0% (41)	13.6%	13.5%	N/A

Any additional evidence or comments

The practice had completed audits on their diabetic patients and we were able to see a marked improvement in their QOF scores. Please note that unverified data for 2018/2019 data had yet to be published:

Overall the QOF for diabetic patients had improved: -
01/04/2016 to 31/03/2017 – 76.3% exception reporting 38.5%
01/04/2017 to 31/03/2018 – 79.6% exception reporting 12%
01/04/2018 to 31/03/2019 – 98% exception reporting 2%

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
01/04/2016 to 31/03/2017 – 50.8% exception reporting 5.8%
01/04/2017 to 31/03/2018 – 52.6% exception reporting 6.1%
01/04/2018 to 31/03/2019 – 72% exception reporting 5.2%

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
01/04/2016 to 31/03/2017 – 81% exception reporting 1.4%
01/04/2017 to 31/03/2018 – 79% exception reporting 3.8%
01/04/2018 to 31/03/2019 – 87% exception reporting 2.2%

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
01/04/2016 to 31/03/2017 – 73% exception reporting 13.5%
01/04/2017 to 31/03/2018 – 73% exception reporting 12%
01/04/2018 to 31/03/2019 – 81% exception reporting 9.5%

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>	67.5%	73.4%	76.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	25.3% (98)	7.1%	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) <small>(QOF)</small>	84.0%	88.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	25.0% (25)	12.3%	11.5%	N/A

Any additional evidence or comments

The practice had completed audits on their patients with asthma and COPD and we were able to see a marked improvement in their QOF scores and a reduction in their exception reporting. Please note that unverified data for 2018/2019 data had yet to be published.

Overall the QOF for asthma patients had improved: -
01/04/2016 to 31/03/2017 – 95.2% exception reporting 41.7%
01/04/2017 to 31/03/2018 – 95.5% exception reporting 25.3%
01/04/2018 to 31/03/2019 – 100% exception reporting 1%

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
01/04/2016 to 31/03/2017 – 67.3% exception reporting 41.7%
01/04/2017 to 31/03/2018 – 67.5% exception reporting 25.3%
01/04/2018 to 31/03/2019 – 78% exception reporting 0.5%

Overall the QOF for COPD patients had improved: -
01/04/2016 to 31/03/2017 – 81.7% exception reporting 34.6%
01/04/2017 to 31/03/2018 – 90.5% exception reporting 25%
01/04/2018 to 31/03/2019 – 100% exception reporting 7%

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
01/04/2016 to 31/03/2017 – 72.2% exception reporting 30.8%
01/04/2017 to 31/03/2018 – 84% exception reporting 25%
01/04/2018 to 31/03/2019 – 90% exception reporting 4.9%

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)	62.2%	80.1%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.5% (26)	4.2%	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)	84.1%	91.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (3)	6.3%	6.7%	N/A

Any additional evidence or comments

The practice had completed audits on their patients with hypertension and we were able to see a marked improvement in their QOF scores. Please note that unverified data for 2018/2019 data had yet to be published.

Overall the QOF for hypertension patients had improved: -

01/04/2016 to 31/03/2017 – 71.7% exception reporting 3%
 01/04/2017 to 31/03/2018 – 60.9% exception reporting 2.5%
 01/04/2018 to 31/03/2019 – 100% exception reporting 1%

The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less

01/04/2016 to 31/03/2017 – 67.1%
 01/04/2017 to 31/03/2018 – 62.2%
 01/04/2018 to 31/03/2019 – 81%

Families, children and young people

Population group rating: Good

Findings

The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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,	79	82	96.3%	Met 95% WHO based target (significant variation)

Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)				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)	87	91	95.6%	Met 95% WHO based target (significant variation positive)
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)	84	91	92.3%	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)	88	91	96.7%	Met 95% WHO based target (significant variation positive)

Any additional evidence or comments

At our previous inspection in July 2018, we saw that only one target had met the 90% requirement (Percentage of children aged one with completed primary course of 5:1 vaccine - 98%)

At this inspection we saw that all four targets had been exceeded.

The nurses we spoke with told us that if patients did not attend for their immunisations they would call the patient's guardian. If they still did not attend the patients' GP was informed and a letter sent.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

End of life care was delivered in a coordinated way which considered 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 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.

