

Care Quality Commission

Inspection Evidence Table

Springfield Surgery (1-552982214)

Inspection date: 2 October 2019

Date of data download: 27 September 2019

Overall rating: **Good**

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

Effective

Rating: Good

We decided to inspect the service following our Annual Regulatory Review (ARR). This was because the information available to us regarding the practice identified a potential change to the quality of care provided since the last inspection. Due to unforeseen circumstances the practice had experienced some challenges due to clinical staffing that had impacted on the practice performance. During the inspection we found that these challenges had been resolved and we saw significant improvements with the QOF data. However, improvement is still required in relation to cervical screening and child immunisations. Because of this we have rated the working age population group as requires improvement.

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.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Practice staff were able to access evidence based guidelines such as those from the National Institute for Health and Care Excellence (NICE) through their computers. New updates were discussed at practice meetings.• The practice was proactive in using various guidelines and reports to identify how it may improve services to patients. For example, in relation to end of life care.• The practice told us that they had undergone training in relation to guidelines developed in collaboration with Birmingham Children's Hospital for six of the most common children's conditions.• The practice had protocols in place to support staff for example, in relation to the diagnosis and	

monitoring of hypertension.

- The practice made use of a comprehensive pain assessment tool to support patients and assess their needs.
- Practice nurses advised they accessed vaccine guidelines and updates to help them keep up to date.

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) <small>(NHSBSA)</small>	0.22	0.75	0.75	Significant Variation (positive)

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- 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.
- The practice recently took part in a physiotherapy pilot. Six sessions were held by physiotherapists from the Royal Orthopaedic Hospital to encourage movement, improve balance and strength and confidence in older patients.
- The practice had patients in a local residential care home and undertook monthly visits to the home.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered at a minimum a structured annual review to check their health and medicines needs were being met. Diabetic patients were offered a standard six monthly review. 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.
- Published QOF data for 2017/18 showed the practice had performed significantly lower than local and national averages for Chronic Obstructive Pulmonary Disease (COPD) and for hypertension indicators. The practice advised that there had been exceptional circumstances during that period and shared with us their 2018/19 unvalidated QOF data. This showed the practice had achieved 93% for COPD indicators and 85% for hypertension indicators which was much improved and in line with their previous QOF performance.
- 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 appropriate treatment.
- The practice did not currently offer ambulatory blood pressure monitoring for patients with suspected hypertension. However, they encouraged patients to undertake home 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) <small>(QOF)</small>	83.7%	80.1%	78.8%	No statistical variation
Exception rate (number of exceptions).	25.4% (86)	12.5%	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>	71.0%	77.2%	77.7%	No statistical variation

Exception rate (number of exceptions).	6.2% (21)	10.4%	9.8%	N/A
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	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>	73.5%	81.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	7.4% (25)	11.4%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	74.8%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	8.4% (29)	6.3%	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>	25.8%	91.4%	89.7%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	11.2%	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)	73.6%	83.1%	82.6%	Variation (negative)
Exception rate (number of exceptions).	5.1% (22)	4.5%	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)	81.0%	88.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.7% (2)	8.2%	6.7%	N/A

Any additional evidence or comments

- There had been a general fall in QOF performance for 2017/18, this had been most significant for COPD and hypertension compared to the practice's previous years' performance. The practice told us about the challenges they had faced during 2017/18 which had impacted on their QOF data overall. They shared with us unvalidated data for 2018/19 which showed much improved performance across the clinical domains. The practice achieved 97% of QOF points in 2018/19 compared to 88% in 2017/18.
- The practice explained additional action they had taken to improve performance for example, taking on an additional GP partner and supporting the practice nurse in training in spirometry. They had also signed up for the CCG GP mentorship scheme to help develop the practice's respiratory service.
- The 2017/18 QOF data showed high exception reporting rates for 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. The practice shared with us the 2018/19 QOF data (unvalidated) which showed lower exception reporting rates at 12.6%.

