

# Care Quality Commission

## Inspection Evidence Table

### Nelson Medical Centre (1-5842428535)

Inspection date: 23/10/2019

Date of data download: 04 November 2019

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

## Safe

## Rating: Good

### 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.	Yes <sup>1</sup>
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 staff.	Yes
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: 1. Nelson Medical Centre is part of the East Norfolk Medical Practice (ENMP). The practice lead and deputy lead for safeguarding were located at a different ENMP location. The leads have protected time each week to carry out safeguarding activities. All staff spoken with were aware of the leads and knew how to contact them.	

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 and if relevant to role.	Yes <sup>1</sup>
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: <ol style="list-style-type: none"> <li>On the day of the inspection the provider did not have a staff immunisation policy however, the immunisation status of staff in relation to Hepatitis B and Measles was documented. Immediately following the inspection, the practice produced and shared a copy of the policy that contained appropriate levels of screening for different staff.</li> </ol>	

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: October 2018	Yes
There was a record of equipment calibration. Date of last calibration: October 2018	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: May 2019	Yes
There was a log of fire drills. Date of last drill: October 2019	Yes
There was a record of fire alarm checks. Date of last check: October 2019 (checked weekly)	Yes
There was a record of fire training for staff. Date of last training: October 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: October 2018	Yes <sup>1</sup>
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> <li>In addition to the fire risk assessment the provider undertook a documented monthly audit of fire risk issues such as checks of the extinguishers to ensure they were intact and not tampered with.</li> </ol>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial <sup>1</sup>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2018.	Yes
Explanation of any answers and additional evidence: 1. The practice could not evidence any premises risk assessment activity to ensure staff and patients were kept safe that was specific to this location.	

### Infection prevention and control.

#### Appropriate standards of cleanliness and hygiene were 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: July 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
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

### 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes <sup>1</sup>
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 <sup>2</sup>
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.	Yes
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. An induction programme was in place to ensure all temporary staff were aware of practice policies and procedures. Staff were multi skilled and able to cover for each other to ensure continuity of duties in the event of staff absence.</li> <li>2. Staff we spoke with demonstrated that they understood how to prioritise patients who reported signs and symptoms of deterioration. All staff had completed sepsis training relevant to their role. We also saw information on display to guide staff on how to manage patients presenting with sepsis symptoms.</li> </ol>	

### 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 <sup>1</sup>
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 <sup>2</sup>
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:	
<ol style="list-style-type: none"> <li>1. Referrals to specialist services were tasked to the secretaries to complete. The secretaries kept a log to track the referrals sent, that an appointment had been received by the patient and that the patient attended the appointment.</li> <li>2. There was formal and supportive clinical oversight of test results including those reviewed by non-clinical staff. Regular audits to monitor and ensure results were being correctly actioned were in place.</li> </ol>	

### Any additional evidence or comments

The practice ensured that safety, quality and performance was managed effectively through a clinical management reporting system. Weekly checks including those performed by administration staff (for example summarising) were undertaken to monitor areas such as unfiled workflow documents, unactioned electronic tasks, and medication reviews awaiting GP's action. This ensured GPs and staff were managing their workload in a timely manner. The report included information relating to referrals and medical record summaries awaiting completion.

### Appropriate and safe use of medicines

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

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.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes <sup>1</sup>
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 <sup>2</sup>
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 <sup>2</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes <sup>3</sup>
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	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.	Yes
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

Medicines management	Y/N/Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>To have assurance of the competency of non-medical prescribers, a senior clinician undertook reviews of their prescribing. Where issues were identified, a discussion was held with the staff member.</li> <li>The practice had employed a clinical pharmacist who led medicines reviews for patients on repeat medicines. In addition, they led on ensuring patients who were on high risk medicines were monitored appropriately.</li> <li>The practice had been proactive and had significantly reduced the number of prescribed controlled drugs. Patients were reviewed in a face to face consultation and where appropriate, alternative therapies and a structured reduction plan was agreed. To ensure continuity of care the patient was encouraged to see the same GP each time.</li> </ol>	