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)	77.5%	72.1%	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) <small>(PHE)</small>	73.2%	70.2%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) <small>(PHE)</small>	63.4%	58.6%	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) <small>(PHE)</small>	62.9%	71.3%	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) <small>(PHE)</small>	52.8%	49.8%	51.9%	No statistical variation

Any additional evidence or comments

The practice had seen a marked improvement for their cervical cancer screening with 2018/2019 figures showing the practice having screened 82% of women eligible. Nurses and reception staff, we spoke with, told us that they were flexible with appointments and ensured that any women who called for an appointment would be given one so as not to deter them from attending. GPs also reminded eligible patients of the importance of screening if their notes showed they had not been for a test within the recommended time frame. The practice was also part of the CCG cancer prevention programme.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

End of life care was delivered in a coordinated way which considered 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 had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, 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) <small>(QOF)</small>	90.0%	90.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	65.5% (19)	11.6%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	85.7%	90.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	51.7% (15)	10.5%	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) <small>(QOF)</small>	80.8%	81.7%	83.0%	No statistical variation
Exception rate (number of exceptions).	38.1% (16)	5.2%	6.6%	N/A

Any additional evidence or comments

The practice had completed audits on their patients with mental health concerns and we were able to see a marked improvement in their QOF scores and a reduction in their exception reporting. Please note that unverified data for 2018/2019 data had yet to be published.

Overall the QOF for patients with a mental health concern had improved: -

01/04/2016 to 31/03/2017 – 91% exception reporting 62.5%

01/04/2017 to 31/03/2018 – 98.1% exception reporting 65.5%

01/04/2018 to 31/03/2019 – 98% exception reporting 0%

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months

01/04/2016 to 31/03/2017 – 56% exception reporting 51.9%

01/04/2017 to 31/03/2018 – 80.8% exception reporting 38.1%

01/04/2018 to 31/03/2019 – 97% exception reporting 7.5%

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

01/04/2016 to 31/03/2017 – 83.3% exception reporting 62.5%

01/04/2017 to 31/03/2018 – 90% exception reporting 65.5%

01/04/2018 to 31/03/2019 – 96% exception reporting 33.3%

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months

01/04/2016 to 31/03/2017 – 78.6% exception reporting 56.3%

01/04/2017 to 31/03/2018 – 85.7% exception reporting 51.7%

01/04/2018 to 31/03/2019 – 92.8% exception reporting 33.3%

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)	479.3	537.7	537.5
Overall QOF exception reporting (all domains)	4.4%	5.3%	5.8%

Any additional evidence or comments

The practice was able to show us evidence of their improved QOF scores

01/04/2016 to 31/03/2017 – 453 out of a maximum 559 points

01/04/2017 to 31/03/2018 – 479.3 out of a maximum 559 points

01/04/2018 to 31/03/2019 – 555.9 out of a maximum 559 points

	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

12 audits had been undertaken since July 2018 which had resulted in changes to clinical management and medicines for individuals, in line with guidance.

Examples of audits completed,

- Audit of patients who had a particular contraceptive implant inserted and removed
- Audit of patients who had an Intrauterine Contraceptive Device inserted
- Audit of patients who had receive vitamin B12 injections
- Audit of patients on Valproate of child bearing potential (full cycle audit)
- Audit of patients who have had a splenectomy and their immunisation status (full cycle audit)
- Audit of the prescribing of high-risk antibiotics (full cycle audit)
- Audit of NOAC prescribing (10 patients audited by CCG pharmacy team and ongoing audit by the in-house clinical pharmacist)
- Diabetes audit 2018/19
- Diabetes renal safety audit 2018
- Diabetes National Diabetes Audit 8 Key Care Processes and 3 Treatment Targets
- Audit of Parkinson's Disease patients
- Audit of Inadequate Smears 2018.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	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.	n/a
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that the practice had not ensured staff were up to date with their mandatory training, or that staff had received an appraisal. The practice had also not completed induction records for locums.</p> <p>At this inspection, we found that all staff had completed their training and had received an appraisal. Staff we spoke with told us they had been able to do the training during their working day or while at home which had been paid as overtime. They told us they had found the appraisal useful and felt listened to with an open discussion.</p> <p>The practice had designed a new locum induction pack and we saw evidence that it had been used. However, one locum file we reviewed did not record the training certificates required.</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) <small>(QoF)</small>	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	n/a

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
<p>Explanation of any answers and additional evidence:</p> <p>Clinical staff worked opportunistically to support patients to live healthier lives. This included discussing health and lifestyle issues as part of routine appointments. There was information available to support patients to improve their health. The practice was also able to use social prescribing for their patients and could signpost patients and carers to various support groups.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	84.1%	94.7%	95.1%	Significant Variation (negative)
Exception rate (number of exceptions).	0.5% (8)	0.9%	0.8%	N/A

Any additional evidence or comments

The practice was able to show us evidence of their improved QOF scores. Please note that unverified data for 2018/2019 data had yet to be published.