Families, children and young people

Population group rating: Good

Findings

- The practice was not meeting the minimum 90% target or WHO based national target of 95% (the recommended standard for achieving herd immunity) for 2018/19 for the four childhood immunisation uptake indicators. The practice advised of the difficulties and complexities of the practice population. During 2017/18 the practice told us that they had participated in a GP immunisation quality scheme pilot through Public Health England and put in place actions to try and improve uptake. Data for the last quarter (July to September 2019) showed some improvement in relation to age two childhood immunisations.
- The practice contacted the parents or guardians of children who did not attend for their childhood immunisations.
- 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 provided support under specialist supervision to patients on the trans care pathway.

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)	80	91	87.9%	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)	72	86	83.7%	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)	71	86	82.6%	Below 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)	73	86	84.9%	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>

Any additional evidence or comments

As part of the GP immunisation quality scheme pilot it was identified that the practice had a high waiting list for immunisations due to insufficient capacity. The practice advised that they had reduced their waiting list from 70 to 2 patients. The practice shared with us their childhood immunisation data for quarter 2 2019/20. This showed improvement in the three age two child immunisation categories (two of which were now meeting the 90% minimum targets). However, child immunisation uptake relating to age one primary course of immunisations and age 2 booster immunisation for Pneumococcal infection were still below 90%.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Staff told us they used alerts to identify eligible patients and undertook vaccinations opportunistically.
- 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 had

carried out 114 health checks in the last 12 months.

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. They also made use of text messaging to remind patients of their appointments and for ease of cancelling appointments if no longer required. In addition, extended access appointments were available from the health centre in the evening and at weekends.
- Uptake of cervical cancer screening was significantly below the 80% target.

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)	59.3%	N/A	80% Target	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)	51.6%	63.8%	72.1%	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)	42.8%	44.0%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	80.0%	74.2%	69.3%	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)	100.0%	52.1%	51.9%	No statistical variation

Any additional evidence or comments

- The practice uptake for cervical screening showed the practice was below the 80% national uptake (Public Health England data) and higher levels of exception reporting compared to local and national averages. The practice advised that there were a high number of patients who declined screening relating to cultural barriers. They advised that the data was comparable to other local practices with similar demographics and whilst they reminded patients they did not believe in pressurising patients to undertake the procedure. The practice advised that they coded when patients had refused the test and that there were 433 patients with this code.
- The practice had identified an action plan to help promote the uptake of national cancer screening programmes. Practice staff told us that they followed up those who did not attend with letters from the practice. They felt that their uptake had improved and that QOF data for 2018/19 (unvalidated data) showed the practice had achieved 85%. However, this was not directly comparable to the Public Health England data which does not take into account the relevant screening intervals.

- We saw posters displayed in the waiting area promoting breast screening.
- The practice was currently involved in a national audit aimed at improving early detection of cancer.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice recognised that they had a large vulnerable patient contingent within their practice list. They had signed up to the safe surgery scheme to help support patients (who may otherwise struggle to receive primary healthcare) to register with the practice. Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check and had carried out 22 out of 60 reviews in the last 12 months. The practice had recently taken on a GP with special interest in learning disabilities who planned to lead on learning disability annual health checks.
- 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 was actively working to improve standards of end of life care and recognised different cultural needs across their population. They reviewed all unexpected patient deaths to identify any areas for improvement.
- The practice had reviewed their end of life care register to ensure patients who may need support were identified. Between February 2019 and April 2019 their end of life register had improved from 0.25% of the practice list to 0.4%.
- The practice had a register for patients who were vulnerable, these patients were discussed as part of the practices vulnerable adults safeguarding meeting.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. Staff told us that follow up searches were undertaken, and letters sent to patients who had missed their vaccines.
- The practice demonstrated that they had a system to identify people who misused substances and offered support for this group of patients at the practice under shared care arrangements.
- The practice had registered as an IRIS practice so that it could better support patients who were at risk of domestic abuse.
- The practice had links with a social prescribing scheme (Springfield Project), offering a range of support for patients who may be isolated or vulnerable in order to improve their wellbeing.

