

Care Quality Commission

Inspection Evidence Table

Olive Medical Practice (1-7262793866)

Inspection date: 25 September 2019

Date of data download: 27 August 2019

Overall rating: Requires Improvement

The overall rating for this practice is requires improvement. Concerns were identified for providing safe services and improvements were identified as being required for providing Effective, Caring, Responsive and Well Led services. These areas impacted on all population groups and so we have rated five out of the six population groups as requires improvement. Working age people (including those recently retired and students) was rated as inadequate.

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

Safe

Rating: Inadequate

The practice is rated as inadequate for providing safe services. This inspection identified the practice was working hard to improve the safety of services provided. However we noted gaps in the management and coding of patient information and records, patients' test results and management of tasks were not timely, there was no evidence that some patient safety alerts had been actioned and clinical staff working in advanced roles were not sufficiently monitored.

Safety systems and processes

The practice had implemented systems, practices and processes to keep people safe and safeguarded from abuse. However some processes and practices required further improvement.

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.	Partial
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

Safeguarding	Y/N/Partial
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> <ul style="list-style-type: none"> • There was good evidence that the practice was working hard to ensure all aspects of safeguarding were safe and effective. Contact had been established with the safeguarding team within the local Clinical Commissioning Group (CCG). • The practice had recently submitted a completed audit of safeguarding systems processes and practices as part of their compliance with the Safeguarding Children Toolkit for General Practice. An action plan in response to the audit was in the early stages of implementation • One GP partner was the safeguarding lead for both children and adult safeguarding matters. Records available showed that all staff including clinicians were trained to the correct levels. • Policies, procedures and contact information was readily available to the whole staff team both in consultation rooms and on the practice's electronic information management system. • Whilst the practice had generated a list of children on a safeguarding register, the list wasn't routinely reviewed at meetings; new cases were discussed as necessary with the clinical team. Health visitors were contactable but did not attend the meetings. • We noted some gaps in the procedures to safeguard people. For example one young person on the child protection register had not attended appointments for a blood test, and appointments with a psychological counselling and cognitive behaviour therapy service. The non-attendance at these appointments was not followed up. The principle GP confirmed there was no system established to monitor patients who did not attend appointments. Following our inspection the practice manager forwarded a copy of the 'Did Not Attend' (DNA) policy and this required the principle clinician to take the appropriate action following non-attendance at an appointment or scheduled vaccination. In addition the policy stated a monthly search would be undertaken to ensure vulnerable children and adults were followed up. • We also observed that the practice coding of one vulnerable patient did not include coding of the patient's associated family members. One patient had been removed from the child protection plan but this had been filed without GP oversight and not coded correctly and one patient had a child protection plan coded but information showed the child was a Looked After Child and not subject to a child protection plan. (A Looked After Child is a child who has been in the care of their local authority for more than 24 Hours). 	

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.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

Explanation of any answers and additional evidence:

- We examined a sample of staff recruitment files, including clinical, managerial and administrative staff. We observed that all files were organised with a monitoring checklist to ensure all the correct documentation was in place.
- The recruitment files we reviewed all contained the correct documentation including identification and Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We noted in one file that a DBS check undertaken by another service provider had been accepted by the practice. We discussed this, and the practice took immediate action to obtain an up to date DBS check.

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: May 2019	Y
There was a record of equipment calibration. Date of last calibration: April 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: May 2019	Y
There was a log of fire drills. Date of last drill: NA	N
There was a record of fire alarm checks. Date of last check: Weekly checks	Y
There was a record of fire training for staff. Date of last training: Various dates in 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: May 2018	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • All staff were trained in fire safety and knew how to respond in the event of a fire alarm. There were designated staff allocated the role of fire marshals. They were clear on the role and responsibilities of this role and specific training to support them with this role was planned. • The new practice management team have been addressing the issues identified by the fire risk assessment undertaken in 2018. Many of the required actions had been completed. However a fire drill which was planned just before the inspection had to be postponed as the fire alarm system 	

had developed a fault and required an engineer to come to repair the fire safety system.