### 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.	Yes <sup>1</sup>
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes <sup>2</sup>
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.	Yes <sup>3</sup>
Number of events recorded in last 12 months:	Four <sup>4</sup>
Number of events that required action:	Four
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>The practice had implemented processes to analysis trends of events and incidents to identify themes and mitigate future risk.</li> <li>There was an open culture in which all safety concerns raised were valued and integral to learning and improvement. All staff were encouraged to report incidents, and we found that staff were committed to reporting concerns. All incidents were discussed with staff to ensure they had the confidence to report within a no blame culture.</li> <li>We saw evidence to demonstrate that incidents and significant events were discussed in formal practice meetings.</li> <li>We discussed the low number of significant events and the practice informed us that as an independently registered location of the East Norfolk Medical Practice, several significant events were recorded at head office. They had recorded 41 significant events across all four sites.</li> </ol>	

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

Event	Specific action taken
Delayed referral it was identified that the protocol was not followed. There was no significant harm to the patient.	The protocols were re-shared with appropriate staff and compliance with the process was reviewed two months later and found to be correctly followed.

There was a error in recording clinical information in the notes of a patient with the same name but different date of birth	The practice introduced a same name protocol within two weeks. No re occurrence had occurred.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes <sup>1</sup>
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> <li>Staff received, filtered, cascaded and followed safety alerts up. We checked two examples (one drug reaction and a reminder to inform patients they must take certain medicines after food) where relevant, patient searches and actions were undertaken.</li> </ol>	

## Effective

## Rating: Good

We rated the practice as good for providing effective services however, the population group working age people (including those recently retired and students) were rated as requires improvement because.

- The practice cancer screening rates for example, cervical, breast and bowel screening were lower than national averages. The practice told us they were aware of this and had reviewed performance in relation to cancer screening and reviews. The practice told us they were in the process of inviting patients in for cervical screening appointments.

### 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 <sup>1</sup>
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 were in place 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.	N/A
Explanation of any answers and additional evidence: 1. The duty GP supported advanced practitioners daily. A senior GP undertook a range of audits and formal supervision to ensure patients were being monitored effectively.	

## Older people

## Population group rating: Good

### Findings

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



and prescriptions were updated to reflect any extra or changed needs.

- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group
- The practice had introduced a comprehensive older person's assessment toolkit to focus on general health, activities of daily living and advanced care planning. The CCG adopted this module when they commissioned an enhanced care home service.
- The practice had gained the Veteran friendly status with the Royal Collage of General Practitioners.

## People with long-term conditions

## Population group rating: Good

### Findings

- The practice performance in relation to all QOF indicators for long-term conditions was below the CCG and England averages for 2017/18. Published data for QOF 2018/2019 showed improvement; however, some performance remained below local and national averages and exception reporting remained higher in most indicators than the CCG and national averages.
- Patients with long-term conditions had 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.
- There was a dedicated prescribing team, led by the GP prescribing lead, to ensure effective and timely reviews of medicines.
- The practice identified that some patients with diabetes attended their yearly retinal screening but did not always attend a diabetic review. The practice liaised with the retinal screening service to ensure the appointments were co-ordinated. In addition, the practice invited Slimming World, and representatives from the NHS structured diabetic education programme (DESMOND) and exercise advisors to be available in the waiting rooms for patients to access. These staff were able to engage with patients and encourage education and self-management.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of their long-term condition for example asthma.
- 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.3%	76.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	18.3% (78)	15.1%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.6%	76.3%	78.1%	No statistical variation
Exception rate (number of exceptions).	16.7% (71)	11.5%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.0%	77.3%	81.3%	No statistical variation
Exception rate (number of exceptions).	20.9% (89)	17.6%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.7%	73.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	4.2% (18)	11.6%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.3%	85.0%	89.6%	No statistical variation
Exception rate (number of exceptions).	14.0% (29)	10.9%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading	85.6%	83.3%	83.0%	No statistical variation

measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <sup>(QOF)</sup>				
Exception rate (number of exceptions).	7.7% (66)	5.4%	4.0%	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 (01/04/2018 to 31/03/2019) <sup>(QOF)</sup>	95.1%	87.2%	91.1%	No statistical variation
Exception rate (number of exceptions).	15.3% (11)	7.9%	5.9%	N/A

