

# Care Quality Commission

## Inspection Evidence Table

**Dr Rashid Akhtar (1-533212045)**

**Inspection date: 24 September 2019**

**Date of data download: 27 September 2019**

### Overall rating: Good

We inspected the practice in January 2019, and rated the practice as requires improvement overall as the practice did not have clear and effective processes for managing risks, issues and performance. The overall governance arrangements were ineffective. The practice is now rated good overall, the practice was able to demonstrate they had made significant improvements to ensure safety and quality of the service.

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

### Safe

**Rating: Good**

We inspected the practice in January 2019 and rated the practice as inadequate for providing safe services as not all risks had been assessed and managed, such as infection prevention and control, the absence of emergency medicine and equipment. The practice did not have reliable systems in place for the appropriate and safe use of medicines. Staff did not always have the information they needed to deliver safe care and treatment. During this inspection we saw significant improvements to safety systems and processes. The service is now rated as good for providing safe services.

#### Safety systems and processes

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

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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence of regular multi-disciplinary team meetings with the community matron which provided the opportunity to discuss and share concerns relating to vulnerable adults. Meetings were also held with the Health Visitor to discuss safeguarding concerns relating to children and details of these meetings were recorded.</p> <p>On reviewing employment records, we found a member of clinical staff who had been appointed since our previous inspection had commenced post with a DBS from their previous employer and this had not been risk assessed. On the day of the inspection we saw that the practice had now undertaken their own DBS check.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>A member of staff who had been appointed since our previous inspection had commenced post prior to receipt of satisfactory references to demonstrate character and conduct. However, at the time of the inspection satisfactory references had been obtained.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person.	Y
Date of last inspection/test: October 2018	
There was a record of equipment calibration.	Y
Date of last calibration: April 2019	
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: June 2019	Y
There was a log of fire drills. Date of last drill: September 2019	Y
There was a record of fire alarm checks. Date of last check: September 2019	Y
There was a record of fire training for staff. Date of last training: Various dates within the last 12 months	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: February 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: An appointment had been booked for 26.10.2019 for further testing of all portable appliances. The fire risk assessment had been updated since the previous inspection to reflect risks associated with evacuating patients with a disability	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: April 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2019	Y
Explanation of any answers and additional evidence: The practice had also completed risk assessments in areas such as the storage of oxygen and access for patients with a disability.	

## 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: September 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
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:

The practice had addressed areas for improvement that we had identified at our previous inspection. This included a legionella risk assessment which was last carried out in April 2019 by an external contractor (Legionella is a term for a bacterium which can contaminate water systems in buildings) and the correct labelling of clinical waste bags awaiting collection.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in January 2019, the practice did not have a practice nurse in post, the practice now employed a practice nurse who worked one session a week.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had made improvements to the system in place for monitoring patients on high risk medicines, this included updating records to clearly demonstrate that the patient had received appropriate monitoring of their health. Patient electronic records now demonstrated why a patient did not have a test or investigations as appropriate codes were used.</p>	

### Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.99	0.92	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)	9.0%	5.7%	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)	5.45	5.26	5.63	No statistical variation
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)	3.89	1.58	2.08	Tending towards variation (negative)

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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice could demonstrate the prescribing competence of non-medical prescribers. The advanced nurse practitioner (ANP) had regular clinical supervision with the lead GP, which was documented and included case reviews and a review of the appropriateness of prescribing.</p> <p>The practice had implemented several positive changes to address areas for improvement identified at the previous inspection. This included comprehensive systems for ensuring Patient Specific Directions (PSD's) were completed appropriately and improvements in the monitoring of patients on high risk</p>	

Medicines management	Y/N/Partial
medicines. All medicines required in the event of a medical emergency were in place, records confirmed that the defibrillator was checked regularly to ensure it remained in working order and a second thermometer was purchased for the two fridges used to store vaccines.	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded since last CQC inspection (January 2019):	10
Number of events that required action:	10
Explanation of any answers and additional evidence: At our previous inspection, we discussed with the lead GP the threshold for reporting to ensure all types of relevant events were captured. During this inspection we saw that the practice was identifying and reporting a range of events. Significant events were discussed in staff meetings and were stored on the intranet to ensure they were easily accessible to all staff, reporting was encouraged and supported.	

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

Event	Specific action taken
Referral for investigation rejected due to incorrect information	Discussed at practice meeting that the correct information is required before a referral is made to reduce likelihood of rejection and avoidable delay.
Missed opportunity for checking a patient's pulse	Reinforced to staff the need to check opportunistically to improve detection rates for a specific heart condition.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Patient safety alerts such as information from the Medicines and Healthcare Regulatory Agency (MHRA) were received by the practice manager and then sent to clinical staff by email to ensure any actions were completed. Any relevant learning was shared with staff during practice meetings. We saw an example of actions taken following a recent alert.	



