Care Quality Commission

Inspection Evidence Table

Park and St Francis Surgery (1-541666110)

Inspection date: 29 May 2019

Date of data download: 28 May 2019

Overall rating: Good

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

Safe Rating: Good

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse except in relation to staff training records.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
There were systems to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial

We saw guidance was produced for staff in relation to e-Consult and for those patients requesting to see a GP on the same day. For example, any patient under 18 years, the very elderly, patients with learning difficulties or those with no internet access must be added to the telephone triage list for a call back. This indicated that those identified as vulnerable were being given priority care.

The practice safeguarding children's policy contained appropriate guidance on staff training, in line with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document guidance (2019). The practice safeguarding adults' policy, called the 'Vulnerable Adults' policy, did not contain information relating to staff training.

On review of the practice's staff training log, we found the safeguarding training of staff was not fully in line with the most recent Intercollegiate Guidance documents. For example, we found:

- Out of the 11 members of the nursing team:
    - Four practice nurses and the advanced nurse practitioner had a record of completing safeguarding children level 3 training in the previous 12 months. The three remaining practice nurses, the research nurse, the health care assistant and the phlebotomist had a record of completing safeguarding children level 2 training in the previous 12 months. (The Intercollegiate Guidance document (2019) states all practice nurses and advanced nurse practitioners should complete safeguarding children training to level 3). Since inspection the practice has confirmed its practice nurses were working towards completing their safeguarding children level 3 training.
    - Three practice nurses and the advanced nurse practitioner had a record of completing safeguarding adults' level 2 training. The remaining members of the nursing team had no record of safeguarding adults' training documented. (The Intercollegiate Guidance document (2018) states all practice nurses and advanced nurse practitioners should complete safeguarding adults' training to level 3, while health care assistants and phlebotomists should complete safeguarding adults' training to level 2).
- Out of a total of 24 members of non-clinical staff, all but one member had a record of completing safeguarding level 1 training within the previous twelve months. The training log did not identify if this was for safeguarding adults or children. The remaining one staff member with no record was identified as on long-term absence from the practice. (The Intercollegiate Guidance documents (2018 & 2019) states practice managers and all reception staff should complete safeguarding children training to level 2, and administrators' complete level 1, while safeguarding adults' training should be completed to level 2 for practice managers and level 1 for reception staff and administrators).
- All 10 GPs and the 2 GP registrars attached to the practice had completed the required safeguarding adults' and children training relevant to their role.

The practice confirmed it only used clinical staff members to act as chaperones. An enhanced certificate was in place for these staff members to act as chaperones. The non-clinical staff that we spoke to during the inspection confirmed they had not been asked to act as a chaperone and the task was commonly undertaken by the practice nurses or the health care assistant.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes

Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff had any necessary medical indemnity insurance.	Yes
Explanation of any answers and additional evidence: Recording of vaccination status for staff members at the practice was an ongoing project. For example, out of a total of 47 staff members, we found evidence of 18 who did not have a record of immunity to measles, while an additional 20 staff members did not have a record of immunity to hepatitis B. The practice confirmed it was aware of this issue and had already identified an action plan on how to address these gaps of information.	

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	Yes
There was a record of equipment calibration. Date of last calibration: February 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: May 2019	Yes
There was a log of fire drills. Date of last drill at St Francis: 23 May 2019 Date of last drill at Park Surgery: 15 August 2018	Yes
There was a record of fire alarm checks. Date of last check at St Francis: 20 May 2019 Date of last check at Park Surgery: 28 May 2019	Yes
There was a record of fire training for staff. Date of last training: Booked for 13 & 15 August 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: May 2018	Yes
Actions from fire risk assessment were identified and completed.	Yes

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: May 2018	Yes

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2019	Yes
Explanation of any answers and additional evidence: We saw that a legionella risk assessment for both surgery sites was completed in November 2018. We saw that appropriate management of risk and an action plan was in place to address the findings of the most recent risk assessment. For example, St Francis Surgery had a new boiler installed in April 2019.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit: January 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: Training requirements for infection prevention and control were referred to in the practice's public IP&C Annual Statement which stated all staff receive yearly training in IP&C. On review of the practice's training log, we found out of a total of 47 staff, seven had received IP&C training in the previous 12 months. All other staff were recorded to have dates booked for IP&C the month following inspection. We saw that cleaning audits were completed at both sites in 2019.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes