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

01/04/2016 to 31/03/2017 – 83.6% exception reporting 0.8%

01/04/2017 to 31/03/2018 – 84.1% exception reporting 0.5%

01/04/2018 to 31/03/2019 – 95% exception reporting 0.6%

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
Explanation of any answers and additional evidence: Written consent for minor surgery was obtained and scanned into patient records. Clinical staff had a good understanding of mental capacity and the situations in which best interest decisions needed to be made and the appropriate processes for this.	

Caring

Rating: Good

Kindness, respect and compassion

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

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

CQC comments cards

Total comments cards received.	37
Number of CQC comments received which were positive about the service.	34
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment Cards	Patient's comments were positive and some went into detail how the practice had supported them and their families. We saw comments that receptionists, nurses and GPs were excellent, supportive, encouraging and caring, explaining care and treatment and taking time with patients; patients said they were treated with respect. The three mixed comments we received were in relation to having to sometimes wait to see the GP if they were over running.
NHS Choices	We noted there were positive comments about the level of service and patient care.
Family and Friends Test	During 17/04/2018 to 15/04/2019 2,850 patients had responded with 96% saying they would recommend the practice.

National GP Survey results

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6571	232	113	49%	1.72%

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)	90.4%	91.4%	89.0%	No statistical variation

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 treating them with care and concern (01/01/2018 to 31/03/2018)	86.0%	90.0%	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)	98.4%	97.5%	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%	86.6%	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 conducted a patient survey at the beginning of 2019 over a four-week period. Patients could respond via a paper survey or online and 94 patients had completed the survey. 97% of patients said they would be likely to recommend the practice and 0% said they would be unlikely to recommend (3% didn't answer or gave a neutral response).</p> <p>The practice informed us of two comments from patients in relation to not being informed that the GP was running late and that the tannoy system was not always clear as to which patient was being called. We were informed that reception staff had been reminded to inform patients if they were aware that a GP was over running. We also saw posters in the waiting area informing patients to speak to a receptionist if they felt they had waiting a long time after their allotted appointment time. The practice also informed us that they had future plans to install a visual calling screen.</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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

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)	92.4%	95.9%	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 about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: The practice had leaflets and posters displayed in the waiting area relating to support groups in the local area as well as national help schemes. Information about support groups was also available on the practice website.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 117 patients as carers; this represented approximately 1.7% of the practice list. This had increased in the last six months from 107.
How the practice supported carers.	There was information on local carers' organisations and services displayed in the waiting area. Staff were aware of local organisations and when required signposted patients to them.
How the practice supported recently bereaved patients.	Staff told us that if families had experienced bereavement, the GP best known to the family contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Privacy and dignity

The practice respected always respect patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: On the day of the inspection, we observed staff treating patients with dignity and respect. The reception and waiting area were in one room and the practice had partitioned off the two areas. There was a sign in place asking patients to wait until being called forward by the receptionist. Patients could also book in via an electronic booking screen.	

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
<p>Explanation of any answers and additional evidence:</p> <p>There was onsite parking for patients with limited mobility. The access doors to the practice were wide enough for use by persons using mobility aids. Patients were seen on the ground floor. There were appropriate toilet facilities for all patients.</p>	

Practice Opening Times	
Day	Time
Monday	8am – 6pm
Tuesday	8am – 6pm
Wednesday	8am – 6pm
Thursday	8am – 6pm
Friday	8am – 6pm
<p>Extended hours - 6.30pm to 8.20pm, on alternating Monday and Thursday evening.</p> <p>On the day appointments could be booked via reception or on line. Patients could book appointments up to four weeks in advance and telephone appointments were available. Receptionists could request an urgent GP telephone appointment if they felt the patient urgently needed to be spoken with before making an appointment.</p> <p>The practice was part of a federation of GP practices that offered evening appointments until 9pm and weekend appointments – Saturday and Sunday 9am until 1pm. These appointments were run from several locations in Leatherhead, Epsom and on the Downs.</p> <p>The federation also ran a children's extended clinic from 4pm to 8pm on weekdays, which the practices patients could attend. Appointments could be booked through the practice or directly.</p>	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6571	232	113	49%	1.72%

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)	96.9%	96.6%	94.8%	No statistical variation

Older people

Population group rating: Good

Findings

All patients had a named GP who supported them in whatever setting they lived.