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 latest published QOF data for 2017/18 showed the practice had performed lower than local and national averages for mental health indicators. The practice shared with us their 2018/19 unvalidated QOF data, this showed the practice had achieved 100% for both mental health indicators identified as an outlier. This was in line with their previous QOF performance on mental health prior to 2017/18.
- 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.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. The practice made use of alerts to ensure these patients were given urgent appointments and we saw an example of this.
- 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.
- The practice offered an inhouse counselling service two days each week.

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)	68.2%	93.3%	89.5%	Variation (negative)
Exception rate (number of exceptions).	2.2% (1)	9.5%	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)	68.9%	93.4%	90.0%	Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	7.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) ^(QOF)	76.5%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	6.0%	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)	493.1	546.1	537.5
Overall QOF score (as a percentage of maximum)	88.2%	97.7%	96.2%
Overall QOF exception reporting (all domains)	10.0%	6.1%	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 practice shared with us unvalidated QOF data for 2018/19 which showed much improved performance across the clinical domains with 97% of QOF points achieved in 2018/19 compared to 88% in 2017/18.

The practice carried out a full cycle audit during 2018 and 2019 which looked at the management of patients on a range of high-risk medicines. Results showed significant improvements between the baseline and last audit in the management of this group of patients.

The practice had carried out an audit in response to the Sodium Valproate safety alert which identified risks to unborn children if taken during pregnancy. The audit undertaken in April 2019 and September 2019 identified further work required in order to meet standards set by the practice.

The practice carried out minor surgery audits in 2016 and 2019. The audit reviewed quality standards including complications following procedure and accuracy of diagnosis. The audit concluded that the practice was carrying out a safe service in relation to minor surgery.

Any additional evidence or comments

- The practice reviewed unexpected patients deaths to identify areas for improvement in relation to end of life care.
- The practice had reviewed a recent publication from the Muslim Council of Great Britain on end of life care to identify how they could better improve support muslim patients and their relatives.
- The practice had undertaken a comprehensive review of their prescribing and developed an improvement plan. The practice received support from their PCN pharmacist in undertaking polypharmacy reviews.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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/A
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"> All staff had access to a range of online training. The nursing team had been supported to undertake role specific training to support the needs of the practice. For example, nursing staff had been supported in training for respiratory conditions and diabetes. One of the GP partners helped provide supervision and support to the nursing team to help ensure competence in undertaking patient reviews and opportunities to discuss more complex patients. New staff received appropriate induction training, and this was confirmed by a new member of the team. Members of the nursing team told us that they were supported by the practice to attend conferences and nurse forum events. Staff also received annual appraisals and we saw examples of these. 	

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.	N/A
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had patients in a local residential care home and provided monthly doctors' visits for those patients. • The practice held regular multi-disciplinary team meetings with other health and social care professionals to support their most vulnerable patients. These included safeguarding meetings with the health visitor and gold standard meetings for end of life care. • The practice was able to share information electronically with the out of hours service to help support continuity of care. 	

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> <ul style="list-style-type: none"> The practice offered social prescribing support and was proactive in referring patients to a local social prescribing project (The Springfield Project) which offered patients various opportunities to improve patients general wellbeing. The Springfield project offered patients various activities including support to gain basic qualifications, employment, fitness and creative workshops. The practice website included a range of health and wellbeing advice and self help support for various conditions. There was also information available in the waiting area to support patients. For example, in relation to diabetes, weight management and mental health. Patients with a prediabetic condition were offered support through referral to the diabetes national prevention programme. The practice had signed up to become a Parkrun practice an initiative to encourage physical activity and improve wellbeing of their patients and staff. The practice offered in-house smoking cessation support. 	

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>	91.5%	96.1%	95.1%	No statistical variation

Exception rate (number of exceptions).	0.5% (4)	0.6%	0.8%	N/A
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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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Minor surgery was carried out at the practice. We saw evidence that formal written consent was obtained for those procedures and explanation of any risks.• We saw that a minor surgery audit had been completed in 2019 which included an audit of consent.• The practice had access to easy read materials relating to health checks and cervical screening for patients who may find it difficult to understand these procedures and to enable them to give informed consent.• There was a template on the clinical system for staff to follow when assessing a patient's mental capacity for care and treatment.	