- A comprehensive health and safety policy and accompanying risk assessments were in place with supporting action plans.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 20/09/2019 (as part of the practice health and safety risk assessment).	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 20/09/2019	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Comprehensive health and safety policies and procedures were in place and accessible to all staff on the practice electronic information system. All staff were involved in identifying risk and recording risk assessments. • Each room within the practice had its own risk assessment in place. • The practice had undertaken some refurbishment to make the patient waiting area much more welcoming and pleasant. Further refurbishment work was planned. • Some signage including electronic information referred to the name of the practice under the previous NHS contract holder and CQC registered provider. • The downstairs back door was propped open during our visit and the yard gate was also unlocked. Staff locked this once we identified this. 	

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: 14/09/2019	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: <ul style="list-style-type: none"> • The practice had benefited from the support from the infection prevention and control (IPC) lead from the CCG. Actions identified by CCG IPC lead had been implemented. This included ensuring flooring and the taps on handwash basin supported good practice. • The practice nurse was the lead for infection control and additional training to support them with this role was planned. • Comprehensive IPC policies and procedures were now available and accessible to all staff. • Actions still being implemented following the last IPC audit included updating records of staff immunisation status. The timescale for completion was October 2019. 	

- An audit of waste management consignment notes had been undertaken.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were in place.

	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.	P
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A paediatric pulse oximeter was not available. This measures the amount of oxygen in the blood and therefore maybe required in an healthcare emergency. 	

Information to deliver safe care and treatment

Staff did not always have 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.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
The practice demonstrated that when patients use multiple services, all the information	Y

needed for their ongoing care was shared appropriately and in line with relevant protocols.
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice was participating in a pilot scheme to manage document workflow at a local hub site. This was at an early stage. Two of the practice administration team attended the hub site for training to undertake this role. • We noted that the patient electronic record system contained 30 pages of tasks in the global inbox. Upon closer examination we saw 20 pages were notifications and or tasks which had been actioned but not marked as completed or deleted. • There were 161 laboratory reports in the inbox, those dated from 20/09/2019 had not been viewed or actioned. Older results, we were told, had been actioned but were sitting in a clinician's inbox for information and had not been filed. • We noted a number of cytology reports, including one from 29/08/2019 had not been viewed and a failsafe system to ensure all these results were reviewed was not yet established. • There were 88 documents requiring filing. We reviewed a small sample and found two documents had not been actioned. The oldest from 13/09/2019 required a prescription to be updated. Another document requested swab results.

Appropriate and safe use of medicines

The practice mostly 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.11	0.99	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	6.0%	7.1%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	6.73	5.73	5.63	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.98	3.03	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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> <ul style="list-style-type: none"> As part of the practices' overarching improvement action plan, a two week audit of incoming prescriptions including telephone, walk ins, online access and email requests had been undertaken. The practice worked with the CCG medicine optimisation team to monitor prescribing and to identify actions to improve. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> The practice was aware the number of medication reviews for patients prescribed four or more medicines was low and had recently recruited two clinical pharmacists who it was expected would be able to support the practice to increase this number. The practice used a regular locum advanced nurse practitioner (ANP) to undertake two minor illness sessions on a Monday. No formal recorded systems of monitoring the ANP decision making or prescribing was established. The lack of clinical oversight potentially put patients at risk. The provider advised that a system to monitor prescribing of non-medical prescribers was planned to be implemented in the near future with the support of the local GP federation. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However learning opportunities which had been identified externally were not always acted upon.

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: Since May 2019	5
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice management team, with the support of the local GP federation, had developed an action plan and this included reviewing how the practice responded to incidents. A policy with a standard template was available and significant events were standard agenda items and discussed at the weekly clinical meeting and monthly practice meeting. The practice manager used the National Reporting and Learning System (NRLS) to share incidents and promote learning locally and nationally. 	

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

Event	Specific action taken
Sudden death	A comprehensive review undertaken of patient appointments and contact with local hospital consultant. The review identified no action required. The significant incident was recorded and logged within the practice electronic information system. It was also discussed at the practice clinical meeting in August 2019.
Appointment made with incorrect	Reception staff booked a blood test incorrectly with the practice

clinician.	clinical pharmacist, who was not trained to take blood samples. Following a review of the incident a matrix was created for the reception team to identify what types of appointments each staff member in an advanced clinical role can provide.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice was signed up as per contractual requirements to the Central Alerting System (CAS). This is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information. We saw a list of the alerts received through CAS and actions taken as appropriate were logged within the practice management information system. • We noted female patients prescribed Valproate, (a medicine prescribed for epilepsy or seizures) had been audited and these patients had appropriate safeguards in place. • We were unable to locate evidence of receipt and action of other recent alerts sent out by the Medicines and Healthcare Products Regulatory Agency (MHRA). For example, Febuxostat used to prevent attacks of gout (circulated in July 2019) and Carbimazole used to treat hyperthyroidism (January 2019). The lack of action in relation to these alerts potentially put patients at risk. Searches were undertaken, and the practice confirmed they would take action. 	

