

Care Quality Commission

Inspection Evidence Table

Kingsbury Court Surgery (1-569475140)

Inspection date: 20/06/2019

Date of data download: 14 June 2019

Overall rating: Good

At the January 2018 inspection we rated the practice as requires improvement.

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

Safe

Rating: Good

At the January 2019 inspection, we rated the practice as inadequate for providing safe services because:

- There were insufficient systems around the prescribing of medicines that required additional monitoring.
- The practice did not hold all recommended emergency medicines needed to deal with a range of medical emergencies.
- Infection control procedures needed strengthening.
- Children who attended A&E did not routinely receive follow up from the practice. This could mean safeguarding concerns were not identified.
- A security risk assessment had not been completed. There was no evidence that fire drills had been conducted. A fire risk assessment had been completed however, this required strengthening.

At the June 2019 inspection we rated the practice as good for providing safe services because:

- The practice had created systems to ensure all patients had appropriate medicines monitoring and review.
- The practice had risk assessed the emergency medicines they did not hold, and this was managed appropriately and shared with staff.
- Infection prevention and control procedures had been strengthened. The policy had been reviewed and an audit with remedial actions had been completed.
- The practice reviewed children who had attended A&E and reviewed these patients appropriately.
- Risk assessments had been completed and action plans were monitored. We saw evidence that remedial actions had been undertaken.

- Regular fire drills were being conducted with learning and improvements seen.
- The practice had not formally assessed the immunisation status of all staff. However, following the inspection they provided evidence of a plan to achieve this.

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 which were accessible to all staff. | Y |
| Policies took account of patients accessing any online services. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| Staff who acted as chaperones were trained for their role. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Monthly clinical meetings were held with local community teams such as health visitors, MacMillan nurses and district nurses to ensure information was shared appropriately.</p> <p>The practice completed monthly audits of children who had not been brought to practice appointments. Each case was discussed within the practice clinical teams and with community teams such as health visitors as appropriate. Further actions to ensure the safeguarding of these children were completed and reviewed as necessary.</p> | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Partial |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |

| | |
|---|--|
| The practice did not keep a record of staff immunisation and vaccination status. However, following the inspection we received evidence of an action plan with associated time scales to ensure the practice held appropriate records and offered vaccination where necessary. The practice had completed risk assessments with regard to both clinical and non-clinical staff to ensure vaccinations were in line with guidelines. We received evidence that this process had commenced with clinical staff. | |
|---|--|

| 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: 01/08/2019 | Y |
| There was a record of equipment calibration. Date of last calibration: 01/03/2019 | 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: 14/6/2018 | Y |
| There was a log of fire drills. Date of last drill: 17/06/2019 | Y |
| There was a record of fire alarm checks. Date of last check: 14/06/2019 | Y |
| There was a record of fire training for staff. Date of last training: Ongoing as required | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed. Date of completion: 28/11/2018 | Y |
| Actions from fire risk assessment were identified and completed. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>At the January 2019 inspection we found:</p> <ul style="list-style-type: none"> No fire drills had been completed since 2016. Shortly following the inspection, we received evidence that a fire drill had been conducted. A fire risk assessment had been completed however there had been no actions highlighted. <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> Fire drills were completed on a bi-monthly basis and a record was kept of learning and improvements. For example, we saw evidence that processes have been changed in regard to ensuring no further patients or staff enter the front of the building as the assembly point is at the rear. | |

- We saw actions highlighted in the fire risk assessment had been highlighted and completed.
- The practice conducted weekly fire checks including checks of emergency lighting, extinguishers, fire doors and the alarm system

| Health and safety | Y/N/Partial |
|---|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 01/01/2019 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 20/11/2018 | Y |
| Explanation of any answers and additional evidence: We saw the appropriate risk assessments were completed with actions highlighted and completed. We saw evidence that necessary actions and changes were discussed at regular practice development meetings. | |

