

Care Quality Commission

Inspection Evidence Table

Wollaston Surgery (1-3296309981)

Inspection date: 28th and 29th October 2019

Date of data download: 27 October 2019

Overall Rating : Requires Improvement

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

Safe Rating: Requires Improvement

We rated the practice as Requires Improvement for providing a safe service.

We found:-

Safeguarding systems, processes and practices were developed, implemented and communicated to staff.

There were gaps in the systems to assess, monitor and manage risks to patient's safety.

The practice did not have a formalised process in place to monitor patients' health in relation to the use of medicines prior to prescribing.

Standards of cleanliness were not always met.

There was a lack of clinical oversight in the dispensary.

The system in place for ensuring patient safety alerts had been received and actioned was not effective.

Safety systems and processes

The practice did not always have 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all	Yes

Safeguarding	Y/N/Partial
staff.	
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	

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

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: Wollaston – 6/4/19 Bozeat – 7/4/19	Yes
There was a record of equipment calibration. Date of last calibration: Wollaston – 20/8/19 Bozeat - 13/8/19	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	No

There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: Wollaston – weekly but gaps seen in fire safety recording book. Bozeat – weekly	Yes*
There was a log of fire drills. Date of last drill: every six months	Yes
There was a record of fire alarm checks. Date of last check: Wollaston - weekly but gaps seen in fire safety recording book. Bozeat -	Yes*
There were record of emergency lighting checks. Date of last check: Wollaston - weekly but gaps seen in fire safety recording book. Bozeat - weekly	Yes*
There was a record of fire training for staff. Date of last training: 24 and 25 October 2019 by Health and Safety Manager from the Northamptonshire Clinical Commissioning Group.	Yes
There were fire marshals. Wollaston - Yes Bozeat -Yes Date of last training: 24 and 25 October 2019 by Health and Safety Manager from the Northamptonshire Clinical Commissioning Group.	Yes
A fire risk assessment had been completed. Date of completion: Wollaston - February 2019 by Operations Manager Bozeat – February 2019 by Operations Manager Further fire risk assessment and control measures inspections was carried out on 24 and 25 October 2019 by Health and Safety Manager from the Northamptonshire Clinical Commissioning Group.	Yes
Actions from fire risk assessment were identified and completed.	No *
A legionella risk assessment had been completed: Wollaston – 18/5/18 Bozeat -18/5/18	Yes
Legionella Water Temperature Testing had been completed as per policy: Wollaston – No Bozeat - No	No*
Actions from legionella risk assessment were identified and completed.	No*

Wollaston – Bozeat -	
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection we looked at the risk assessments that had been completed in respect of fire safety and legionella. Recommendations had been advised but actions had not been completed but were seen on the practice risk register to be completed. We spoke with the management team and they told us and showed us evidence that the legionella actions would be completed by an external company on 7 November 2019. The practice had reviewed what actions were required in respect of fire safety and work had commenced on completing the required actions.</p> <p>We found a computer server in a meeting room which contained patient notes. The cabinet was not fire proof. The management team immediately spoke to the clinical commissioning group to discuss the fire safety and next steps.</p> <p>We checked the fire safety log book and found gaps in the weekly testing. For example, 11th and 26 September 2019.</p> <p>We looked at the Legionella Water Temperature Testing log and found that water temperatures had been recorded but not all the rooms had been tested on a monthly basis as per the risk assessment and national guidance.</p>	

Health and safety	Y/N/Partial
<p>Premises/security risk assessment had been carried out.</p> <p>Date of last assessment: Wollaston – 23/10/19 Bozeat – not seen</p>	Partial*
<p>Health and safety risk assessments had been carried out and appropriate actions taken.</p> <p>Date of last assessment: Wollaston – 23/10/19 Bozeat -3/1/19 by MDU</p>	Partial*
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection on 29 October 2019, we saw at Wollaston Surgery that Health and Safety and Premises risk assessments had been carried out on 23 October 2019. Actions had been identified but due to the time frame the majority had not been actioned. The management team were aware that actions were required and we were told these would be added to the practice risk register. The practice had reviewed what actions were required in respect of health and safety and work had commenced on completing the required actions.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Wollaston:- Not seen on the day of the inspection Bozeat – 18 October 2018	No
The practice had acted on any issues identified in infection prevention and control audits.	No*
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection we saw an infection control policy was in place.</p> <p>On 28 October 2019 we visited the branch surgery at Bozeat. We found the building to be clean and tidy. However, we looked at the cleaning plan policy which set out what was required daily, weekly, monthly areas to be cleaned. The cleaning records we reviewed showed that cleaning only took place three times a week, and week commencing 9 September 2019 cleaning took place on this date. We spoke to the management team who told us they were currently reviewing the cleaning arrangements for both Wollaston and Bozeat Surgeries.</p> <p>We found that the clinical waste bin stored outside was not secured to the wall. The management team immediately took action and assured us that this would be secured by the 30 October 2019.</p>	

Risks to patients

There were gaps in 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.	No
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No

Explanation of any answers and additional evidence:

The practice had a risk register in place which we looked at on inspection. Risks had been identified and some had actions identified but not completed.