Effective

Rating: Requires Improvement

The practice is rated as requires improvement for providing effective services. The practice acknowledged that they were working hard to ensure the different population groups received effective safe care. A comprehensive programme of quality improvement activity was being implemented.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice team confirmed that action to improve the overall management of the service provided to patients commenced in May 2019, when the support of the local GP federation was commissioned to help the practice. A management structure including recruitment of a new practice manager and deputy was implemented. A comprehensive review of each strand of service delivery was undertaken with the support of the GP federation and an action plan with designated lead responsibilities and timescales was recorded and implemented. At the time of this inspection visit the practice team were able to demonstrate the progress they had achieved in improving services to meet patients needs but acknowledged that this was still a work in progress. The Quality and Outcomes Framework (QOF) data recorded within this evidence table relates to the previous registered provider. 	

- The practice team confirmed performance in QOF for 2018/19 (not yet published) was not very good, but implementation of the action plan since May 2019 and the subsequent recruitment of a clinical pharmacist and a programme of staff training to upskill team members was anticipated to have a positive impact for the QOF year 2019/20.
- QOF data for 2018/19 was available at this inspection
- The practice was also being supported with the local clinical commissioning group (CCG) quality initiative Quality and Outcomes Enhanced Services Transformation (QOEST).

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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.85	1.04	0.75	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> • Older people were assessed for frailty as part of the local CCG quality initiative, QOEST. Those identified as having severe to moderate frailty were referred to the local integrated neighbourhood team (INT) • 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 had recently employed a clinical pharmacist and it was anticipated that GPs would have the additional support and expertise of this staff member to undertake structured annual medication reviews for older patients. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • The practice was training and upskilling a health care assistant to undertake Flu vaccinations, although flu clinics had not been arranged at the time of this inspection. The practice nurse confirmed these were being planned for October.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> • The provider advised that since taking over the practice they had encountered significant challenges in recruiting and retaining practice nurses. This had affected the call and recall for long term condition reviews process as there was no one available to undertake the reviews. • At this inspection a practice nurse was recruited and had been in post two months and support was being provided by the local GP federation to run monthly searches for reviews. • The practice had also arranged for a clinician with a special interest in diabetes to undertake clinics in October. • 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 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) <small>(QOF)</small>	82.0%	78.6%	78.8%	No statistical variation
Exception rate (number of exceptions).	22.8% (153)	11.3%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	80.1%	80.6%	77.7%	No statistical variation
Exception rate (number of exceptions).	21.3% (143)	7.7%	9.8%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	82.6%	82.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.0% (114)	10.3%	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>	54.7%	76.6%	76.0%	Significant Variation (negative)
Exception rate (number of exceptions).	12.9% (62)	4.7%	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	96.0%	92.6%	89.7%	No statistical variation

31/03/2018) ^(QOF)				
Exception rate (number of exceptions).	29.6% (21)	6.4%	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)	86.5%	84.3%	82.6%	No statistical variation
Exception rate (number of exceptions).	9.8% (58)	3.1%	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)	100.0%	97.8%	90.0%	Variation (positive)
Exception rate (number of exceptions).	6.7% (1)	11.0%	6.7%	N/A

Any additional evidence or comments

- The above QOF data, including the exception reporting was collected under the former provider of the GP service. Exception reporting is the exclusion of a patient from a health care quality indicator due to a variety of reasons, for example if they are newly diagnosed or newly registered with a practice, or where the treatment is judged to be inappropriate by the GP.
- Unverified data at the time of the inspection for the QOF year 2019/20 showed the practice was on track to improve its achievement of asthma reviews from 2017/18 (54.7%) to 69%.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. The practice confirmed that the lack of a practice nurse had affected their performance in offering this to babies and young children.
- The practice had liaised with the local children's surveillance team and following a review it was identified that children were receiving the immunisations but the documentation confirming this had been submitted late, which impacted on the collated data. No up to date data was available at the time of this inspection.
- The practice team stated they had improved their call and recall system for the immunisation programmes and contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment 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 were directed to a local service for sexual health and contraception.