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 |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 20/01/2019 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| There was a system to notify Public Health England of suspected notifiable diseases. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| Explanation of any answers and additional evidence: At the January 2019 inspection we found: <ul style="list-style-type: none">• The infection prevention and control (IPC) policy was not practice specific and did not include all necessary details, including waste collection, sharps management or communicable diseases.• An IPC audit had not been completed. At the June 2019 inspection we found: <ul style="list-style-type: none">• The IPC policy had been reviewed and included all relevant details and who to contact for further advice and guidance. This had been shared with staff who were aware of its contents.• An IPC audit had been completed. We saw evidence that an action plan had been developed and progress was tracked.• The practice had developed cleaning schedules that were signed daily by the cleaning agency. | |

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 |
| The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | 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 |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice relied heavily on regular locum GPs, however, these were fully inducted and monitored. A regular locum had recently become a salaried GP and the practice were also using a locum advanced nurse practitioner to ensure patients had access to clinical care. Receptionists were skilled in signposting to appropriate clinicians.</p> | |

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referral letters contained specific information to allow appropriate and timely referrals. | Y |
| Referrals to specialist services were documented and 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 |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | 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>The practice used a workflow optimisation team who had clinical backgrounds to manage all referrals and correspondence into the practice. All correspondence was managed within 48 hours of receipt.</p> <p>Pathology results were appropriately managed. We saw that these were dealt with in a timely manner with no evidence of a backlog.</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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA) | 0.99 | 0.89 | 0.88 | 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). (01/04/2018 to 31/03/2019) (NHSBSA) | 8.8% | 8.7% | 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) | 6.55 | 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) | 2.31 | 2.10 | 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. | Y |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Partial |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Y |
| The practice had a process and clear audit trail for the management of information about | Y |

| Medicines management | Y/N/Partial |
|---|-------------|
| changes to a patient's medicines including changes made by other services. | |
| 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 |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>At the January 2019 inspection we found:</p> <ul style="list-style-type: none"> • Patient Group Directions (PGD's) were not signed by each nurse to ensure that vaccinations were given safely. • There was no formal clinical supervision or audit of non-medical prescribers to ensure they were prescribing appropriately. We received evidence that this had been completed following the inspection. • We saw that medicines requiring additional monitoring were not appropriately managed and blood test results were not documented within the patient records. • The practice did not hold all emergency medicines and risk assessments had not been completed to mitigate the risk of not having all the recommended drugs available. These were not checked regularly. • The practice held a defibrillator and oxygen however, these were not checked regularly. • There were gaps in the recording of fridge temperatures to support the appropriate use of the cold chain. Following the inspection, we were told that the system for monitoring fridge temperatures had been reviewed. <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> • The practice kept blank prescriptions in printer trays overnight however, these were not stored | |

| Medicines management | Y/N/Partial |
|---|-------------|
| <p>securely. This was rectified at the inspection and shortly after the inspection we received evidence of a revised protocol ensuring blank prescriptions were securely stored overnight.</p> <ul style="list-style-type: none"> • All PGD's had been reviewed. The practice had created a tracker to ensure these had all been read and signed by the appropriate clinicians. • All non-medical prescribers had prescribing audits completed on a regular basis. This included the locum advanced nurse practitioner and locum GPs. The audits had highlighted that deferred prescriptions for antibiotics were not being appropriately recorded in patient records. This was discussed in clinical development meetings and re-audits were planned. • We saw evidence that medicines requiring additional monitoring were appropriately managed and blood test results were being recorded on the patient records. We also saw the medicine reviews were completed prior to repeat prescribing. • We saw that risk assessments had been completed to ensure that appropriate emergency medicines were held. Records and logs had been created to ensure that these remained in date and they were checked regularly. The log included the risk assessments and staff were aware of which medicines were held. • Trackers had been created for the defibrillator and oxygen and these were checked weekly. • We saw evidence that the fridge temperatures were monitored on a daily basis and that the cold-chain was used appropriately. | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Y |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | Five |
| Number of events that required action: | Five |
| Explanation of any answers and additional evidence: The practice had reviewed the significant event policy and shared this with staff. The practice had created a tracker to more accurately monitor significant events. Actions and learning were recorded and reviewed at practice meetings. The staff told us they felt confident in raising concerns to the management team and were confident they would be dealt with. | |