At the inspection on 29th October 2019, we looked at the staffing levels for Wollaston Surgery and spoke to staff who worked there. Information we had reviewed at the Care Quality Commission prior to the inspection and staff we spoke with told us there was not enough staff. We also looked at the clinical team staffing levels and found that there appeared to be a lack of nursing hours to provide the service. We found that a number of staff were working extra hours in order to provide the service. We spoke with the management team who told us they needed to reassess what services/hours needed to be provided by the team to ensure patients receive safe care and treatment and staff do now work excessive hours.

We did not see any evidence that the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence:	

Appropriate and safe use of medicines

The practice did not have all the systems in place for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.04	0.96	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)	8.2%	8.0%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	6.72	6.14	5.63	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	2.02	2.12	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	No - Wollaston Yes - Bozeat
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial*
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of	Yes

Medicines management	Y/N/Partial
unusual prescribing, quantities, dose, formulations and strength).	
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We found that the practice did not have a formalised system in place for the recall of patients with long term conditions to ensure they were reviewed in a timely manner. Patients records we reviewed did not identify any risk to patient safety.</p> <p>We looked at the practice standard operating procedure (SOP) for repeat prescribing and medication review updated in September 2019 and found there was clear guidelines on the process for patients who requested a repeat prescription however, the SOP did state that a recall system was in place which would also ensure that patients who do not order their medication were also reviewed.</p> <p>We reviewed the Patient Group Directions (PGDs) held at Wollaston and found that one was out of date, one had not been signed by a GP or nursing team.</p> <p>We looked at the prescription security and found that at Wollaston they did not record the prescription numbers when they were moved into a clinical room.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	No
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute	Yes

prescriptions.	
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	No*
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	No
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The practice took part in the Dispensary Service Quality Scheme (DSQS). This scheme rewards Practices for providing high quality services to their dispensing patients. A self-assessment is completed where the practice confirm they have met the criteria for the DSQS scheme.</p> <p>We looked at the folder for near misses in the dispensary for 2019. We found that two near misses had been recorded. One was in regard to a dispenser picking the wrong medicine from the shelf and one was a wrong prescription being given to a patient. We were told these were discussed informally and that the staff worked closely together and would discuss issues as they arose. Dispensary meetings did not take place where these were discussed, actions identified, and any learning shared.</p>	

Track record on safety and lessons learned and improvements made

The practice did not always have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	8

Number of events that required action:	8
Explanation of any answers and additional evidence:	
We looked at meeting minutes and did not see any evidence that significant events had been discussed and learning and actions shared.	

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

Event	Specific action taken
X-ray of a lower limb. Originally reported as normal. However, when reviewed again a small fracture was found.	Clinicians to follow up on clinical suspicion but no specific learning identified for the practice.
A prescription received was made up and checked in the dispensary. Medicine was incorrect.	Increase staffing levels in the dispensary. Both dispenser and checker need to take more care when carrying out their role.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes*
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<p>We looked at the system in place for significant events. We found these had been recorded and investigated but there was limited detail on learning and actions. In meeting minutes we looked at, we could not see where these had been shared with actions and learning. We also found two examples of incidents which could have been considered as significant events, for example, an incident with a refrigerator temperature and a faulty ECG machine.</p> <p>We found the systems for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) patient safety alerts were received and actioned appropriately was not embedded or effective within the dispensary at Bozeat. We found at Wollaston Surgery a system was in place, but it was not effective as not all alerts had been received. We looked at the Northamptonshire Safety Alert protocol reviewed in September 2019 which still had old data such as Primary Care Trusts (PCT) within it.</p> <p>Examples of alerts that had not been actioned included: -</p> <p>A safety alert on 19 June 2019 in regard to a medicine used for patients with diabetes to improve blood sugar control.</p> <p>A safety alert on 17 July 2019 in regard to an anti-coagulant medicine where patients need to ensure they take the medicine with food.</p> <p>A safety alert on 17 July 2019 in regard to a medicine used for Gout which could increase the risk of heart disease.</p>	

At the time of our inspection, we also found that there was no system in place to review older patient safety alerts to ensure no new patients were affected (for example placed on medication after an alert has been issued or were new to the area).