- 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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	77	88	87.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	93	105	88.6%	Below 90% minimum
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) (01/04/2018 to 31/03/2019) (NHS England)	95	105	90.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	94	105	89.5%	Below 90% minimum

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: Inadequate

Findings
<ul style="list-style-type: none"> • The practice confirmed that achievement in cervical cytology was low and that it was challenging getting patients to attend for this screening. Up to date data was not available to demonstrate current achievement. • The practice nurse told us they followed up patients requiring this screening both opportunistically and following a non-attendance at an appointment. The practice nurse provided several examples where patients had confirmed they would attend an appointment but repeatedly did not attend. • The practice was reviewing and developing its systems to ensure eligible patients, such as those attending university for the first time were called in for the meningitis vaccine. • At the time of this inspection the practice advised due to lack of sufficient clinical staff, NHS health checks for patients aged 40 to 74 years were not being routinely offered. However, it was anticipated with recruitment of two clinical pharmacists and the training of a health care assistant that these health checks would be provided in the near future. • Patients could book or cancel appointments online and order repeat medication without the need

to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	51.3%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	48.2%	61.3%	69.9%	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)	31.6%	52.1%	54.4%	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)	55.6%	76.7%	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)	33.3%	49.7%	51.9%	No statistical variation

Any additional evidence or comments

- The practice was aware that data for the cancer detection rate from 2017/18 (under the previous provider) was low. To help improve this the practice the CCG lead for cancer had provided some education for the staff team.
- In February 2019, a specific bowel screening clinic was provided for patients who had not responded to the NHS bowel cancer screening programme. These patients were invited to attend a dedicated clinic, where during the appointment the screening kit was discussed, supported with a video and leaflets. Nineteen patients attended the clinic and of these 11 bowel screening kits were completed.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- Systems to ensure patients with a learning disability were offered an annual health check were being established.
- The practice referred patients requiring end of life care to the integrated neighbourhood team.
- End of life care was delivered in a coordinated way which took into account the needs of those

whose circumstances may make them vulnerable.

- GPs at the practice undertook home visits even at weekends so that patients' religious and cultural needs, wishes and references could be respected.

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.
- 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.
- 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.
- Patients with poor mental health, including dementia, 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) <small>(QOF)</small>	97.0%	93.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	13.2% (5)	12.8%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	92.9%	90.0%	Variation (positive)
Exception rate (number of exceptions).	7.9% (3)	10.1%	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) <small>(QOF)</small>	100.0%	85.3%	83.0%	Variation (positive)
Exception rate (number of exceptions).	6.3% (1)	6.2%	6.6%	N/A

Monitoring care and treatment

The practice was implementing action to ensure a comprehensive programme of

effective quality improvement activity was embedded.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	537.5	529.6	537.5
Overall QOF score (as a percentage of maximum)	96.2%	94.7%	96.2%
Overall QOF exception reporting (all domains)	14.7%	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

- The above QOF data is data collated under the previous provider of the GP service.
- The practice had commissioned the support of the local GP federation to support them in improving the quality of services provided. An overarching improvement plan was in place and this was supported by specific action plans for each area of service delivery.
- A clinical audit plan was being developed.
- One recent clinical audit reviewed DOACs (Direct Oral Anticoagulants used to prevent blood clots). This identified 17 patients prescribed these medicines in March 2019. Patients were reviewed to ensure the appropriate checks on renal function had been undertaken and that the dosing was correct. As a result of this audit two patients received a face to face appointment and their medicine dosage was changed. The audit was repeated in September 2019, which identified six patients requiring a weight check and one patient requiring a medicine dosage review. All were actioned, and a repeat audit was scheduled.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y

There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
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> <ul style="list-style-type: none"> • A formal process of monitoring clinical decisions made by staff working in advanced roles was not yet established. • GPs confirmed they were accessible to support the practice's clinical staff including the locum advanced nurse practitioners as required. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
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

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>	96.8%	96.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.8% (11)	0.8%	0.8%	N/A

Consent to care and treatment

The practice 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
Any additional evidence or comments <ul style="list-style-type: none"> One GP was a specialist deprivation of liberty safeguards (DoLS) assessor 	