There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: We saw that all available staff had either received sepsis awareness training in the previous six months or were booked to receive the training in the month following inspection. (Sepsis is a deadly reaction to infection and early identification is key for prompt treatment). We saw that sepsis notices were displayed throughout both premises to promote awareness. Clinicians were using the National Early Warning Score (NEWS2) toolkit to support quick diagnosis of sepsis. (NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness, such as 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
There was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.65	0.82	0.88	Tending towards 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). (01/04/2018 to 31/03/2019) (NHSBSA)	11.5%	11.3%	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 and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	6.28	5.95	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.30	2.04	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence: The practice had use of MAPS (Monitoring Administration and Prescribing Service) to support its monitoring process of high-risk medicines. On review of the practice's emergency medicines stock and emergency equipment, we saw evidence to demonstrate the practice was regularly checking stock and equipment. However, we found one emergency medicines container at the St Francis Surgery site contained a vial of Adrenaline that was out of date. This was immediately replaced, and oversight was confirmed. We checked all other emergency medicine stocks at both sites, and all other emergency medicines, including Adrenaline, were in date. The practice was part of an on-going project to reduce the number of patients receiving opioid medicines (strong relieving medicines with potentially harmful side effects). Patients who received opioid medicines were sent a letter containing information about the risks of long-term opioid use. Patients were signposted to websites for alternative management of chronic pain and encouraged to have a review with their GP to see if their opioid medicine use could be reduced or stopped completely.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	36
Number of events that required action:	36

Explanation of any answers and additional evidence: Due to the reporting system that the practice used for significant events, we saw limited evidence of the practice identifying and learning from themes of significant events. This was generally done by the local clinical commissioning group at a locality level. However, the practice was learning and improving its services from individual events as and when they arose.

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

Event	Specific action taken
Data breach	Practice reported the incident to the Information Commissioner's Office (ICO), the practice's Caldicott Guardian and all other relevant parties as per Information Governance protocol. The event was discussed with the GP partners. The ICO closed the case.
Ongoing use of hormonal contraception following cancer diagnosis	Initial diagnosis was confirmed to have been prompt. Practice confirmed letters to tertiary health care services had been sent to query the continued use of the hormonal contraception following a cancer diagnosis. No response was received in return, tertiary services stated letter was never received. Contraception was eventually stopped following publication of a new study in 2017. Practice now plans to review all medication of patients who receive a cancer diagnosis to ensure all medication remains appropriate.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

Effective Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	0.42	0.66	0.77	No statistical variation

Older people Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice has introduced a monthly frailty clinic to discuss those most vulnerable with a multi-disciplinary team including adult services, community nurses, elderly mental health, and members of the GP Federation's Transformation Team.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and 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.
- The practice had trained its health care assistant to support the lead diabetic nurse in the running of the practice's diabetes clinic.
- The practice demonstrated how it was supporting patients who experienced chronic pain in reducing their reliance on opioid medicines. An audit of inappropriate opioid use was undertaken to identify patients that no longer required opioid medicines to prevent potential harm, possible addiction and reduction in pain thresholds from chronic use. The initial audit in December 2018 identified 52 patients who met the criteria for the audit. Each patient was written to highlighting the negative effects of opioids and were signposted to websites for more information on managing chronic pain. The letter to patients also encouraged a review with their GP if further guidance was required. The audit was repeated in May 2019 and identified 38 patients who met the criteria. This indicated that 14 patients so far had ceased taking opioid medicines, equivalent to a 28% reduction. The practice had shared the results of this audit and subsequent actions with local surgeries and presented at Medicine Management Team across two locality meetings which involved over 20 practices.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	81.9%	78.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	14.8% (88)	15.7%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.9%	77.0%	77.7%	No statistical variation

Exception rate (number of exceptions).	13.1% (78)	12.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	84.7%	81.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	16.8% (100)	16.0%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	81.3%	75.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	26.3% (274)	11.5%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	86.9%	90.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	15.6% (24)	15.2%	11.5%	N/A

Any additional evidence or comments
The practice provided up to date information which had not been externally verified, regarding its Quality and Outcome Framework (QOF) data in relation to 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. The QOF indicator result had risen to 86% as of 1 April 2019 but the exception reporting data had also risen, to 27.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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)	79.8%	81.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.5% (91)	5.1%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	89.7%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (5)	6.2%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with or above the World Health Organisation (WHO) targets of 95%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice held quarterly meetings with the local health visitor and school nurse to discuss vulnerable families.
- 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)	126	131	96.2%	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)	152	159	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)	151	159	95.0%	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)	151	159	95.0%	Met 90% minimum (no variation)

Working age people (including those recently retired and students)

Population group rating: Good

Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified	78.9%	76.1%	71.7%	No statistical variation

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)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	76.4%	76.8%	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)**	67.8%	64.7%	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)**	80.9%	74.7%	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)	60.3%	54.0%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.