The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

The practice could signpost patients to local support groups.

Patients could receive text message appointment reminders.

People with long-term conditions

Population group rating: Good

Findings

Clinicians would opportunistically review patients if necessary when they had failed to attend for reviews.

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 patients with long-term conditions approaching the end of life was coordinated with other services.

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 patients 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.

Children subject to protection plans were highlighted in clinical records.

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. For example, extended opening hours and weekend appointments provided at a different location.

Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

Patients were able to book appointments on-line and order repeat prescriptions. Patients were able to make online requests via the website.

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 could accommodate those patients with limited mobility or who used wheelchairs.

The practice provided an auditory loop in the practice for those patients with hearing difficulties.

When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

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 in the area and signposted their patients to them.

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
<p>Explanation of any answers and additional evidence:</p> <p>Requests from patients for a home visit were recorded by reception staff. Visits were triaged by the doctor during the morning. Patients might be telephoned to see if they were well enough to come down to the practice. The doctors decided who needed a visit according to the clinical need and ensuring where possible the doctor that the patient normally sees would carry out the visit for continuity of care.</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)	76.0%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	89.3%	69.8%	68.6%	Tending towards variation (positive)
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)	74.2%	65.9%	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)	87.9%	78.0%	74.4%	Tending towards variation (positive)

Source	Feedback
Comment Cards	We received six comments from patients that appointments were available to them when requested.

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.	6
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint that GP failed to diagnose and treat a post-operative infection.	All points reviewed and investigated by the practice including clinical decision. GPs reflected on use of communication and the need to explain the rationale behind decisions made.

Well-led

Rating: Good

At our previous inspection in July 2018, we rated the practice as inadequate for providing well led services because we found evidence of gaps in the practice leadership. For example, concerns with policies, significant events, MHRA alerts, training, appraisals, QOF, PGDs and gaps in recruitment files. The practice had made significant improvements and so the rating reflects the amount of work and improvement the practice had done. Leaders of the practice had improved; patient care, training for staff, systems to review significant events and safety alerts and the safeguarding of vulnerable adults and children.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At our previous inspection in July 2018, we found that the practice did not have a comprehensive oversight of governance, risks and actions to mitigate those risks. At this inspection we found a significant improvement in all areas. Leaders within the practice had created action plans and visual displays for staff to follow and show when tasks had been completed. Action had been taken in all areas of non-compliance and the leaders in the practice tackled these challenges in innovative ways to drive and improve the delivery of high-quality, person-centred care. They had used the CQC inspection to review care provided to patients, processes and policies and to make improvements all round. Staff we spoke to told us that they had seen a marked improvement and felt proud of the work they had achieved in such a short time. All staff felt included in the areas of improvement and saw this as a continuation of the work they were already doing to improve patient care. Staff said the leadership team all had an open-door culture where staff could discuss anything of concern at any time regarding work, support needed either at work or at home.	

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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found there was a clear vision and set of values. However, not all areas of this were implemented effectively. At this inspection we found that there was a realistic strategy to achieve the priorities and the practice was effectively monitoring progress against delivering the strategy.</p> <p>The practice had developed its aims and objectives, which provided a summary of the core goals underpinning the care and treatment they provided. Some of the practice's aim were to:</p> <ul style="list-style-type: none"> • To provide the best possible medical care to patients • To treat all patients with courtesy, compassion and respect • To promote good health and well-being to patients • To ensure all staff receive appropriate training and support • To encourage reflective practice by sharing and learning from mistakes and near misses • To keep up to date with guidance on best practice and governance • To consider economic and environmental sustainability in the provision of healthcare 	