Caring

Rating: Requires Improvement

The practice is rated as requires improvement for providing caring services. GP patient survey results showed higher levels of dissatisfaction when compared with local and national services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was not always 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

CQC comments cards	
Total comments cards received.	19
Number of CQC comments received which were positive about the service.	13
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	6

Source	Feedback
Comments cards.	Thirteen CQC comment cards described the service, GPs, nurses and the reception team positively. Comment cards described the service as 'good', and 'improved'. Staff were described as 'caring' and 'helpful'. The less positive comments referred to problems with telephone and appointment access.
Patient feedback	We spoke with one patient the day after the inspection. They provided positive feedback regarding the quality of care they received. They emphasised the improvements made at the practice. These included access to appointments, the redecoration and increased levels of privacy in reception and GPs not rushing you during the consultation.
NHS choices	There had been one review posted in November 2018 which commented very positively on the services and a second review posted in March 2019 referred to difficulty accessing appointments.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7612	467	114	24.4%	1.50%

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 (01/01/2019 to 31/03/2019)	81.9%	90.3%	88.9%	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 (01/01/2019 to 31/03/2019)	76.2%	88.2%	87.4%	Tending towards variation (negative)
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 (01/01/2019 to 31/03/2019)	93.4%	95.4%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	55.6%	85.7%	82.9%	Variation (negative)

Any additional evidence or comments

<ul style="list-style-type: none"> The practice was aware of the NHS GP patient survey results and monitored this and other feedback from friends and family. An action plan was implemented to respond to patient feedback. The practice team set up a patient participation group to encourage involvement from patients in the delivery and management of the service

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment, although patient feedback was not always positive.

	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice manager had introduced pre printed communication cards in reception to assist patients to identify a particular need to reception staff. For example, one card stated, 'I would like to speak confidentially', another stated 'Please be patient I have difficulty speaking' and 'Please involve my carer...' Members of the staff team were bi-lingual and were able to support patients who's first language was not English. 	

Source	Feedback
Interviews with patients.	One patient we spoke with stated the GP service they and their family received was much improved. They said appointment consultations with GPs were less rushed, with GPs taking time to listen.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	82.1%	92.8%	93.4%	Variation (negative)

	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
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Percentage and number of carers identified.	The practice had identified 53 patients as carers. This equated to less than 1% of the patient population. The practice manager confirmed that this was one area on the practice action plan where they had just commenced canvassing patients to ascertain whether they were a carer or had the services of a carer.
How the practice supported carers (including young carers).	The practice received support from a local carer's service and had set up a dedicated notice board in the reception area for patients. Flu vaccinations and health checks will be offered to carers.
How the practice supported recently bereaved patients.	The practice provided support to patients on an individual basis and this included a visit or telephone call if it was appropriate. They signposted patients to bereavement support services. GPs would visit patients at home to certify death quickly in response to religious and cultural needs.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patient feedback indicated there was a lack of privacy at reception and that patients waiting could over hear other patients' conversations. In response to this the practice had refurbished the reception area and the desk and this allowed better communication and promoted privacy. • An electronic self-check in was also available. 	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	NA
Online consultations took place in appropriate environments to ensure confidentiality.	NA
The practice advised patients on how to protect their online information.	Y

Responsive

Rating: Requires Improvement

The practice is rated as requires improvement for providing responsive services. Patient feedback indicated dissatisfaction with access to appointments. This impacted all population groups and so we rated all population groups as requires improvement.

Responding to and meeting people's needs

The practice organised and delivered services to 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

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 to 18:30
Tuesday	08:00 to 18:30
Wednesday	08:00 to 18:30
Thursday	08:00 to 18:30
Friday	08:00 to 18:30
Appointments available:	
Monday	08:00 to 13:00 and 14:00 to 18:30
Tuesday	08:00 to 13:30 and 15:00 to 18:30
Wednesday	08:30 to 12:30 and 15:00 to 18:30
Thursday	08.15 to 13:00 Afternoon Queries
Friday	08:00 to 12:00 Afternoon Queries
Extended Access Wednesday	18:30 to 20:30

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7612	467	114	24.4%	1.50%

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 (01/01/2019 to 31/03/2019)	90.7%	94.5%	94.5%	No statistical variation

Older people

Population group rating: requires improvement

Findings
<p>The provider is rated as requires improvement for providing responsive services. The concerns identified overall affected all patients including this population group.</p> <ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. 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.