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)	75.8%	87.6%	89.5%	Tending towards variation (negative)
Exception rate (number of exceptions).	6.1% (4)	13.0%	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)	56.3%	88.2%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	3.0% (2)	11.7%	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)	69.4%	82.5%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.9% (4)	6.6%	6.6%	N/A

Any additional evidence or comments

During the inspection, the practice provided information which had not been externally verified, regarding its Quality and Outcome Framework (QOF) data in relation to Mental Health indicators as follows:

- 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 as of 1 April 2019 had risen to 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months as of 1 April 2019 had risen to 87%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months as of 1 April 2019 had risen to 89%.

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)	517.0	538.3	537.5
Overall QOF exception reporting (all domains)	5.2%	5.4%	5.8%

Any additional evidence or comments

The practice was aware that its Quality and Outcome Framework (QOF) reporting was below CCG and national averages. In response to this, the practice undertook an audit in 2019 of its QOF coding system to identify issues and support an improved recording and reporting system. A result of the audit identified that data was being reported on and appropriately collected, but at times, was not being appropriately linked together. For example, for those patients living with osteoporosis, patients were being coded as having the condition, they were being coded has having had a scan and, if applicable, were being coded if a fracture had occurred, but an accumulation of these findings were not being recorded effectively. As a result, the practice had an administrator dedicated to following up on all areas of the QOF audit, with clinical help as required, to ensure all read-codes were appropriately in place.

As a result of the QOF audit, the practice provided up to date but as yet unverified information regarding its overall Quality and Outcome Framework (QOF) score. This showed achievement for 2018/19 had risen to 555.4 out of a maximum of 559 points. (QOF is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice).

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

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

- An audit of patients receiving a medicine to treat osteoporosis was conducted to ensure all patients were receiving appropriate blood monitoring. An initial audit in April 2014 identified 10 patients were receiving the medicine, but none were being monitored appropriately. As a result, the practice wrote to each patient to arrange a blood test prior to their next dose. A repeat audit in September 2014 identified 13 patients were receiving the medicine and were being appropriately monitored. The practice continued to contact patients to arrange a blood test as appropriate. A second repeat audit completed in April 2019 identified 80 patients were receiving the medicine and all 80 were documented as receiving appropriate blood monitoring as per the required standard.
- An audit of referrals was completed by a clinician to check their own referral rate and improve their own practice. A cohort of 50 patients that had been referred to secondary care in 2018 was audited. The clinician found 65% of their referrals had resulted in investigations or treatment had been arranged with outpatient appointments. Of the 50 referrals, it was identified that 25% of the referrals were to the dermatology team at the local hospitals. The clinician concluded that was likely to be due to their confidence in relation to dermatological issues and as a result has commenced a diploma course in dermatology to be more informed and to develop to a specialism in that area.
- The practice completed an audit of its e-Consult requests and incoming calls on 24 April 2019. In one day, the practice received 53 e-Consult requests and 138 incoming calls from patients requesting an appointment. Of those 191 patient contacts, the practice made 46 appointments with

a GP, and a further 34 appointments with the nurse practitioner. Of the remaining 102 contacts, the practice had either resolved the issue over the telephone, created a prescription over the telephone, arranged a routine appointment, arranged an appointment at the GP federation hub, sent text message reminders about an appointment or arranged a home visit. The review led the practice to hold a GP and nurse meeting to review the e-Consult entries to ensure the correct processes were being used and appropriate decisions were being made. The practice had not yet reviewed the audit.

- An audit relating to female patients of child-bearing age and receiving a medicine to treat epilepsy was undertaken in 2018 and 2019. It was identified following a safety alert that those patients receiving the medicine, should have documented advice in their medical notes and a signed letter from a consultant neurologist. On review in September 2018, the practice identified six patients who met the criteria, of those six, one had a signed letter and two others were receiving appropriate contraception. Letters were sent to all patients to arrange a review with a GP; all six were seen in October-November 2018. A repeat audit in May 2019 identified the same six patients, five of whom now had a signed letter from a neurology consultant in their records.