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

| Event | Specific action taken |
|--|--|
| A print out of a patient record was left in a care home communal area during a home visit. This was found by the care home staff and shredded. | The practice reported the information governance breach to the Bedfordshire Clinical Commissioning group and completed the appropriate documentation. The incident was discussed at the practice clinical governance meeting. All staff completed refresher training in data security. |
| A patient who was allergic to penicillin was prescribed a penicillin-based antibiotic. | The patient's medicines were changed when the mistake was highlighted. The practice discussed the incident at the practice clinical governance meeting and all staff were reminded to be vigilant when prescribing antibiotics and to ensure allergies and side effects were appropriately documented. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence: At the January 2019 inspection we found: <ul style="list-style-type: none"> There was limited oversight of action that had been taken in response to safety alerts. | |

At the June 2019 inspection we found:

- The practice had created a tracker to maintain oversight of safety alerts and the actions taken.
- We saw examples of actions taken on recent alerts for example, regarding sodium valproate.
- We looked at records that showed that a safety alert regarding antidepressant use, published in 2016, had not been acted on. Following the inspection, we received evidence that four patients had been identified as receiving a higher than recommended dose of antidepressant medicine and these patients had been reviewed and their medicines changed as appropriate. The practice had contacted the local medicines management team to ensure the correct guidelines were being followed and had plans to repeat the audit in four weeks to ensure all actions needed had been completed.

Effective

Rating: Good

At the January 2019 inspection, we rated the practice as requires improvement for providing effective services because:

- There was no evidence of regular medicine reviews for patients requiring repeat prescriptions.
- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.

At the June 2019 inspection we rated the practice as good for providing effective services because:

- The practice had reviewed the system for monitoring repeat medicines and we saw evidence that these reviews had been completed for patients prior to prescribing.
- The practice had reviewed all children who had not received their immunisations and found that many had received immunisations elsewhere. They had worked closely with the clinical commissioning group to ensure all children had received appropriate immunisation.

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | 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 to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| Explanation of any answers and additional evidence: At the January 2019 inspection we found: <ul style="list-style-type: none">• Medicine reviews were not being routinely completed for those receiving repeat prescriptions. | |

At the June 2019 inspection we found:

- Records we looked at confirmed that patients on repeat medicines were having these reviewed prior to issuing prescriptions.
- Relevant guidance was discussed at practice clinical development meetings to ensure all staff were aware of any changes.

| 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) | 0.71 | 0.84 | 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 had created a frailty register and discussed the patients with the community matron on a monthly basis. Each patient discussed had an action plan that was regularly reviewed.
- 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.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered 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 shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| 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) | 79.0% | 79.3% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 18.6% (89) | 15.8% | 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) | 64.9% | 76.0% | 77.7% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 13.8% (66) | 13.8% | 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) <small>(QOF)</small> | 83.0% | 82.2% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 16.7% (80) | 15.7% | 13.5% | N/A |

| Other long-term conditions | Practice | CCG average | England average | England comparison |
|---|------------|-------------|-----------------|--------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 72.0% | 76.6% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 3.0% (15) | 8.1% | 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> | 89.2% | 90.1% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 19.1% (35) | 13.9% | 11.5% | N/A |

| Indicator | Practice | CCG average | England average | England comparison |
|---|-----------|-------------|-----------------|--------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 79.4% | 82.1% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 5.1% (74) | 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) | 86.8% | 92.6% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 3.2% (6) | 5.0% | 6.7% | N/A |

Any additional evidence or comments

The practice ensured that exception reporting was only completed when the patient had been invited for review three times. They were working with the clinical commissioning group to engage with patients who were less likely to attend for reviews. The practice had focused on patients with diabetes in the current QOF year.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. The practice was aware of this and have reviewed the data to highlight where children have not received immunisation. The practice was proactive in contacting these families and found that some children had received immunisations elsewhere.
- The practice continued to translate invitation letters for immunisations into various languages to increase uptake.
- The practice contacted the parents or guardians of children due to have childhood immunisations to ensure appointments had been booked.
- 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 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.
- Young people could access services for sexual health and contraception. The practice kept free chlamydia testing kits in the practice toilet facilities with signage of where to go for further information and support.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|---|-----------|-------------|------------|---|
| 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) | 74 | 77 | 96.1% | Met 95% WHO based target (significant variation positive) |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England) | 87 | 99 | 87.9% | Below 90% minimum (variation negative) |
| 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) | 88 | 99 | 88.9% | Below 90% minimum (variation negative) |
| 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 | 99 | 88.9% | Below 90% minimum (variation negative) |