People with long-term conditions

Population group rating: requires improvement

Findings
<p>The provider is rated as requires improvement for providing responsive services. The concerns identified overall affected all patients including this population group.</p> <ul style="list-style-type: none"> Recruitment of a practice nurse and a clinical pharmacist assisted the practice to develop an appointments system so that patients with multiple conditions could have their needs reviewed in one appointment. The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The practice liaised regularly with integrated neighbourhood team 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: requires improvement

Findings

The provider is rated as requires improvement for providing responsive services. The concerns identified overall affected all patients including this population group.

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

Working age people (including those recently retired and students)

Population group rating: requires improvement

Findings

The provider is rated as requires improvement for providing responsive services. The concerns identified overall affected all patients including this population group.

- 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 8.30pm on a Wednesday. 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 in the evening and at weekends. These included cytology appointments.

People whose circumstances make them vulnerable

Population group rating: requires improvement

Findings

The provider is rated as requires improvement for providing responsive services. The concerns identified overall affected all patients including this population group.

- The practice was reviewing and building its register of patients living in vulnerable circumstances including 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.

People experiencing poor mental health (including people with dementia)

Population group rating: requires improvement

Findings
<p>The provider is rated as requires improvement for providing responsive services. The concerns identified overall affected all patients including this population group.</p> <ul style="list-style-type: none"> • 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.

Timely access to the service

Feedback and data indicated people felt they were not able to access care and treatment in a timely way.

	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> <ul style="list-style-type: none"> • In response to patient feedback the practice had undertaken an audit of capacity against demand for appointments. The practice reviewed appointment availability and adapted the appointment schedule to meet peaks in demand. For example, on the Monday before the inspection we identified that all clinicians were scheduled to work throughout the day with a very high number of appointments. These were all booked up by 8.30am. • In addition to try and meet patient demand the practice had introduced a 'query' system whereby patients asking for an appointment, when all had been taken were listed with a brief synopsis of their concern. This was then reviewed by the duty GP who either contacted the patient directly or asked reception to contact the patient with a response. Thirty six calls were made to patients on the Monday before the inspection. 	

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	34.3%	N/A	68.3%	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	39.6%	72.1%	67.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	31.2%	67.5%	64.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	53.3%	75.4%	73.6%	Tending towards variation (negative)

Any additional evidence or comments

- The practice continued to seek solutions to improving access for patients, including promoting patient education and sign posting to advice and guidance on self care.
- Some reception staff were trained in care navigation but due to the staff changes since taking over the practice and the ongoing recruitment this additional service was not yet fully used.

Source	Feedback
CQC Comment cards	Six out of the 19 comment cards referred to difficulty getting appointments. Two comments cards referred to a much improved service in recent months
Patient feedback	One patient we spoke with stated that access to appointments had improved in recent months

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care

Complaints	
Number of complaints received since May 2019 (when the practice manager was recruited).	4
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> <ul style="list-style-type: none"> • We noted that only one of the complaints we examined was a written complaint. This had had a written response that included an explanation of the situation, the outcome of the investigation and an apology. It also contained information should the complainant wish to progress their complaint further. • The other complaints were logs of verbal complaints made to the practice. These were recorded and the actions taken to respond to the complaint logged. Notes also recorded that the outcome of the complaints had been discussed with the complainant and that they were satisfied with this. • A 'grumbles' log had also been set up and this we heard was being used to review service quality. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patients could hear consultations taking place while seated in the waiting room.	Work was undertaken to sound proof the waiting room.
Call back request for a GP – was not logged /actioned	Following investigation and review a standard operating procedure was created. This was discussed at the practice team meeting.

Well-led

Rating: Requires Improvement

The practice is rated as requires improvement for being well led. This inspection identified that the new provider and practice team with the support of the local federation were implementing a comprehensive quality improvement plan. There was recognition that further improvements as part of their plan were still required.