Any additional evidence or comments
The practice was a sessional research practice. This meant the practice conducted at least 10 clinical studies each year. We saw evidence of research studies for 2019 that the practice was actively recruiting patients to take part in. To undertake such a programme of research the practice employed a research nurse to assist the GPs. GP partners decided if a proposed study was ethically sound and would improve patient care. We saw evidence of a proforma form used to decide on research projects. The practice believed that by taking part in the research projects their patients benefitted from a closer review of their care and treatment. Research studies identified by the practice for 2019 included the management of chronic obstructive pulmonary disorder with an inhaler; access to medicines by patients and carers for those patients receiving palliative care; withdrawal from long-term anti-depressants; and the reduction of re-occurring urine tract infections by the administration of a supplement. The practice confirmed patients selected for research studies benefitted from closer patient care and the income raised from the research studies provided the practice with more funds to support the NHS care of all of its patients.

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.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes

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,	89.8%	94.3%	95.1%	Variation (negative)

schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0.5% (19)	0.7%	0.8%	N/A

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance, but we found evidence to demonstrate that this was not being recorded consistently.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Partial

Explanation of any answers and additional evidence:

The practice told us it had a consent policy which all clinical staff were expected to adhere to. However, through our conversation with clinical staff members, we found consent was not being consistently recorded in line with the practice's policy. For example, we saw written consent forms available for patients to sign when receiving a joint injection or undergoing minor surgery at the practice. Once completed and signed, these forms would be scanned onto patients' records. The use of the joint injection consent forms was agreed at a GP partners' meeting in November 2018 and saw minutes of the meeting to confirm this. However, we found consent forms were not being consistently used for minor surgery, and instead, at times, verbal consent was being documented as free text in the patient's records.

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
Explanation of any answers and additional evidence: The practice had made adjustments to the reception area by installing a low desk to enable patients who required a wheelchair to speak with receptionists easier. The practice told us it was able to book British Sign Language interpreters for those patients who lived with a profound hearing impairment.	

Practice Opening Times	
Day	**Time**
St Francis Surgery Opening times:	
Monday	8.00am-6.30pm
Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm
Park Surgery Opening times:	
Monday	8.00am-12.30pm
Tuesday	8.00am-12.30pm
Wednesday	8.00am-12.30pm
Thursday	8.00am-12.30pm
Friday	8.00am-12.30pm

Any additional evidence or comments
The practice offered extended hours for pre-bookable appointments with a GP and a practice nurse at the Park Surgery site every Saturday morning from 8.00am to 11.00am. On the day of inspection, 29 May 2019, we asked the practice to confirm its appointment availability

across both sites. At 12.30pm, we found:

- The next urgent appointment with a duty GP was at 4.10pm on the day of inspection.
- The next available routine GP appointment was 24 June 2019 at 9.30am.
- The next available routine practice nurse appointment was 5 June 2019 at 9.15am.
- The next available routine practice nurse appointment for an asthma review was 1 June 2019 at 8.10am.
- The next available routine practice nurse appointment for a diabetes review was 16 June 2019 at 9am.
- The next available routine health care assistant appointment was 3 June 2019 at 10.50am.
- The next available phlebotomist appointment was 31 May 2019 at 10.50am.

Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was able to access the services of three GP federations in the local area. Appointments were available Monday to Friday 5.00pm until 8.30pm, Saturdays 8.00am to 5.00pm and Sundays 8am until 1.00pm across the three federations.

Information about the extended access services and out of hours care was available on the practice's website.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
16,891	232	121	52.2%	0.72%

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)	98.2%	96.3%	94.8%	Tending towards variation (positive)

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice had introduced a monthly Frailty Clinic to link GPs with consultants, social care, mental health and the voluntary sector to support those patients identified as most vulnerable. The practice reported approximately 120 patients and carers had benefitted from this clinic since 2015. We were told the frailty clinic model had also been adopted by the local GP Federation who were now using the same model with nine other local GP practices.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- 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.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8.15pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.