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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. The practice was aware that lower than average health checks had been completed and were working with the clinical commissioning group to invite higher numbers of people each month.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. Texting services were used to remind patients of appointments.

| 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) (PHE) | 67.7% | 74.0% | 71.7% | No statistical variation |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 73.7% | 73.2% | 70.0% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE) | 53.4% | 56.3% | 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) | 63.6% | 60.9% | 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) | 63.9% | 55.8% | 51.9% | No statistical variation |

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- All patients with a learning disability were offered an annual health check. The practice supported two homes for people with learning disabilities. A senior partner was the lead for these services and conducted regular ward rounds, annual reviews and had liaised regularly with staff.
- 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 met regularly with multi-disciplinary teams to discuss patients who were at the end of their lives. They also conducted mortality reviews to improve practice where needed.
- 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. We saw evidence that appropriate referrals were made to support services.
- The practice conducted regular reviews of adults in care homes.
- Clinical records for vulnerable people were highlighted to ensure they received appropriate support.

**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.
- The practice had a mental health link worker who had sessions at the practice once a week. They reported that this service had helped them engage with these patients.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication. The practice had reviewed the system for checking uncollected prescriptions. We saw evidence that this was effective.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. The practice had been involved in a new initiative to help identify patients with memory loss and early signs of dementia that involved an electronic tool for patients to complete. When dementia was suspected there was an appropriate referral for diagnosis.
- The dementia lead GP had completed care plans for patients with dementia and pro-actively screened patients in care homes for symptoms of dementia.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health were referred to appropriate services.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|--|-----------|-------------|-----------------|--------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 92.6% | 90.1% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 10.0% (3) | 20.2% | 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) | 84.6% | 91.3% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 13.3% (4) | 17.1% | 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) | 77.4% | 83.9% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 4.5% (4) | 8.4% | 6.6% | N/A |

Monitoring care and treatment

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

| Indicator | Practice | CCG average | England average |
|--|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 530.6 | 538.7 | 537.5 |
| Overall QOF score (as a percentage of maximum) | 94.9% | 96.4% | 96.2% |
| Overall QOF exception reporting (all domains) | 6.6% | 6.4% | 5.8% |

| | Y/N/Partial |
|---|-------------|
| Clinicians took part in national and local quality improvement initiatives. | Y |
| The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. | Y |
| Quality improvement activity was targeted at the areas where there were concerns. | Y |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Y |

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

past two years

At the January 2019 inspection we found:

- There was some evidence of clinical audit however this was not structured.
- There was a lack of audit around the prescribing practice of non-medical prescribers and locum staff.

At the June 2019 inspection we found:

- The practice had created a tracker and structured programme of audit activity. The practice had completed 26 audits since February 2018 and seven of these were two cycle audits.
- These audits had included review of the prescribing practices of non-medical prescribing and locum GP's. This had identified that deferred prescriptions for antibiotics had not been appropriately recorded in patient notes. We saw evidence that this had been discussed with the relevant staff and the practice have plans to repeat these audits.
- We saw evidence that audits were completed following safety alerts and updated guidance to ensure patients were receiving evidence-based treatment. This included a monthly audit of any patients who were prescribed sodium valproate.
- An audit had been completed in January 2019 to identify patients with hypertension that were prescribed a high dose of statins. We saw that patients identified were invited to the practice for a medicines review. The second cycle of the audit was completed in June 2019 where all patients were on recommended dosages.
- The practice completed monthly audits of children who did not attend or were not brought to their appointments, both at the practice or within secondary care. Each case was reviewed individually to consider what actions were needed.
- Organisational audits were completed on a regular basis. For example, we saw evidence that audits to track correspondence into the practice were used to improve workflow systems.