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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 practice had undergone a challenging time during 2017/18 which had affected the staffing levels at the practice. While this has since been resolved the practice has looked at future sustainability of the workforce by increasing clinical staffing and placing a strong focus on staff wellbeing to drive high quality care.• The practice recognised the challenges they faced serving a diverse community. The practice was located in an inner city, socially deprived area. Staff told us that they had large numbers of vulnerable patients on their list and were working to identify and develop their services so that they could best support this group.• The practice was part of the SmartCare Central Primary Care Network. One of the clinical partners has recently taken on the role as the chair of the local primary care network. Through the PCN they were working with other practices to deliver wider support to the local population.	

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:	

- The practice had clearly set out its vision and values for the service and what it wanted to achieve. We found that this was shared with staff and well embedded within the practice.
- The practice had developed a sustainable leadership strategy. The model focussed on compassionate leadership building on team relationships, creating a safe environment where everyone feels valued and motivated to deliver a high quality service. Leaders were given dedicated time to undertake management responsibilities.
- The practice had developed a business plan which set out their priorities for the next 12 months. This had been shared with both the whole practice and patient participation group.

Culture

The practice had a culture which drove high quality sustainable care. The wellbeing of staff was central to this.

	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.	N
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Compassionate leadership and staff wellbeing was a key influence within the practice. The practice had a very strong emphasis on ensuring the wellbeing and resilience of their workforce. Leaders at the practice had set up a programme to support and empower their staff to look after themselves and improve their health, wellbeing and lifestyle with the aim that this would help support resilience, motivation, job satisfaction and retention of staff. The programme consisted of six sessions which included sessions on diet and exercise and managing stress. Feedback from staff and patients demonstrated staff felt valued, worked well as a team and this was reflected in the care they provided to their patients. Clinical and non-clinical staff we spoke with were very positive about the support they received from the senior team. They found leaders approachable and spoke highly of the leadership and the whole practice team. The practice had held weekends away to bring the team together and develop as a practice. Their next weekend away was planned for October 2019. Staff with particular areas of interest and wanted to take lead roles were encouraged and supported to do so. Staff had access to online equality and diversity training which some of the staff had completed. The practice had a whistleblowing policy in place. However, staff we spoke with were not aware if the practice had a freedom to speak up guardian. 	

- We received 40 completed CQC comment cards from the practice, patients were very positive about the service and all members of the staff team. Patients described compassionate care and treatment they received.

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

Source	Feedback
Staff interviews	We spoke to members of the clinical and non-clinical team (including new members of staff) who told us that they were well supported by the leadership team, that staff wellbeing was a high priority within the service and that they received a comprehensive induction.
Staff Survey July 2019	Nine members of the practice team responded to the practice's staff survey. Results were very positive about the culture of the practice. Staff said they felt valued, that they were able to approach senior staff and felt able to contribute ideas and suggestions to the practice.
Evaluation of the Building a compassionate workplace and community holistic resilience in primary care programme	Staff were given the opportunity to provide feedback on this programme and how it could be improved. Overall, all staff said they would recommend the programme to others.

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:	
<ul style="list-style-type: none"> • The practice held meetings on regular basis to discuss issues affecting the practice and the service patients received. These included clinical meetings, full practice meetings, and multidisciplinary team meetings. • Staff had clear roles and responsibilities. There were clear lead roles for example in relation to safeguarding, the quality outcomes framework and carers. 	

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> <ul style="list-style-type: none"> • The practice had effective systems in place for managing safety alerts, incidents and complaints. We saw that incidents over the last 12 months had been reviewed for any recurring themes. • Performance relating to QOF, the CCG led universal offer for enhanced services, prescribing and patient survey data were monitored at the partners meetings. • The practice had systems for identifying and managing risks which included clinical and non-clinical risks. They encouraged all staff to help identify service risks and any mitigating action. • The practice maintained fail safe mechanisms for any clinical samples undertaken to check results were received. • Regular searches were undertaken to check that patients on high risk medicines were followed up for regular monitoring. • We found the premises to be well maintained and risks relating to the premises were managed by the landlord. Appropriate risk assessments and premises checks were in place. • All staff received basic life support training and there was an alarm system available to alert other members of staff to an emergency. The practice nurse had also run a session covering emergency scenarios with staff. • The practice had a Business continuity plan in the event of major disruptions to the service. A copy was held off site should the premises be inaccessible. 	