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. The practice offered appointments for patients with learning disabilities at its branch site (Park Surgery) as it was a smaller location and was quieter as a result. Home visits were also available for reviews of patients with learning disabilities.
- The practice had achieved Dementia Friendly and Veteran Friendly accreditation status. As a result of these statuses the practice had made adjustments to both sites and the services it provided. For example, Dementia Friendly picture signage was installed throughout both site premises to enable patients living with dementia to navigate the premises more easily.
- The practice provided evidence of an action plan of how they were going to become the first practice in the local area to become an accredited Lesbian, Gay, Bisexual & Transgender (LGBT+) Friendly practice. Actions included amending the practice's registration form to include sexual orientation, to arrange LGBT+ awareness training for all staff and to produce a protocol for supporting transgender patients as well as managing patient records as patients underwent transition procedures.

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 continued to offer a practice-funded counselling service to its patients living with poor mental health. Following an identification of limited mental health support for its patients, the practice made arrangements for a practice-funded counselling service to be set up. The GPs in the practice contribute to fund the service, and the practice allowed the service to operate from its Park Surgery site in the afternoons when no primary care services were being offered. The service was staffed by trainee counsellors who were supervised by a trained counsellor. Patients were offered the choice of this counselling service if they did not wish to wait for other mental health services to be available. Initially, 36 patients were seen a year, over a six-week period, receiving cognitive behavioural therapy within 216 hour-long sessions provided. The service has significantly reduced waiting times for mental health support services to between three to 12 weeks.

Timely access to the service

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

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

National GP Survey results

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)	90.2%	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)	77.1%	74.7%	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)	66.1%	68.6%	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)	82.5%	78.7%	74.4%	No statistical variation

Any additional evidence or comments
To improve access, the practice told us it had implemented the following measures: • e-Consult had been available since 2018. (e-Consult allows patients to consult online with their own GP as well as seek self-help advice and be signposted to other health services). The practice reported it was the highest user of e-Consult in the country, but specific details were not available. • There was an urgent care duty team available every week day. Upon calling the practice, patients would be added to a call list, a member of the urgent care duty team would return the call and triage the patient on the telephone. Outcomes of the call would either result in an appointment for that day with a member of the urgent care duty team, a follow up appointment on another day with the patient's own GP or practice nurse as appropriate or patient would be advised how to self-manage their symptoms appropriately. • As of April 2019, the practice had employed an advanced nurse practitioner (ANP) to support the urgent care duty team. (An ANP is a registered nurse who has received further qualification to be

able to assess, diagnose, and treat patients as well as prescribe medicines as required).

CQC comments cards	
Total comments cards received.	40
Number of CQC comments received which were positive about the service.	30
Number of comments cards received which were mixed about the service.	7
Number of CQC comments received which were negative about the service.	3

Source	Feedback
Comment cards	Patients who completed positive comment cards said appointments were accessible, waiting times both for an appointment and once arrived at the practice were short. Comments also referred to the use of e-Consult for quicker prescription requests, the new triage service provided quick responses. Comment cards which contained mixed comments reported difficulty in getting an appointment in general or with a preferred GP for continuity purposes. Mixed comments also referred to the process of e-Consult that required multiple questions to be answered when patient is already unwell and the response time when unwell is not very timely. Negative comments referred to long waiting times for appointments, long waiting times once at the practice without being informed and a dirty environment.
NHS UK website	St Francis Surgery: The practice was rated 2.5 out of 5 stars for appointments, and 4 out of 5 stars for telephone access from five out of six reviews. Comments made by patients referred to quick responses from an e-Consult submission, long queues at the reception desk, or long waits for appointments that are not urgent. Park Surgery: The practice was rated 3.5 out of 5 stars for appointments, and 4.5 out of 5 stars for telephone access from five reviews. Comments made by patients referred to being able to get an appointment when it was required and being offered a cancelled appointment on the same day.
Patient interviews	We spoke with patients during the inspection who told us they had only praise for the practice. Patients confirmed they could access appointments as required.

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.	15
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.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Example(s) of learning from complaints.

Complaint	Specific action taken
Online prescription request not responded to by the practice on two occasions.	The practice investigated the complaint and found no evidence of the online requests being submitted. The practice apologised and offered a follow up meeting to explain its investigation.
Unable to get through on the telephone to submit a prescription request.	The practice apologised for the inconvenience as well as signposting patient to its new e-Consult service for future prescription requests.