### Any additional evidence or comments

- The practice demonstrated clear awareness of their QOF performance and the clinical team monitored QOF with the support of staff. The practice was able to demonstrate that patients who had been exception reported had been done so appropriately. The practice had a range of systems in place to monitor patients' outcomes for all indicators. An action plan had been implemented to improve patients' outcomes. For example: monthly multi-disciplinary meetings were held to discuss patients that were difficult to engage. The practice had introduced a diabetic 'one stop shop', where patients attending their retinal screening were offered their condition review on the same day. The practice identified there was a reduction in urgent care requirements in the summer months they utilised staff to undertake long term condition reviews; they referred to this process as project summer.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had not met the minimum 90% target for three of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The practice had identified several factors that affected the programme. The practice explained that this was due to the transient population and known cultural challenges within the practice population. The practice informed us that a number of patients were from European background and they may have chosen for childhood immunisations to be carried out in their native European countries, but this information was not shared with the practice. The practice had taken steps to improve the childhood immunisation uptake and informed us they were working closely with the health visitors to overcome barriers.
- To improve uptake, the practice had allocated nurse time for the practice nurse to specifically call parents/guardians to discuss the benefits and risks of immunising their child. In addition, they sent bulk SMS reminder texts and ensured an appointment was made when the child was reviewed at the six-week baby check.
- The practice has recruited staff from various nationalities (including Russian, Lithuanian, Polish and Portuguese) that have significant patient numbers within their patient population. They call the patients with the same language to highlight the benefits of immunisation and screening and to encourage them to attend.
- To ensure they identified those parents/guardians that would benefit from early help and support, the practice had employed a Patient Welfare Manager who attended, with the GPs, the Early Help Hub, a Norfolk Council led service which included a multi-disciplinary team including health visitors.
- The practice had arrangements for following up failed attendance of children's appointments

following an appointment in secondary care or for immunisation and liaised 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 had developed a sexual health advice promotion poster with tear off slips with contact details for patients.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England) England)	51	56	91.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England) England)	29	33	87.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England) England)	29	33	87.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	29	33	87.9%	Below 90% minimum

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

Population group rating: Requires improvement

#### Findings

- The practice scored significantly lower in all cancer indicators actions had been identified and were being implemented. However, improvement in outcomes were not evidenced.
- The practice was aware of their poor cervical screening results and explained that this was due to the transient population and known cultural challenges within the practice population, which had an impact on the cervical screening uptake. The practice had taken steps to encourage uptake. For example, there was a policy to send reminder letters and text messages to patients who did not attend for their cervical screening test. The practice informed us that patients were being invited

three times by two methods at least. Data in this evidence table (2017/18) was for a previous contract holder, however, 2018/19 data showed some improvements but remains below 70%.

- The practice had taken part in a cervical screening awareness week from 10 to 16 June 2019 to encourage uptake.
- The practice had a system to ensure results were received for all samples sent for the cervical screening programme.
- 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 offered extended hours at nearby practices that are part of the East Norfolk Medical Practice.
- Patients were able to request a telephone consultation with their named GP.
- The practice had a social media account that was used to promote health information
- Text reminders for appointments are sent out.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	65.3%		80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (PHE)	58.2%	74.8%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (PHE)	40.7%	57.9%	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. (PHE)	47.6%	62.0%	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)	35.0%	46.6%	51.9%	No statistical variation

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a homeless care service, which included an outreach service at the Salvation Army hall, street work and multi-disciplinary team working based from the local housing trust. Services included immediate access for homeless patients.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. The practice hosted an in-house drug and alcohol service which included a 'blue folder' clinic to manage patients with drug seeking behaviour.
- The practice had implemented a multi-disciplinary team called the High Intensity User Group to review patients that required the use of the service more frequently.
- Same day appointments and longer appointments were offered when required.

**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.
- The practice had applied to be a pilot site for the Norfolk and Suffolk NHS Foundation Trust to provide some mental health support and some services for people with a learning disability where patients could attend their appointment at the practice.
- 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.
- All staff had received dementia training in the last 12 months.
- 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 (01/04/2018 to 31/03/2019) <small>(QoF)</small>	100.0%	79.6%	89.4%	Significant Variation (positive)

Exception rate (number of exceptions).	25.0% (21)	19.0%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	98.5%	80.2%	90.2%	Tending towards variation (positive)
Exception rate (number of exceptions).	21.4% (18)	15.8%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	85.7%	81.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	12.5% (7)	10.3%	6.7%	N/A

### Any additional evidence or comments

The practice was able to demonstrate that patients who had been exception reported had been done so appropriately. The practice had a range of systems in place to monitor patients' outcomes for all indicators. They had identified a high exception reporting for all indicators. The practice had developed a protocol which required that exception reporting would be done by the mental health lead only, after three invites sent by two different methods. The protocol included to carry out monthly reviews of mental health.