## Effective

**Rating: Good**

### 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: The practice had made significant improvements to their system to review patients on high risk medicines since our previous inspection.	

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)	1.16	0.70	0.75	No statistical variation

### Older people

**Population group rating: Good**

#### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.



- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

Population group rating: **Good**

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	74.9%	79.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	3.5% (7)	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) (QOF)	84.4%	78.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	3.0% (6)	8.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	70.8%	78.7%	80.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	15.2% (30)	11.5%	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>	84.1%	77.5%	76.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.7% (3)	4.6%	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>	95.7%	90.5%	89.7%	No statistical variation
Exception rate (number of exceptions).	16.1% (9)	12.6%	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) <small>(QOF)</small>	82.0%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.8% (10)	4.4%	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) <small>(QOF)</small>	95.2%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.2% (1)	5.4%	6.7%	N/A

### Any additional evidence or comments

The practice's QOF achievement for patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was tending towards a negative variation and the exception reporting rate was higher than the local and national averages. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. We reviewed this at our last inspection and again during this inspection although the QOF data had not been refreshed. We saw the practice had an active call and recall system for patients with long term conditions including diabetes and exception reported patients appropriately. The practice had an above average practice population aged 65 years and some patients were on the maximum tolerated dose of insulin for their diabetes. The practice's performance diabetes indicators were mostly comparable with the local and national average with lower levels of exception reporting. We looked at the reason for the exception reporting and saw that patients had been exception reported appropriately for example they had declined or did not attend.

QOF achievement for patients with Chronic Obstructive Pulmonary Disease (COPD) who had had a review with a health care professional was also comparable to local and national averages. However, the exception reporting rate was higher. This was also reviewed at the previous inspection and again during this inspection. We looked at the reason for the exception reporting and saw that patients had been exception reported appropriately for example they had declined or did not attend following recall.

### Families, children and young people

Population group rating: **Good**

#### Findings

- The practice has not met the minimum 90% target for two of four childhood immunisation uptake indicators.
- The practice 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 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 signposted and referred patients to the appropriate services where necessary.
- 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	24	27	88.9%	Below 90% minimum

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)				
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)	33	35	94.3%	Met 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)	33	35	94.3%	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)	31	35	88.6%	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

The practice was slightly below the target range of 90% for the percentage of children aged one who had received primary course of immunisation and children aged two who had received the immunisation for measles, mumps and rubella. We saw that the practice actively encouraged uptake, a practice nurse was appointed in February 2019 and their role included administering vaccinations and following up any non-attendances. The practice provided recent data from the Child Health System which showed for the most recent quarter the practice achievement for these immunisations was 96%.

### Working age people (including those recently retired and students)

### Population group rating: Requires improvement

#### Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice's uptake for cervical screening was, below the 80% coverage target for the national screening programme.

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	67.3%	N/A	80% Target	Below 70% uptake

period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	79.7%	64.2%	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)	57.7%	42.1%	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)	92.9%	65.8%	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)	71.4%	50.0%	51.9%	No statistical variation

#### Any additional evidence or comments

At our previous inspection the practice's uptake for cervical screening was below the 80% coverage target for the national screening programme and we recommended the provider consider how to increase the uptake. There had been no new published data since our last inspection. However, unvalidated QOF data provided by the practice, although not comparable data showed the practice achievement for women aged 25-49 years as 61%. To help improve uptake, the practice had employed a sessional practice nurse since our previous inspection, the practice was reviewing the impact of the appointment of the nurse on cervical screening uptake over a period of six months with a view to increase hours if required. A female locum GP also carried out screening and patients were also able to attend a local clinic for screening however, we did not see any information promoting this arrangement. We saw that the practice followed up women who did not attend and the clinicians undertaking the screening monitored their results. The practice acknowledged this was an area for ongoing improvement.

#### People whose circumstances make them vulnerable

Population group rating: **Good**

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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 had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

## People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- 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.
- 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) (QOF)	100.0%	91.6%	89.5%	Tending towards variation (positive)
Exception rate (number of exceptions).	14.3% (2)	13.5%	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)	100.0%	93.1%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.1% (1)	10.8%	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)	100.0%	83.6%	83.0%	Variation (positive)
Exception rate (number of exceptions).	11.8% (2)	6.7%	6.6%	N/A



### Any additional evidence or comments

The practice achievement for mental health indicators were above local and national averages, two of the indicators had higher level of exception reporting however, the number of patients was low.