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:	
<ul style="list-style-type: none">• The GP service prior to the registration of the new provider had been inspected and, rated inadequate and placed into special measures. The new provider of the GP service took over the NHS contract in November 2018. During the early months of the new providers at the practice experienced a number of challenges particularly in relation to staffing both at practice management level and within the clinical nursing team.• The GP provider commissioned support from the local GP federation and in May 2019 they recruited a new practice manager and deputy practice manager. Further staff recruitment was undertaken and included a practice nurse, reception staff and more recently two clinical pharmacists.• With the assistance of the GP federation the GP provider created a quality framework for the overall management of the practice which was supported with comprehensive action plans to improve service delivery for patients and to create a dynamic resourceful staff team.	

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

Explanation of any answers and additional evidence:

- Practice leaders were clear on their priorities. The vision for the service stated: Olive Medical Practice is committed to providing quality patient centred care within the community, a privilege we cherish and a duty which obliges”.
- The vision was supported with a number of objectives, and a business development plan, which listed all the key areas necessary for the practice to deliver a quality service and achieve their vision.
- The quality improvement framework used opportunities provided by patient, staff and stakeholder feedback, complaints and significant events to foster a culture of quality improvement and service development.
- The business development plans were subject to regular review and adaptation in light of the changing priorities. All staff were encouraged to provide feedback and ideas for improvement.

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

Explanation of any answers and additional evidence:

- The practice team recognised they were on a journey of improvement and there was a commitment to continually develop and improve to provide the best service possible to patients.
- All staff spoken with told us that there had been a significant cultural change with the new GP provider and management team. Reception staff told us that the GPs and management were accessible, and there was an inclusive atmosphere.
- Staff were enthusiastic and eager to discuss their role and responsibilities and they told us they felt supported to undertake training and development opportunities.
- The practice team maintained a log of compliments received from patients and other stakeholders.

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

Source	Feedback
Staff	Staff we spoke with were clear about their role and responsibilities at the practice. Staff said the practice team was open in its approach, friendly and willing to listen.
Meeting Minutes	Meeting minutes showed a range of areas were discussed, including standing agenda items. A staff comments box had been set up, following a team members suggestion so that staff could share ideas and concerns anonymously if they so wished.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However there were gaps in the clinical systems of governance.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P
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:	
<ul style="list-style-type: none"> The practice's quality improvement strategy was supported with a range of action plans for each strand of service delivery. These were monitored and updated at regular intervals. The local GP federation provided weekly support to the practice management team. Systems to monitor clinical performance using the Quality and Outcomes Framework (QOF) and the CCG quality initiative Quality and Outcomes Enhanced Services Transformation (QOEST) had been recently established and were being embedded. Comprehensive and up to date policies and procedures were available and accessible to all staff. Records of staff training were available and evidence that staff, including the practice nurse had had an appraisal and or discussion about personal development plans were also available. 	

Managing risks, issues and performance

Some processes for managing clinical risks, issues and performance were not consistently implemented or effective.

	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.	N

There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>We identified some areas of potential risk in the management and recording of patient clinical information. For example:</p> <ul style="list-style-type: none"> • Systems to follow up patients, who did not attend appointments including those with a child protection plan were not established. There were omissions in coding of family members living with patients with a child protection plan in place. • The practice clinical record system was not managed effectively as the global inbox contained 30 pages of tasks, although 20 pages of these had been actioned, just not confirmed completed or deleted. • Systems to monitor and respond to test results, including cytology reports were not implemented effectively. • No formal recorded systems of monitoring the advanced nurse clinical decision making was established. • Systems to respond to patient safety alerts were not comprehensive as we were unable to locate two alerts issues in January and July 2019. 	

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.	P
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Data provided by QOF and QOEST was used to review and improve performance. • Systems to establish a programme of regular review of information and performance were being implemented, and expanded as performance improved. 	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's	Y

Office.	
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice manager reviewed feedback from patients and developed an action plan to respond to this. Improvements included refurbishment of the patient waiting area to increase privacy and increasing the number of appointments available. The practice was building its patient participation group. One meeting had been undertaken. Staff confirmed they felt part of the team and were involved in the improvements at the practice. There was a staff suggestion box for those staff who felt uncomfortable speaking directly to the management team. The practice team worked closely with the clinical commissioning group (CCG), the local GP federation, and were members of the primary care network. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> One patient confirmed they were a member of the patient participation group. They had attended the first meeting and stated they found it very useful.

Continuous improvement and innovation

Systems and processes for learning, continuous improvement and innovation were being developed and implemented.

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

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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.