### 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)	549	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.2%	No Data	96.4%
Overall QOF exception reporting (all domains)	9.7%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive 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

The practice carried out a range of audits to monitor patient outcomes and improve the quality of care provided. We reviewed some of the completed audits. For example:

- The practice had completed a three-cycle audit on sodium valproate, a medicine that had been identified as potential risks in pregnancy. It is recommended that patients on this medicine are reviewed and the risks discussed. Cycle one identified seven patients (three excluded) none had a documented review. All were followed up. Cycle two; one patient had been reviewed, one patient had a repeat contraceptive prescription but no documented review (this was tasked to the named GP to follow up) and two patients declined to engage. Alerts were put on their records to discuss opportunistically. Cycle three, saw no change. It had been identified that these patients had a review at the hospital and the practice were finding it difficult to confirm a review had occurred.
- We saw a two-cycle audit on patients that were immune suppressed. The audit was to identify the patients were taking prophylactic antibiotics and had received the recommended vaccinations. Cycle one identified 11 patients and compliance to guidelines for each vaccine and prophylactic antibiotics ranged from 35% to 67%, 0% of patients were fully compliant. Cycle two saw an increase of compliance from 73% to 85% and four patients were fully compliant. The conclusion identified a high rate of non-responses to letters and texts and phone calls these patients' notes were flagged to remind clinicians to discuss opportunistically.

## 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 <sup>1</sup>
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.	Yes
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.	Yes <sup>2</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
1. Annual appraisals were completed, and staff had opportunities to further develop their skills. A staff development programme was in place to encourage staff to continue to further their development. This included staff employed in advanced clinical practice, some staff had been	



supported to attend advanced prescribing courses and the healthcare professional masters qualification.

- To support education and learning for staff employed in advanced clinical practice, a senior GP conducted formal case reviews and observed consultations (with the patient's permission) once a month.

## 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)	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 organisations were involved.	Yes <sup>1</sup>
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:	
1. The practice liaised regularly with other organisations, including district nurses, community matrons, homeless shelters and charities, local food banks and support groups. This enabled the practice to deliver personalised and tailored care to the patient population.	

## 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 <sup>1</sup>
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 <sup>2</sup>
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:	

1. Substance misuse services were available at the practice to support patients with alcohol and drug dependency.
2. The practice held several health events for patients, including talks on advance care planning, dementia, general health issues and diabetes.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.1%	94.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.7% (10)	0.6%	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

## Caring

## Rating: Requires Improvement

At our inspection we rated this practice as requires improvement for providing caring services. This was because:

- GP survey data was lower for all indicators relating to patients' experience during consultations.

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes <sup>1</sup>
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: 1. The practice recognised there was a large community within their patient population who did not have English as a first language. There was information available in the waiting room in different languages and staff showed good awareness of the management of patients with different cultural backgrounds.	

CQC comments cards	
Total comments cards received.	25
Number of CQC comments received which were positive about the service.	24
Number of comments cards received which were mixed about the service.	Zero
Number of CQC comments received which were negative about the service.	One

Source	Feedback
CQC comment cards	Of the 24 positive comments we were told that staff were helpful, thoughtful and polite, the GPs, nurses and receptionists went above and beyond and nurses were quick and efficient. Some cards named staff stating they had received exceptional

	care and wanted them to be thanked. The one negative response was a new patient registration that found it difficult to get an appointment to establish their repeat prescription.
PPG	We spoke with a PPG member who stated the practice fully engaged with them and took on board suggestions. All care delivery was described as brilliant and that signposting to other services had been a very positive support system for them.

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6340	431	52	12	0.82%

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) <small>(GPPS)</small>	66.5%	88.1%	88.9%	Significant Variation (negative)
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) <small>(GPPS)</small>	68.8%	87.4%	87.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019) <small>(GPPS)</small>	72.6%	94.0%	95.5%	Significant Variation (negative)
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) <small>(GPPS)</small>	67.9%	81.8%	82.9%	Tending towards variation (negative)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes
The GP national survey results were significantly below CCG and England averages for several indicators. The survey covered the months of January to April 2019; The provider contract had been awarded two months prior to the surveys being sent out. The provider told us that changes had been	

made but the improvements may not have been apparent at the time the survey was collected. CQC comment cards received at the inspection stated that there had been proactive positive improvements in the past 12 months.