Effective staffing

The practice was able 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 the January 2019 inspection we found:</p> <ul style="list-style-type: none"> There was no programme of clinical supervision for the nursing team. There was no monitoring of nurse prescribing practices. <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> Audits had been completed for all non-medical prescribers. Nursing and healthcare assistant staff received clinical supervision and competence assessments. Staff told us they felt supported in their roles. | |

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) | Y |

| | |
|---|---|
| (QOF) | |
| We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Y |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice held regular multi-disciplinary team meetings to share information between services and coordinate patient care.</p> | |

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 |
| Patients had access to appropriate health assessments and checks. | 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>The practice continued to be proactive in seeking opportunities for social prescribing and worked with a local social prescriber and wellbeing services.</p> <p>The reception staff had been trained in care navigation to ensure patients were directed to appropriate services.</p> <p>Self-care information, leaflets and posters were available in the waiting areas.</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> | 95.9% | 94.9% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.8% (17) | 1.0% | 0.8% | N/A |

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Y |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Y |
| The practice monitored the process for seeking consent appropriately. | Y |
| Policies for any online services offered were in line with national guidance. | Y |

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 |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Y |
| Explanation of any answers and additional evidence: Patients we spoke with told us that staff treated them with care and compassion. | |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 11 |
| Number of CQC comments received which were positive about the service. | 7 |
| Number of comments cards received which were mixed about the service. | 4 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|--------------------|--|
| Patient interviews | Patients told us they were treated with kindness and care. They commented that reception staff were helpful when trying to make appointments. |
| CQC comment cards | Patients told us they were treated with dignity and respect. They commented that staff were helpful and the nursing team were supportive and kind. Some patients told us there was sometimes difficulty in getting an appointment with their chosen doctors. |

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 |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 8914 | 265 | 96 | 36.2% | 1.08% |

| 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) | 88.4% | 88.7% | 89.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018) | 87.2% | 85.7% | 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) | 93.7% | 95.7% | 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) | 78.9% | 82.0% | 83.8% | No statistical variation |

Any additional evidence or comments

The practice had recruited additional clinical staff to increase the availability of appointments. They also book any locum staff in advance so there is a clear structure of appointments enabling advance appointments to be booked.

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

Any additional evidence

The practice had a suggestions box and was completing a patient survey at the time of our inspection. The patient survey was due to be analysed over the next three months. The practice had noted that the response to patient survey exercises was low and therefore continued to encourage patient feedback.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Y |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |
| Explanation of any answers and additional evidence: Easy read and pictorial materials were available. The practice used translation services as necessary. | |

| Source | Feedback |
|---------------------------|--|
| Interviews with patients. | Patients told us they felt listened to during consultations and any changes in treatment were explained to them. They told us that they felt involved in their care and treatment. |

National GP Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about | 90.9% | 92.7% | 93.5% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------|
| their care and treatment (01/01/2018 to 31/03/2018) | | | | |

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

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | The practice had identified 59 carers. This was 0.6% of the practice population. |
| How the practice supported carers (including young carers). | The practice has reviewed their carers register and removed carers that were no longer appropriate. The practice has appointed a carers champion who had created an information pack of resources. |
| How the practice supported recently bereaved patients. | Bereaved patients were offered face to face appointments and signposted to support groups. The practice gave examples of where they had provided regular emotional support to bereaved patients. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|--|-------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Y |
| Consultation and treatment room doors were closed during consultations. | Y |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Y |
| There were arrangements to ensure confidentiality at the reception desk. | Y |

Responsive

Rating: Good

At the January 2019 inspection, we rated the practice as requires improvement for providing responsive services because:

- The practice relied heavily on inconsistent locum GPs.
- Patients told us there could be difficulty getting an appointment.

At the June 2019 inspection we rated the practice as good for providing responsive services because:

- The practice had recruited a further salaried GP and used consistent locum GPs to improve consistency of care. They had also recruited a regular locum advanced nurse practitioner.
- Patients told us they could usually get appointments when they needed however, there was occasional difficulty if they wanted to see a specific GP.
- The practice had reviewed their appointment system and increased the number of available appointments.