We looked at meeting minutes in relation to MHRA and patient safety alerts. The practice was unable to evidence that all staff were aware of any relevant alerts and where they needed to take action. We could not see any evidence these were discussed or any actions to take forward.

Effective Rating: Good

We rated the practice as Good for providing effective services because:

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.

There was a lack of quality improvement activity.

There was a lack of clinical oversight and structured information sharing.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>On the day of the inspection we found that the practice did not have a formal system in place to keep staff up to date with relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We were told by the management team that these were discussed informally. Meeting minutes we looked at did not contain discussions on NICE guidance and from sample records we looked at we found that the practice did not monitor these guidelines. Since the inspection the practice have told us that the Ardens Clinical Pathway Decision Tools enable the clinicians to access the latest evidence based resources in line with NICE which ensures best practice, medicines management and patient safety.</p>	

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>	0.21	0.75	0.75	Significant Variation (positive)

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice did not have a formalised system in place to carry out structured annual medication reviews for older patients. The practice had a frailty index register in place and those on the register had care plans in place. The practice held proactive care meetings (PAC) every week. Patients who were discharged from hospital were contacted by the practice to ensure their current health care needs were met. All staff had the required level of safeguarding training. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> We found that patients in this group were not having their healthcare needs met in a manner that ensured as far as practical their treatment was safe. The practice did not have a formalised system in place for medication and long-term conditions reviews. We looked at the practice standard operating procedure (SOP) for repeat prescribing and medication review updated in September 2019 and found there was clear guidelines on the process for patients who requested a repeat prescription however the SOP did state that a recall system was in place which would also ensure that patients who do not order their medication were also reviewed. The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. 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 and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
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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)	94.4%	81.3%	78.8%	Significant Variation (positive)
Exception rate (number of exceptions).	23.6% (66)	17.7%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) ^(QOF)	85.8%	78.9%	77.7%	No statistical variation
Exception rate (number of exceptions).	19.6% (55)	11.4%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) ^(QOF)	86.0%	81.8%	80.1%	No statistical variation
Exception rate (number of exceptions).	23.6% (66)	14.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) ^(QOF)	71.3%	76.3%	76.0%	No statistical variation
Exception rate (number of exceptions).	6.7% (22)	9.0%	7.6%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) ^(QOF)	92.9%	91.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	18.3% (19)	13.8%	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)	85.3%	83.4%	82.6%	No statistical variation

Exception rate (number of exceptions).	8.2% (63)	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)	85.6%	92.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.2% (3)	4.8%	6.7%	N/A

Any additional evidence or comments

Although the clinical exception rate was for patients with Diabetes, Hypertension and COPD who received a review was high, the practice told us that they had recently started to use an Arden's and Gem template which would standardise the reviews of patients with long term conditions. At the time of the inspection this was still in the early stages of implementation.

Families, children and young people

Population group rating: Good

Findings

- The practice has met the minimum 90% target for all four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of the 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's uptake for the cervical screening programme was 75.6%, which was below the national average of 80%.
- 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.
- 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,	41	41	100.0%	Met 95% WHO based target

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)				
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)	37	41	90.2%	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)	38	41	92.7%	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)	38	41	92.7%	Met 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

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Working age people (including those recently retired and students)

Population group rating: Good

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.
- 25.9% of the patients were registered for on-line access.

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	75.6%	N/A	80% Target	Below 80% target

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)	78.9%	74.9%	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)	63.4%	56.6%	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)	50.0%	69.4%	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)	64.5%	53.0%	51.9%	No statistical variation

Any additional evidence or comments

At the inspection the practice showed us their data for cervical screening which was 79.8% against a target of 80% and cancer screening was 66.6%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice did not have a formalised system in place to carry out structured annual medication reviews for patients with a learning disability.
- The practice had a care co-ordinator. We saw that care planning templates, to help plan and deliver care for patients with more complex needs were in place.
- 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 had registers in place for patients with dementia and poor mental health.
- The practice did not have a formalised system in place to carry out structured annual medication reviews for patients with poor mental health including dementia.
- We saw that care planning templates, to help plan and deliver care for patients with more complex needs, were in place.
- Same day and longer appointments were offered when required.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.0%	94.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	15.4% (16)	17.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.8%	94.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.7% (8)	13.5%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	88.9%	85.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.9% (2)	9.0%	6.6%	N/A