The practice had completed an in-house survey, the survey ran from July to September 2019 and covered 6 questions. There were 66 surveys return this represented 1% of the practice population

	Yes%
Is it easy to get through on the phone?	72%
The receptionists are polite and helpful?	97%
The surgery was clean	98%
Had enough time with the doctor/nurse	90%
The opening times of the practice are satisfactory	89%
I feel I was treated with care and concern	89%

66 surveys were completed the results were shared with the PPG and service development group an action plan was being drafted and was to be approved at the Partners meeting in November 2019.

### Any additional evidence

The practice used the NHS Friends and Family Test to gather feedback from patients. Data gathered for August 2019 showed that 27 responses were received and 63% of patients said they were either likely or extremely likely to recommend the practice and 22% gave a neutral response of neither likely or unlikely.

### 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 and advocacy services.	Yes

Source	Feedback
Comments from the in-house survey	Everyone is very helpful and medical staff are great I was late for my appointment, but I still saw the GP. Staff are always polite and takes time to explain in detail and I feel listened to

### 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	70.7%	93.4%	93.4%	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
about their care and treatment (01/01/2019 to 31/03/2019) <small>(GPPS)</small>				

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 243 patients that were also carers including several young carers. This represents 4% of registered patients.
How the practice supported carers (including young carers).	There was a carers noticeboard in the patient waiting area with signs that encouraged patients to inform the practice if they were a carer. Carers packs with information regarding support for carers were available at the reception desk. Carers were offered an annual flu vaccination.
How the practice supported recently bereaved patients.	The practice offered individualised care for recently bereaved patients. They had a bereavement pack that explained what to do next. The information included how to register a death, documents required, people to inform and how to support grieving children.

## 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 <sup>1</sup>
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. There was a glass screen at the reception desk and telephone calls were taken at the back of the office to ensure confidentiality. The practice used an electronic check in to reduce queues at the reception desk. The electronic check in was available in different languages.</li> </ol>	

## 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

#### Practice Opening Times

Day	Time
Opening times:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Extended appointments were available at other nearby sites throughout the week	
Monday	Newtown Surgery 7am-8am
Tuesday	Newtown Surgery 7am-8am
Wednesday	Newtown Surgery 7am-8am
Thursday	Newtown Surgery 7am-8am
Friday	Newton Surgery 7am-8am
Saturday	Lighthouse Surgery 8am-12noon
Sunday	Lighthouse Surgery 8am-12noon
Wednesday	Lighthouse Surgery 18.30-20.00
Thursday	Lighthouse Surgery 18.30-20.00
Friday	Lighthouse Surgery 18.30-20.00

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6340	431	52	12	0.82%

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) <small>(GPPS)</small>	77.8%	93.5%	94.5%	Significant Variation (negative)

### Any additional evidence or comments

The practice had reviewed appointments available and had increased the number of consultations (both GP and nurse). They also offered appointments at a different location when their appointments were allocated. Feedback from the CQC comment card identified a positive response to appointment availability patients had commented they were seeing improvements over the past 12 months.

## 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. Home visits are reviewed by the patients named GP to ensure continuity of care.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- A GP (supported by a paramedic) was allocated to individual care home and the patients are put on the GP practice list for continuity of care. Weekly multidisciplinary team meeting (MDT) were held at each care home.
- The practice had reviewed patients who had died at their preferred place of death 12 months prior to the practice allocating GPs to care homes, there were eight deaths, seven had died in hospital (this was not their preferred place of death). Twelve months later eight deaths occurred seven died in their recorded preferred place of death (care home or hospice).
- East Norfolk Medical Practice, which Nelson Medical Centre is part of, had employed four paramedics who, as part of their role carry out home visits to older patients.
- The practice provided GP support to the Out of Hospital Team which looked after older patients in 'beds with care' at a local care home.



## People with long-term conditions

Population group rating: Good

### Findings

- Patients were empowered to understand their conditions and take control of their treatment. For example, the practice was aware they had a high non-compliant diabetic prevalence rate and that patients needed additional support and education to help them manage their condition appropriately. The diversity of the practice staff team meant they had diverse language skills to speak directly with the majority of patients in their own first language.
- 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

- Additional nurse appointments were available at a nearby site from 7am to 8am Monday to Friday and weekend appointment were available from 8am to 12 noon; also evening appointments were available from 6.30 to 8pm for school age children so that they did not need to miss school.
- 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 three or more accident and emergency (A&E) attendances in one year. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.
- The practice had a good working relationship with the health visitors and worked with them to follow up children and promote their health and wellbeing.