### 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)	545.2	538.1	537.5
Overall QOF score (as a percentage of maximum)	97.5%	96.3%	96.2%
Overall QOF exception reporting (all domains)	4.3%	6.2%	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

<p>The practice had completed the following two cycle clinical audits since the last inspection which demonstrate quality improvement.</p> <ul style="list-style-type: none"><li>An audit reviewing the monitoring in place for patients on a specific medicine. The initial audit was completed in September 2018. Patients on this medicine were identified and checked to see if appropriate monitoring had taken place within the last 12 months. Of the 11 patients identified one had no monitoring in place, actions taken to help improve included ensuring alert systems were in place to highlight that the patient was due a blood test. A re-audit in September 2019 showed that all 12 patients on this specific medicine had received appropriate monitoring.</li><li>An audit reviewing the monitoring in place for patients receiving replacement therapy for a specific condition. The initial audit was completed in July 2018. Patients on this therapy were identified and checked to see if appropriate monitoring had taken place within the last 12 months. Of the three patients identified, all had appropriate monitoring in place. However, the level of a specific hormone was not recorded in any of the records, all three patients were subsequently reviewed, and the levels were recorded. This was identified as an area for improvement. A re-audit in July 2019, at which point there were six patients receiving the therapy, showed of these patients only one did not have appropriate monitoring in place, all had the levels of hormone recorded.</li></ul>
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Non-clinical quality improvement activity included audits of infection prevention and control, health and safety and patient feedback surveys.

## 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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was no formal programme of learning and development however, the practice had a small number of staff and the practice manager had a system in place to monitor training and development for staff.</p> <p>Since our last inspection the health care assistant had completed the Care Certificate standards in May 2019.</p> <p>The lead GP provided formal clinical supervision and mentoring to the practice nurse, advanced nurse practitioner and health care assistant on a regular basis and discussions were documented.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (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
Explanation of any answers and additional evidence:	

## 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
Explanation of any answers and additional evidence:	

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	96.8%	95.7%	95.1%	No statistical variation

smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.1% (1)	0.7%	0.8%	N/A

### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>Discussion with clinical staff showed that verbal consent was always obtained before care and treatment and where relevant written consent for example, for certain treatments. Written consent forms were scanned directly on to the patient's records and verbal consent was recorded in the patient's notes. Clinical staff spoken with were aware of the importance of consent and showed understanding of areas such as best interest and Gillick competency.</p>	

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

### CQC comments cards

Total comments cards received.	40
Number of CQC comments received which were positive about the service.	37
Number of comments cards received which were mixed about the service.	Three
Number of CQC comments received which were negative about the service.	Zero

Source	Feedback
CQC comment cards	There were 37 positive comment cards, and this included comments about staff who were helpful and caring.
Patient interviews	We spoke with five patients including one member of the Patient Participation Group (PPG). Positive comments included staff being respectful, polite and caring.

## National GP Survey results

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3149.0	279.0	117.0	41.9%	3.72%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	92.9%	83.0%	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)	94.8%	80.2%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	99.4%	91.9%	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)	94.0%	73.5%	82.9%	No statistical variation

### Any additional evidence or comments

The practice was above local and national averages for questions in the 2019 GP Survey related to caring and this was aligned with the patient feedback we received on the day of the inspection.

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

### Any additional evidence

The practice had gathered feedback from patients through the patient participation group (PPG), national surveys and comments and complaints received. The provider told us they had reviewed the results of the

most recent national GP survey and were happy with the results as the results showed that the practice scored higher than the local average in every question. In some questions the practice score was also higher than the national average. There were no areas where the practice was below local or national averages. However, the provider acknowledged ongoing work was required to sustain positive feedback and ensure ongoing monitoring of the quality of the service. The practice had completed an in-house patient survey in September 2019, 23 questionnaires were completed by patients. The feedback was positive, with patients reporting they were happy with the service. Following feedback from one of the patients, the practice had displayed a poster in the waiting area informing patients that patients who had difficulty managing the stairs could be reviewed downstairs.

## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
CQC comment cards	There were 37 positive comment cards and these included comments about being listened to and having needs met.
Patient interviews	We spoke with five patients including one member of the Patient Participation Group (PPG). The feedback was overall positive, patients described staff as helpful and their care and treatment was explained to them.

## 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)	95.9%	88.0%	93.4%	No statistical variation

### Any additional evidence or comments

The results of the national GP survey showed the practice was above local and national average for involvement in decisions about their care and treatment.

	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.	Partial
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: Information leaflets in other languages and in easy read format were not readily available in the practice but could be ordered on request.	