Responding to and meeting people's needs

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

| | Y/N/Partial |
|---|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Y |
| 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 |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |
| Explanation of any answers and additional evidence: At the January 2019 inspection we found: <ul style="list-style-type: none">• Patients told us there was difficulty making appointments as one of the GPs was working in a non-clinical capacity.• Patients told us it was difficult to make appointments in advance.• The practice relied heavily on locums resulting in inconsistent care. At the June 2019 inspection we found: <ul style="list-style-type: none">• The practice has increased the clinical team with another salaried GP and a regular locum advanced nurse practitioner.• The practice continued to use remote working for the workflow optimisation team to reduce strain on space within the practice. This enabled more space to be used for clinical appointments. | |

- The practice had created a more structured appointment system to allow for more advanced booking.
- Patients told us they could get appointments when they needed and CQC comment cards told us that reception staff were helpful when booking. Some CQC comment cards told us that there could be difficulty making appointments.

| Practice Opening Times | |
|-------------------------|---|
| Day | Time |
| Opening times: | |
| Monday | 8am – 6.30pm with telephone consultations until 8pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am – 6.30pm |
| Appointments available: | |
| Monday | On the day, pre-bookable and telephone consultations. |
| Tuesday | On the day, pre-bookable and telephone consultations. |
| Wednesday | On the day, pre-bookable and telephone consultations. |
| Thursday | On the day, pre-bookable and telephone consultations. |
| Friday | On the day, pre-bookable and telephone consultations. |
| | On the day, pre-bookable and telephone consultations. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 8914 | 265 | 96 | 36.2% | 1.08% |

| 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) | 96.4% | 94.0% | 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 provided effective care coordination to enable older patients to access appropriate services.
- 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.
- All patients requesting a home visit were triaged by the GP via a telephone call, prior to visiting.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment. The appointments were lengthened where necessary.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. These patients received regular reviews of their care plans.
- The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues. The practice met with the community matron regularly to review the frailty register and create action plans for these patients.
- 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

- 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. Appointments were available outside of school hours.
- The practice provided 'drop-in' baby immunisation clinics that were at the same time as the midwife clinics to aid communication. Appointments for immunisations were also available during normal clinics for those unable to attend at this time.
- Children who had child protection plans or who were on the safeguarding list were highlighted on the computer record system.

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 used online booking and text messaging services to allow flexibility.
- The practice offered telephone appointments for those unable to attend the practice. This service was available until 8pm on a Monday.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered to patients who had been highlighted as vulnerable when required.
- 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 such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. This included longer appointments and home visits where necessary.
- Patients with a safeguarding risk were highlighted on the computer records and given priority appointments.

**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 high numbers of patients referred to memory clinics and a high identification rate. All patients with a diagnosis of dementia had an associated care plan.
- 90% of patients with a mental health diagnosis had an associated care plan.

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>At the January 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice was aware that it did not have enough GP appointments for the practice population. Patients told us that care could be inconsistent due to locum GP cover. Patients we spoke to told us it could be difficult to access on-the-day appointments. <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice had recruited a salaried GP. The practice was using regular locum GPs and had recruited a locum advanced nurse practitioner to increase clinical capacity. The practice had reviewed their appointment structure to provide consistency of care and advance booking. Patients told us they could make appointments when they needed to. | |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018) | 74.2% | N/A | 70.3% | No statistical variation |
| 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) | 67.8% | 66.3% | 68.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018) | 69.9% | 61.4% | 65.9% | No statistical variation |
| The percentage of respondents to the GP | 68.5% | 71.8% | 74.4% | No statistical |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------|
| patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018) | | | | variation |

| Source | Feedback |
|--------------------|--|
| Patient interviews | Patients told us they could get an appointment when they needed. Most patients told us that appointments were on time. |

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. | 10 |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>At the January 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice did not send written information or responses to complaints. There was no information in the practice policy regarding how to escalate a complaint to the Parliamentary and Health Service Ombudsman (PHSO). <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice sent response letters to all written complaints. The practice had reviewed the complaints policy and it included details of escalation to the PHSO. The practice had created a tracker to record all complaints and compliments received. Any actions taken were recorded and reviewed. All complaints were discussed at regular practice meetings. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|--|
| Patient was spoken to in a rude and abrupt manner when trying to register at the practice. | The patient was given a written apology. The complaint was discussed at a practice meeting and a further session was booked with reception staff to focus on communication skills and public relations. |
| A patient telephoned the practice and booked an appointment however, when they attended the practice the appointment had not been booked. | The reception staff tried to re-book appointment at the same time however, no appointments were available. An appointment was booked for later in the day. A template was developed to ensure all telephone communication was recorded in patient notes. |

Well-led

Rating: Good

At the January 2019 inspection, we rated the practice as requires improvement for providing well-led services because:

- The leadership, governance and culture of the practice promoted the delivery of high-quality person-centred care; however, some systems were ineffective.
- Clinicians did not receive formal clinical supervision. There was no evidence of audits of prescribing for non-medical prescribers.
- Key policies, such as a whistleblowing policy, were not in place or had not been reviewed.