## 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. For example, online booking and telephone appointments with named GPs were available.

- Working age people had access to extended hours appointments at one of the practices weekday mornings between the hours of 7am to 8am and 8am to 12 noon at weekends and Bank Holidays.
- The extended hours offered bookable appointments for routine tests such as phlebotomy, cervical screening and chronic disease monitoring.
- A 'screening task force' had been set up with dedicated staff contacting non-responders or non-attenders of cervical screening and long term conditions reviews.
- The practice utilised social media as a form of communication for patients to engage.

## People whose circumstances make them vulnerable

## Population group rating: outstanding

### Findings

- The practice undertook work to reduce the number of patients prescribed opioid medicines. Patients were invited in to have a discussion and review of these medicines. They were reviewed monthly by the same GP and patient welfare manager. We saw that there had been a reduction in the number of patients prescribed opioids.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice were members of the Faculty of Homeless Health and Inclusion. The practice had arranged a multi-disciplinary event for World Homeless Day, including dental care, opticians and hairdressers. Feedback from the local housing trust regarding the level of input from the GP practice was positive.
- The practice had employed a life coordinator who had helped homeless patients get rehoused. Some of the patients had recently been released from prison.
- The practice held regular events to raise money for 'kipbag' (a charity that raises funds to supply homeless people some comfort). A kipbag will contain a sleeping bag, toiletries, homeless information pack, socks, hat, comb, plasters and wet wipes. The practice in conjunction with the other four sites had purchased 22, they gave them to the Salvation Army to distribute.
- The practice regularly campaigned in the local community to raise awareness for the local foodbank and made food bank appeals when supplies got low.
- The practice had a process that when a patient presented as homeless, a member of staff was allocated to fully assess their needs and signpost them to a clinician if required, offer food vouchers and assist with emergency accommodation and housing needs if possible.
- The practice had a 'Living Well' social prescriber to signpost patients to local services to support them.
- The practice held a 'Christmas Stocking' campaign in 2018 where patients and staff brought toys for children and essential items for people in need. They filled 500 stockings (the target for all five sites is to donate 2,500 in 2019).
- GPs attended the 'Talk Away Take Away' project held at Age Concern for vulnerable patients, homeless patients and patients with social isolation and loneliness.

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

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>• Priority appointments were allocated when necessary to those experiencing poor mental health.</li> <li>• Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. Reception staff were trained as dementia friends.</li> <li>• The practice was aware of support groups within the area and signposted their patients to these accordingly.</li> <li>• Two GP were undertaking a Mental Health Diploma for clinical leadership, with the intention of cascading the training to all clinical staff.</li> <li>• In response to risk, the practice had initiated its own suicide risk register and guidance for clinicians (providing key contact information, and the development of a patient’s safety plan including prescribing advice) and staff had received suicide prevention training.</li> </ul>

**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 <sup>1</sup>
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
<p>Explanation of any answers and additional evidence:</p> <p>1. The practice had implemented an urgent care team (UCT) to manage the high demand for appointments. The team consisted of GPs, physician associates, paramedics and nurses, including a mental health nurse. The practice had also invested in call monitoring software so they could regularly review the incoming call data, abandoned calls, average wait time and other indicators. Feedback was given to reception staff.</p>	

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) <small>(GPPS)</small>	68.4%	N/A	68.3%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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) <small>(GPPS)</small>	57.3%	65.7%	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) <small>(GPPS)</small>	66.0%	64.6%	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) <small>(GPPS)</small>	61.2%	73.8%	73.6%	No statistical variation

Source	Feedback
For example, NHS Choices	NHS choices had two reviews that had been posted since ENMP commenced delivering services. Both were one star rating, the themes were around; the lack of having a named GP and lack of same day appointments.
CQC comment cards	The one negative response was a new patient registration that found it difficult to get an appointment to establish their repeat prescription.

### 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.	Ten
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	zero

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient not happy with the outcome of their clinical consultation	The provider undertook an internal review of the consultation. Assured patient that the same outcome would have been identified, which allayed concerns.
Delay in issuing repeat prescription patient ran out of medication.	The policy was reviewed, and staff were reminded they are required to work within the policy guidance.