Carers	Narrative
Percentage and number of carers identified.	67 (2% of the practice list size).
How the practice supported carers (including young carers).	The practice had identified 2% of its practice population as carers. A member of staff had the lead role for carers. The practice had a carers register to ensure all carers were easily identified and could be offered annual health assessment, the flu vaccination and support and advice. Information was displayed in the patient waiting area sign posting carers to support groups and encouraging carers to identify themselves to staff, so support could be offered. The new patient registration form included a question asking if the patient was a carer to ensure patients were identified early and offered appropriate support.
How the practice supported recently bereaved patients.	The practice had bereavement support information displayed in the patient waiting area. The practice also referred patients to support services and bereavement counselling.

## 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
Explanation of any answers and additional evidence: A notice was displayed informing patients that a private room was available should they wish to speak in confidence away from the waiting room and reminding patients to stand back when in the queue to respect the privacy of those speaking with staff at the desk.	



# Responsive

Rating: Good

## 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
Explanation of any answers and additional evidence:	
The doors to the entrance of the building were not automatic, patients in a wheelchair would require assistance to enter the premises. However, there was a call bell so that patients could alert staff should assistance be required, a sign was also displayed informing patients of the arrangement.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 1.30pm *Between 1.30pm and 6.30pm patients could access GP services at a local Hub practice
Friday	8.30am to 6.30pm
Appointments available:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 1.30pm *Between 1.30pm and 6.30pm patients could access GP services at a local Hub practice
Friday	8.30am to 6.30pm
Extended access service opening times:	
	Monday to Friday 6.30pm to 8pm Saturday & Sunday 9am to 12pm

	<p>The extended access service was provided as part of a joint working arrangement with other local practices within the Primary Care Network.</p> <p>Extended access appointments could be booked by patients through their GP practice and patients were seen at local practices.</p>
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## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3149.0	279.0	117.0	41.9%	3.72%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	98.4%	91.2%	94.5%	No statistical variation

## Older people

## Population group rating: Good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients. The practice worked with local pharmacies to coordinate the service.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

## People with long-term conditions

## Population group rating: Good

### Findings

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

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- The practice offered late evening and weekend appointments that would benefit school age children and ensure they did not need to miss school as the practice was a member of a GP Primary Care Network. These appointments were available at local practices, Monday to Friday from 6.30pm to 8pm and Saturday and Sunday 9am until 12pm.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

## **Working age people (including those recently retired and students)**

**Population group rating: Good**

### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered late evening and weekend appointments that would benefit working age people as the practice was a member of a GP Primary Care Network. These appointments were available at local practices, Monday to Friday from 6.30pm to 8pm and Saturday and Sunday 9am until 12pm.

## **People whose circumstances make them vulnerable**

**Population group rating: Good**

### **Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## People experiencing poor mental health (including people with dementia)

Population group rating: Good

### Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

### Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: Home visits were available for elderly or housebound patients. All requests for home visits were taken by reception staff and then forwarded to a GP to triage and assess. Staff spoken with were aware of when a home visit would not be appropriate as the patient required urgent medical attention.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	79.4%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	81.6%	55.8%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to	75.5%	58.4%	64.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
31/03/2019)				
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)	80.3%	65.0%	73.6%	No statistical variation

#### Any additional evidence or comments

The results of the national GP survey showed that the practice scored higher than the local and national averages in every question relating to access and this was aligned with the feedback we received on the day of the inspection. Overall feedback from speaking with patients and completed CQC comment cards demonstrated that patients could access the service in a timely way, some patients reported it could be difficult to get an advance routine appointment. However, if the need was urgent they would be seen on the same day. Action taken by the practice to improve access included the recruitment of a nurse, increasing the working hours for the advanced nurse practitioner depending on need, joint working with local practices and promoting the extended access service, we saw information in the patient waiting area informing patients of the service.

Source	Feedback
CQC comment cards	Patients were happy with the appointment system and said they could access appointments in a timely manner. There were three comments relating to delays in accessing routine appointments, however, if the need was urgent they would be seen on the same day.
Patient interviews	We spoke with five patients including one member of the Patient Participation Group (PPG). Two patients commented that it was sometimes difficult to get an advance routine appointment however, if the need was urgent they would be seen on the same day.

#### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	Three
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

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

Explanation of any answers and additional evidence:

There had been no new complaints since our last inspection in January 2019. The practice had a small number of complaints, there was no evidence that the system for recording complaints was not effective which impacted on the number of complaints received. The feedback on the day and results from the national GP survey demonstrated that overall patients were happy with the service. Complaints were discussed with staff during team meetings to ensure learning and help improve the service.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy that they were not prescribed a specific medicine	Clinician spoken with, discussed the need to spend more time explaining why they are being prescribed a certain medication.