Well-led Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes

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

Source	Feedback

Staff interviews	Staff we spoke to during the inspection told us they felt supported by the practice and valued. They were encouraged to share ideas for improvements and contribute to developing plans for the practice. Staff reported an open-door policy with managers and a 'no-blame' culture, everything was considered a learning opportunity. Staff stated all colleagues, including senior managers and clinicians were approachable for support and advice. Staff confirmed they enjoyed coming to work and this was demonstrated by many of them being at the practice for a number of years.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:
The partners at the practice had a Partnership Handbook which was reviewed when practice policies were updated. Each GP partners was responsible for signing the Partnership Handbook to demonstrate they were aware of all the updated policies.

We saw evidence of a centrally held list which documented which staff member was responsible for a lead area. For example, who in the practice was the Caldicott Guardian, who in the practice was the safeguarding lead, or who in the practice was responsible for complaints.

The practice held regular staff and clinical meetings to ensure a governance structure was firmly in place. All of which were either minuted or summarised and shared with staff. For example, the practice held:

- Weekly GP partners' meetings
- Weekly line manager meetings with the practice manager
- Monthly team leads meetings.
- Monthly appointment team meetings with the GP lead
- Bimonthly nurse meetings.
- Bimonthly reception meetings
- Quarterly Quality and Outcome Framework (QOF) update meetings.
- Quarterly significant event analysis meetings.
- Twice yearly whole staff meetings.
- An annual partners' away day.

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.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: In light of inheriting over 2,500 patients following the closure of a local practice in 2017, the practice commissioned a resilience audit to ensure the practice was doing all it could to provide services to its practice population. The resilience audit demonstrated areas for the practice to work on and develop, such as the differences in the read-coding of the now closed practice compared to those used by Park & St Francis Surgery.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: Two of the practice's GP partners were not on the practice's current Care Quality Commission registration certificate. The practice demonstrated that the GP partners in question were in the process of completing their applications and requesting enhanced Disclosure and Barring Service check certificates in line with the CQC's protocol for adding partners to a registration. These were dated March 2019 and May 2019.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes

Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
We spoke with three members of the practice's patient participation group during the inspection. They confirmed the practice engages with the group regularly. For example, the PPG holds quarterly meetings with the practice manager and one of the GP partners, and the PPG chair has additional face-to-face meetings with the practice manager as required. The PPG confirmed they have supported the practice in organising quarterly patient information sessions following feedback received from patients about wanting more health awareness. The PPG have arranged for guest speakers to come in and speak with patients on various topics. For example, dementia awareness from one of the PPG's dementia champions, diabetes from one the practice nurses, orthopaedics from a local orthopaedic surgeon, women's health from one of the GPs, men's health from a local consultant urologist, and stomach and bowel disorders from a gastroenterologist consultant. The PPG reported they achieved attendance between 30-100 patients at these information sessions. The PPG had also arranged for a 'monthly speaker stand' in the waiting area of St Francis Surgery. Local services came by and provided information about local support, national charities to patients on various topics. Recent speakers have included Open Sight, Wessex Dementia and Carers Together. The PPG confirmed they felt valued by the practice and stated the practice was open with them and listened to their views. The PPG were not told of individual complaints but were aware of the themes of complaints received by the practice. The PPG confirmed they had supported the practice to become Dementia Friendly, two of its group were dementia champions so had provided the awareness training to staff to support the practice's accreditation. The PPG confirmed the practice was providing services to meet the needs of its practice population and was responding to patient feedback.

Any additional evidence
We saw the practice received compliments from patients, thanking the practice and the staff for its support and ongoing health care services.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement
• The practice was a training practice and at the time of the inspection had two GP Registrar's attached to the practice.

- The practice was a sessional research practice, undertaking approximately 10 research studies a year. The practice employed a research nurse and administrator to support this programme; patients selected for studies benefitted from closer care, and income from the research studies supported all patients receiving NHS care at the practice.
- The practice had developed a pre-consultation questionnaire for patients to complete while waiting for their appointment. As part of a research project with the University of Winchester, the questionnaire was developed to ensure patients' consultations with GPs were appropriately focused. Patients stated the questionnaires helped them to prepare for their appointments while waiting. The research identified positive impact and negative concerns in using the forms but in general found the forms to be beneficial so continued to use them in the practice.
- Frailty clinic to support multi-disciplinary team working between GPs, social care, mental health, consultants and the voluntary sector in managing those patients identified to be most vulnerable.

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 Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥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.