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.	Partial
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"> • Since our previous inspection the practice had implemented TeamNet (a clinical governance system). This supported them in the management of administrative and management tasks. For example, in relation to the management of significant events and safety alerts to help ensure actions were completed. • The practice had developed templates for care planning to ensure they covered all areas. We saw examples of care plans in place for some of the practices more vulnerable patients and saw that these were updated following hospital admissions. • We saw that the practice was proactive in using performance data available to identify areas for improvement. This included prescribing, QOF and patient survey data. • The practice had undertaken an internal infection control audit in February 2019 however it was not clear from the action plan what had been completed. We also found recruitment checks were not always fully recorded to show all relevant checks had been undertaken. However, when we spoke with a new member of staff they confirmed they had been asked to provide the relevant documents. 	

If the practice offered online services:

	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Practice staff told us that they were supported by the SmartCare Federation in relation to information governance and had access to a Data Protection Officer through the federation. • There were appropriate arrangements for managing the security of patients records. 	

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 obtained feedback from patients through the patient participation group (PPG), friends and family test (FFT), in-house patient surveys and the national GP patient survey. The practice had reflected on the results from the patient surveys to identify areas for improvement. For example, increasing the number of afternoon appointments through the recruitment of a new salaried GP. • The practice had an active PPG which met on a quarterly basis. The PPG had organised a Surgery open day in May 2019 to promote the practice. The open day was supported by practice staff who performed health checks and provided health advice to those attending. It was also attended by a range of other agencies including diabetes community champions and Thrive to work. Feedback from patients who attended was positive. • Staff we spoke with told us that the practice was very supportive of ideas from staff and were able to provide a range of examples where their ideas had been implemented. For example, the development of an information sheet for patients undergoing ear irrigation. • As well as regular staff meetings the practice held weekends away for team building and to discuss the vision and values of the practice. The practice had also obtained feedback from staff as part of a staff survey in July 2019. • The practice was part of the SmartCare Federation and primary care network. This enabled them to work collectively with other local practices to help develop services that met the needs of the local population. 	

Feedback from Patient Participation Group.

Feedback

We spoke with the chair of the practice's patient participation group who was very positive about the practice. They felt the practice listened and responded to feedback from patients and that they felt valued as a group.

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:	
<ul style="list-style-type: none">• The leadership team were highly motivated and demonstrated throughout the inspection how they sought to develop and continually improve the practice and the care and treatment patients received.• Staff were supported in their personal development and to meet the needs of those who used the service. They supported staff to take on lead roles.• Staff received annual appraisals to discuss their development needs.• The practice focussed on the wellbeing of staff to help drive performance through motivated staff that were happy in their place of work.	

Examples of continuous learning and improvement

<p>The practice was able to provide various examples of how they sought continuous learning and improvement.</p> <ul style="list-style-type: none">• The practice used the Gold Standard Framework for managing end of life care patients. They were also working to achieve the RCGP Marie Curie Daffodil standards on end of life care to deliver further quality improvements in meeting the needs of this group of patients. They had also recognised different cultural needs at end of life which reflected a significant proportion of their population and were working to recognise and improve care for these patients.• The practice had registered as a RCGP park run practice to encourage patients to be more active. And improve general wellbeing.• The practice was involved in a pilot study run by physiotherapists from the Royal Orthopaedic Hospital. Six weekly sessions were held for patients over 60 years to encourage balance and strength and improve confidence.• The practice supported the needs of vulnerable patients through becoming a safe practice, offering inhouse counselling services, undertaking IRIS training to better support patients at risk of domestic violence, links with a local social prescribing scheme and citizens advice clinics held at the practice.

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

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.