## Well-led

**Rating: Good**

We inspected the practice in January 2019 and rated the practice as requires improvement for providing well led services because the overall governance arrangements were ineffective. The practice did not have clear and effective processes for assessing and managing risks. During this inspection we saw the practice had established effective systems and processes to ensure good governance. The practice is now rated good for providing well-led services.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The long-term plan to ensure sustainability of the service was to merge with two other local practices and move to new purpose-built premises. The aim was to improve facilities for patients and enable the practice to expand services. Since our previous inspection, the plans had progressed further with construction starting at the site of the new build and staff and patient engagement.	

### 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 a mission statement which was displayed in the waiting areas and staff knew and understood the values.	



## 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.	N
Staff had undertaken equality and diversity training.	N
<p>Explanation of any answers and additional evidence:</p> <p>Staff had not undertaken formal training in equality and diversity. However, staff spoken with demonstrated good understanding and awareness on the principles and how they implemented these in practice.</p> <p>There was a whistle blowing policy which allowed staff to refer any concerns. However, there was no delegated speak up guardian. Staff spoken with were confident to raise any concerns and felt they would be listened to.</p>	

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

Source	Feedback
Staff	Staff commented that leaders in the practice were supportive and approachable and they felt confident to raise any issues.

## 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:	
Following our previous inspection, the practice had reviewed and improved their governance arrangements and had acted to improve areas identified at our previous inspection. The practice had recruited a practice nurse and had plans for a merger with other practices with the aim to improve services by increasing clinical capacity and governance oversight. The practice manager and lead GP continued to have regular informal discussions to ensure important information was discussed and shared, although these were not documented there was evidence that systems and processes were in place to assess and monitor the quality of the service for example, through clinical supervision, regular audits and surveys. Gaps in infection prevention and control procedures and the management of medicines had been addressed. We looked at a sample of policies and saw they had been reviewed and were up to date. The business continuity plan had been updated and was comprehensive. The practice was now identifying and reporting a range of significant events.	

## 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.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
The practice had made improvements to systems and processes for identifying and managing risks. However, we saw that a staff member had been appointed prior to receipt of all recruitment checks. although at the time of the inspection we saw that all recruitment checks were in place.	
There was evidence of quality assurance systems for example, a number of clinical and non-clinical audits had been completed which demonstrated quality improvement. At our previous inspection in	

January 2019, we identified that the business continuity plan (major incident plan) was not effective and should be improved. During this inspection we saw that changes had been made and the plan was comprehensive covering a wide range of possible events such as a fire, flood or unexpected staff shortages.

Staff had not received formal training in preparation for a major incident but had understanding on how they would respond in the event of a major incident.

## 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:	
<p>The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The practice was mostly comparable to local and national averages for QOF indicators. The practice's uptake for cervical screening remained below the 80% coverage target for the national screening programme. The practice was aware and taking action to address this.</p> <p>The arrangements for identifying, managing and mitigating risks had been improved for example, in areas such as medicine management and infection prevention and control. There were some gaps in the recruitment process although these had been addressed at the time of the inspection.</p>	

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:	

## 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:	
The results of the most recent national GP survey showed that the practice scored higher than the local average in questions relating to patients experience of a caring and responsive service. In some questions the practice score was also higher than the national average. There were no areas where the practice was below local or national averages. However, the provider acknowledged ongoing work was required to sustain positive feedback and ensure ongoing monitoring of the quality of the service. The practice had gathered feedback from patients through the patient participation group (PPG), in house surveys and comments and complaints received. Following feedback from patients and the PPG the practice had recruited a female practice nurse and were engaging with patients with plans for the new premises.	

### Feedback from Patient Participation Group.

Feedback
The practice had a patient participation group (PPG). We spoke with one member who told us there were approximately 10 members and they met once a month to discuss ideas and service improvements. They explained that an in- house survey had been completed and that patients' views, and concerns were encouraged and acted on. There was a good relationship with the practice, the lead GP and practice manager attended all meetings, this ensured collaborative working. There was a PPG poster in the patient waiting area with information encouraging new participants and minutes of the last meeting.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

## Examples of continuous learning and improvement

Learning and improvement was encouraged through staff appraisals, supervision and meetings. The practice made use of internal and external reviews of incidents and patient safety alerts and learning was shared and used to make improvements. The practice completed clinical audits, which demonstrated how the practice had improved. The practice worked collaboratively with two local practices to provide extended opening hours for patients. Plans to merge services with two local practices and locate to a new purpose-built building were in progress with the aim to further improve services and facilities for patients.

### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.