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
<p>Explanation of any answers and additional evidence:</p> <p>There was a strong collaboration, team-working and a common focus on improving the quality and sustainability of care and people's experiences.</p> <p>Nursing staff we spoke with told us that due to concerns raised by them, they now had protected time during their day to complete necessary checks required within the practice. This had ensured that the nurses had the time to complete them without the pressure of finding additional time during their working day. They told us they had felt listened to and their concerns taken seriously and acted upon.</p>	

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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we found that processes and systems in place did not always support the delivery of good quality and sustainable care. At this inspection we found that the leaders had addresses these issues and now had systems in place which supported processes, patient care and staff development. For example, PGDs and policies were up to date, staff had completed training and had received appraisals.</p> <p>The leaders were aware of areas which required improvement. For example, monitoring and addressing Quality Outcomes and screening rates and had commenced a programme of reviewing and addressing these. We saw that the practice had improved their QOF scores and reduced their exception reporting across many areas and not just those highlighted from our previous inspection.</p> <p>A systematic approach had been taken to improve care outcomes. We saw many governance systems which were managed effectively.</p>	

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	<p>Policies and procedures contained adequate, and specific information, which had been reviewed and information was easy to locate.</p> <p>We saw there was a policy log that showed the dates that policies needed to be reviewed by.</p>
Learning and Improvement	<p>A formal recorded structure of meetings and minutes maintained of actions, discussions and learning had been completed.</p> <p>Opportunities for learning and improvement from significant events and the review of QOF were utilised. However, the recording of outcomes for safety alerts and significant events needed to be further embedded.</p>
Supporting Staff	<p>There were clear lines of accountability and responsibilities.</p> <p>Staff were up to date with their training and non-clinical staff had received an appraisal.</p>
Appropriate and accurate information	<p>Recruitment checklists and processes to demonstrate pre-employment checks had been completed. However, one locum file had not recorded training certificates required.</p> <p>There was administration support and detailed checklists for medicines stocks, expiry dates and emergency equipment.</p> <p>There was an infection control audit programme for the site.</p> <p>Prescription pad security processes were in place.</p> <p>The practice was monitoring prescribing patterns.</p> <p>There was a proactive programme of quality improvement audits.</p> <p>Nurses were using PDGs that were up to date.</p>
Designated Leads	<p>Staff within the practice had designated leads which all staff were aware of. For example, the nurse was the infection control lead and two GP partners were the safeguarding leads.</p>

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	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.	Y
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>At our previous inspection in July 2018, we found that non-clinical staff had not received basic life support training. During this inspection, all staff had received up to date training and were able to tell us an event where they had needed to respond to an emergency. The practice had raised this as a significant event and had reflected on what had happened.</p> <p>Since our last inspection, we found there was a comprehensive understanding of the performance at the practice and this was monitored.</p> <p>Regular reviews took place of patients' medicines. Patients prescribed high risk medicines were monitored.</p> <p>All staff had received an annual appraisal of their work, which included a discussion about their training needs.</p> <p>The practice had a variety of risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.</p>	

Appropriate and accurate information

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

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

Explanation of any answers and additional evidence:

The practice had introduced a system which supported them in monitoring and reviewing significant events and safety alerts. However, the recording of outcomes needed to be strengthened.

Appropriate action was taken as a result of complaints.

There was a range of both clinical and administrative policies, these were easily accessible for all staff.

There was a range of clinical protocols and templates in place, some developed in response to audits.

Communication was effective and organised through structured meetings which were minuted.

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 engaged with patients through a variety of methods, including comments and complaints, patient surveys and through the comments box in the waiting area.	
Staff we spoke with told us they felt included in the running of the practice and that ideas/discussions for improvements was encouraged.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
There was a strong desire and commitment to improve and provide a quality service to patients. The practice had used the previous CQC inspection as a chance to review existing ways of working and improve. We saw that the whole team had been engaged with this process and was encouraged to give suggestions in better ways to work and find improvements for patient care.	
The practice spoke with us about their quality improvement activities. This included to maintain and build upon their achievements, continue with their quarterly QOF strategy meetings and to start an annual long-term condition review to minimise patient appointments and maximise patient care.	
They also had plans to maximise workflow optimisation, improve IT systems, installing waiting room screens and on-line promotions. Their plan also included reviewing their staff mix. For example, by increasing the time spent at the practice by the clinical pharmacist and by engaging with the primary care networks to share resources for their patients.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.