Any additional evidence or comments

Although the clinical exception rate was for patients with dementia and poor mental health who received a review were higher than the CCG and national average the practice had used the Arden's and Gem template which standardised the reviews of patients with long term conditions. Since the inspection the practice have sent us 2019/20 unverified data which we acknowledge and will review on the next inspection.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely

reviewed the effectiveness and appropriateness of the care provided. There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	548.4	537.5
Overall QOF score (as a percentage of maximum)	100.0%	98.1%	96.2%
Overall QOF exception reporting (all domains)	8.1%	6.7%	5.8%

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

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

Any additional evidence or comments
<p>The practice had a programme of continuous audits to monitor quality and to make improvements. They had completed clinical audits but there was no evidence to demonstrate continuous improvements to patient outcomes or any action plans put in place to monitor implementation of any recommendations.</p> <p>We found the system in place for medicines reviews was not effective. We found there was not a clear formalised system in place to ensure all patients who received medicines were reviewed in a timely manner and received regular monitoring in accordance with national guidance. Patient records we reviewed did not demonstrate any risk to patient safety.</p> <p>We found that the practice did not have a formalised system in place for the review of patients with long term conditions to ensure all patients were reviewed in a timely manner. Patient records we reviewed did not demonstrate any risk to patient safety.</p> <p>We looked at the practice standard operating procedure (SOP) for repeat prescribing and medication review updated in September 2019 and found there was clear guidelines on the process for patients who requested a repeat prescription however the SOP did state that a recall system was in place which would also ensure that patients who do not order their medication were also reviewed.</p>

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes*
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial*
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Aspiro Healthcare had a Staff Handbook in place. It provided staff with a clear understanding of the working relationship and emphasised the organisation's expectations.</p> <p>In staff records we looked at not all staff had received an annual appraisal.</p> <p>At this inspection, we asked how the practice could demonstrate and be assured of the competencies of staff. For example, nurses and dispensers. We were told and we saw that the dispensers were able to access on-line update training for this role and were observed in their work but this was not documented for all staff.</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) <small>(QOF)</small>	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or	Yes

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
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 smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	96.2%	94.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.2% (16)	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence:	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated 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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	24 - Wollaston 6- Bozeat = 30
Number of CQC comments received which were positive about the service.	18 - Wollaston 4 – Bozeat = 22
Number of comments cards received which were mixed about the service.	2- Wollaston
Number of CQC comments received which were negative about the service.	4 - Wollaston 2- Bozeat = 6

Source	Feedback
Care Quality Commission Comments Cards	Treatment Good. I feel listened too. Staff thorough with examination and questioning. Very fast referral for ear problem. Good caring service Staff professional and very helpful. Listened too but sometimes feel a bit rushed at an appointment Appointments often run late.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5310.0	267.0	123.0	46.1%	2.32%

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)	94.9%	87.6%	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)	91.4%	86.5%	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)	98.5%	94.8%	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)	92.3%	81.8%	82.9%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

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.	Yes
Staff helped patients and their carers find further information and access community	Yes

and advocacy services.	
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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)	97.6%	92.8%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Limited information leaflets
Information leaflets were available in other languages and in easy read format.	No
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	3.3% - 174 carers
How the practice supported carers (including young carers).	Poster in waiting room. Information on practice website for Northamptonshire Carers and Carers UK. Support offered by practice staff as required.
How the practice supported recently bereaved patients.	Information on practice website for Cruse Northamptonshire Areas and Cruse UK. Support offered by practice staff as required.

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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence:	

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Explanation of any answers and additional evidence:

Practice Opening Times

Day	Time
Opening times: Wollaston	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

Bozeat Branch Surgery – Opening Times

Monday	9am to 12.30. 2.30pm to 6pm.
Tuesday	9am to 12.30. 2.30pm to 6pm.
Wednesday	9am to 12.30.
Thursday	9am to 12.30.
Friday	9am to 12.30. 2.30pm to 6pm.

GP Extended Access Hub – opening times

Additional same day and booked appointments provided by GPs, Nurse Prescribers, Practice Nurses and other clinicians outside of the core General Practice hours.

Available as follows:

18:30 - 20:00 Monday to Friday

08:30 - 12:30 Saturday

08:30 - 10:30 Sundays

Bank Holidays 8:30 - 10:30

Q Doctor Virtual Appointments are available:
 Monday & Thursday 18:30 - 19:30
 Sunday 09:00 - 12:00

All appointments will be provided from Albany House Medical Centre, 3 Queens Street, Wellingborough.
 NN8 4RW

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5310.0	267.0	123.0	46.1%	2.32%

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)	99.4%	94.3%	94.5%	Tending towards variation (positive)

Any additional evidence or comments

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.