At the June 2019 inspection we rated the practice as good for providing well-led services because:

- Governance structures had been reviewed and formalised. Systems to assess risk were effective.
- Non-medical prescribers and locum GPs had prescribing audited on a regular basis which fed into formal clinical supervisions.
- All policies had been reviewed and formal policies had been written to include whistleblowing, governance and infection prevention and control.

Leadership capacity and capability

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

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: The practice management team understood the challenges they faced and understood that the main challenge was to increase clinical capacity. They had worked to recruit staff and increase the number of appointments available. Staff told us that management teams were visible and supportive. | |

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>The practice had a clear set of values and a written mission statement. This had been added to the practice website so that patients knew what they could expect from the practice. Staff we spoke with were aware of the practice values and these were central to the care they provided.</p> | |

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 |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>At the January 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice did not have a whistleblowing policy in place however, this was provided shortly after the inspection. Staff told us they felt able to raise concerns and felt these would be managed appropriately. <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice policies for whistleblowing and the duty of candour were embedded into practice. Staff told us that they continued to feel able to raise concerns. | |

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

| Source | Feedback |
|------------------|---|
| Staff interviews | Staff told us that they had seen and been involved in practice improvements since the last inspection. They told us they were proud to work at the practice and felt supported. Staff felt able to raise concerns or seek advice with management teams and there was an open-door policy. |

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 |
| Explanation of any answers and additional evidence: | |
| At the January 2019 inspection we found: <ul style="list-style-type: none">• There was no governance policy in place. We received evidence that this had been developed shortly after the inspection.• There was no formal review of policies, procedures or governance structures. | |
| At the June 2019 inspection we found: <ul style="list-style-type: none">• The additional policies developed following the January 2019 inspection had been embedded into practice.• We saw evidence that policies were regularly reviewed, and these were shared with staff at practice meetings and on shared computer systems. | |

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 the January 2019 inspection we found:</p> <ul style="list-style-type: none"> • Risk assessments for areas such as fire and health and safety had been completed however, some areas needed strengthening and action plans had not been created to manage remedial work. • The practice had not conducted a security risk assessment. • Risks around infection prevention and control had not been audited or mitigated. <p>At the June 2019 inspection we found:</p> <ul style="list-style-type: none"> • Risk assessments had been completed with remedial actions taken. These actions were regularly reviewed. • A security risk assessment and infection control audit had been completed. • There was a system of audit that led to quality improvements. | |

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 |

| | Y/N/Partial |
|---|-------------|
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |
| Any unusual access was identified and followed up. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Patients were able to book appointments online, request repeat medicines prescriptions and had access to their medical records. The practice had appropriate policies in place to ensure that the information was only accessible to the patient themselves. Appropriate identification and consent were gained prior to providing access to these records and systems.</p> | |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | 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 |

Feedback from Patient Participation Group.

| Feedback |
|---|
| The practice had an active patient participation group (PPG) who met on a quarterly basis. Suggestions from the PPG feed into the clinical development meeting. Representatives from the PPG also attend locality meetings. |

Continuous improvement and innovation

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

| | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement. | Y |
| Learning was shared effectively and used to make improvements. | Y |
| Explanation of any answers and additional evidence: We saw evidence of regular practice meetings with all staff. The practice held monthly clinical development meetings where audits and learning were discussed to drive improvement. These meetings were minuted and shared with staff. | |

Examples of continuous learning and improvement

| |
|---|
| The practice had completed several organisational and clinical audits. These had led to service development discussion and quality improvement. |
| The practice had worked extensively on improving their safeguarding lists and protocols, particularly for children who did not attend or were not brought to appointments to ensure that each case was reviewed individually, and actions taken as necessary. |

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

| Variation Bands | Z-score threshold |
|--------------------------------------|------------------------|
| Significant variation (positive) | ≤ -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.