People with long-term conditions

Population group rating: Good

Findings

- 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

- 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 was open until 8pm on a Monday and Friday.

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 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.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence:	

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)	78.6%	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)	70.4%	65.9%	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 31/03/2019)	64.7%	63.8%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	78.8%	74.3%	73.6%	No statistical variation

Source	Feedback
For example, NHS Choices	Service received from the GPs and reception staff at Wollaston Surgery has always been great. Getting through by phone can be frustrating

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.	6
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No*
<p>Explanation of any answers and additional evidence:</p> <p>From meeting minutes we looked at we could not see where any complaints had been discussed and learning and actions shared.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Immunisation administered incorrectly	Second nurse to check vaccination before it is administered
Appointments for immunisations cancelled on a number of occasions	Avoid cancellation where possible and ensure they are rebooked at earliest convenience

Well-led

Rating: Requires Improvement

We rated the practice as Requires Improvement for Well-led.

We found:-

There was compassionate and inclusive leadership at all levels.

There were gaps in the practice's governance systems and processes and the overall governance arrangements were ineffective.

The practice had not implemented a clear and effective process for managing risks, issues and performance.

We saw there were gaps in the systems and processes for learning and continuous improvement.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial*
They had identified the actions necessary to address these challenges.	Partial*
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: On the day of the inspection, the management team we spoke with were knowledgeable about issues and challenges relating to the quality and future of services and aspired to develop a culture of high-quality sustainable care. However, effective systems were not always in place or fully embedded and the arrangements for governance and management did not always operate effectively. The practice was led by a lead GP with the support of two salaried GPs. One salaried GP was off long term sick and was being covered by a salaried GP from another location. They told us they prioritised safe, high quality and compassionate care. However, we found a lack of focus on the clinical leadership and governance systems required which resulted in issues that threatened the delivery of safe and effective care which had not been identified or adequately managed.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes

The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The practice is part of Aspiro Healthcare which has eight locations across the counties of Bedfordshire, Derbyshire and Northamptonshire. There are 11 GP partners and one managing partner. Six of the locations provide training for medical students and GP Registrars. Their aim is to work in partnership with patients and staff to improve the health and wellbeing status of individuals and the local community. The practice had plans to refurbish the premises in 2020.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff	Like working here but we are often short of staff.

Governance arrangements

There were not always 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.	Partial*
Staff were clear about their roles and responsibilities.	Partial*
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Although systems and processes were in place we found that these were not always operated effectively. For example:-</p> <p>The practice did not have an effective system for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were received and actioned appropriately.</p> <p>Not all risks were managed effectively.</p> <p>The dispensary at Bozeat lacked clinical oversight.</p> <p>Staff levels were not monitored to ensure safe care and treatment.</p> <p>The practice did not have a formalised system in place for medicines reviews. However, patient records we looked at did not show any patient risk.</p> <p>The practice did not have a formalised system in place for the recall of patients with long term conditions to ensure they were reviewed in a timely manner.</p> <p>Policies and Standard Operating Procedures were kept on the practice intranet. We looked at policies and found that the front sheets were not always fully completed and some had different provider names. We were told and we could see that Aspiro Healthcare were in the process of reviewing the policies but this had not been completed on the day of the inspection.</p> <p>Whilst we saw evidence of some meetings taking place, minutes did not include all areas of practice governance and allow opportunities for learning.</p>	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial*
There were processes to manage performance.	Yes
There was a programme of clinical and internal audit.	Yes

There were effective arrangements for identifying, managing and mitigating risks.	Partial*
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: Risks were assessed but not all the actions required had been completed.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	No*
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: We found the systems for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were received and actioned appropriately were not embedded or effective within the practice or the dispensary. We also found that there was no system in place for ongoing reviews of patient's subject to patient safety alerts.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: Aspiro Healthcare had a social fund. This was given to each location in recognition of the hard work	

done by staff. Staff are able to choose what the fund is spent on.

Aspiro Healthcare sent out regular newsletters to staff which contained information such as apprentice awards, changes at the practices, primary care networks, QOF and learning from significant events.

The Care Quality Commission had received some negative feedback about the practice via our share your experience website. This was discussed with the management team on the day of the inspection.

Feedback from Patient Participation Group.

Feedback

The patient participation group told us that they had an open and positive relationship with the practice. They felt that their views were listened to and acted on where appropriate.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial*
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: We saw limited evidence that continuous learning and improvement took place and was shared with the practice team.	

Examples of continuous learning and improvement

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. 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.