## Well-led

Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes <sup>1</sup>
They had identified the actions necessary to address these challenges.	Yes <sup>2</sup>
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: <ol style="list-style-type: none"><li>1. There was an emphasis on governance within the practice and leaders were knowledgeable about issues and priorities relating to the quality and future of the service. They understood challenges and were proactive in addressing them.</li><li>2. Over the last 12 months, the practice had identified where processes and procedures could be developed and enhanced to improve patient care, safety and wellbeing. Significant changes had been achieved over a relatively short time-scale. In 2017/18 QOF data for the percentage of patients with diabetes, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 60% data for 2018/19 improved to 75% with a small increase in exception reporting.</li></ol>	

### 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 <sup>1</sup>
There was a realistic strategy to achieve their priorities.	Yes <sup>2</sup>
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 <sup>3</sup>
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none"><li>1. The practice was aware their main challenges they included, high levels of deprivation, hard to engage patients and maintaining good access.</li><li>2. The strategic objectives being monitored and the practice business plan included details of continuity planning. The practice had started to monitor its own performance against QOF</li></ol>	

indicators and actively obtained patient and staff feedback.

3. Staff we spoke with were all aware of the organisation vision and 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes <sup>1</sup>
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 <sup>2</sup>
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
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. Staff we spoke with told us they were encouraged to raise concerns and those who had told us they felt supported.</li> <li>2. Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.</li> </ol>	

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

Source	Feedback
Staff interviews	<p>Staff told us that all staff worked well as a team. Staff felt supported by the management team. Staff we spoke with told us that GPs had an open-door policy when support was required.</p> <p>Staff spoken with told us they were proud to work for the service, felt consulted and part of a team and knew their contribution was valued. We saw that staff morale was positive and there was a low turnover of staff.</p> <p>Staff told us that the leaders were visible and approachable. They felt supported and were comfortable to raise any concerns that may arise. When issues were raised, staff felt that they were listened and responded to. Staff told us that they enjoyed working at the practice and were motivated by recent changes which they viewed as having been very positive.</p>

## 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.	Yes <sup>1</sup>
Staff were clear about their roles and responsibilities.	Yes <sup>2</sup>
There were appropriate governance arrangements with third parties.	Yes <sup>3</sup>
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> <li>1. Outcomes for cancer screening were significantly below target and CCG averages. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.</li> <li>2. Clinical staff with extended roles were in receipt of competency reviews in the form of appraisals, one to one observation and both verbal and written feedback.</li> <li>3. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.</li> </ol>	

**Managing risks, issues and performance**

**There were processes for managing risks, issues and performance however, some of these required strengthening.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes <sup>1</sup>
There were processes to manage performance.	Yes <sup>2</sup>
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes <sup>3</sup>
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: <ol style="list-style-type: none"> <li>1. Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care was understood.</li> <li>2. The practice had processes to manage current and future performance. There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. However, there were still issues related to patient feedback from the GP survey, where dissatisfaction was identified in some areas there was a plan to address this particular feedback, but actions had not yet been implemented. Outcomes for cancer screening and childhood immunisation were below target.</li> <li>3. The practice reviewed how they function and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively including their role in a major incident.</li> </ol>	



## 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.	Yes
Performance information was used to hold staff and management to account.	Yes <sup>1</sup>
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: 1. The practice held regular meetings with staff. There was an open-door policy where staff could discuss any issue or concerns with the clinicians and management team.	

## 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

Feedback from Patient Participation Group.

Feedback
<p>We viewed Patient Participation Group (PPG) meeting minutes and saw there was an open approach to informing the PPG about changes within the practice, including staff training and improved access schemes in the local community.</p> <p>We spoke with a member of the PPG who informed us they felt a part of the practice and were kept up to date with changes within the practice. The PPG were invited to help the surgery complete surveys and had been vital in setting up health awareness events.</p> <p>They described that the changes over the last year had been handled well and that they were very happy with the new arrangements. The PPG representative told us that they had received good feedback from patients about the changes and were not aware of any negative comments.</p> <p>There was a dedicated information area for the PPG in the waiting room. This included details of the next meeting and stated the PPG's aims and objectives.</p>

## Continuous improvement and innovation

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

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

## Examples of continuous learning and improvement

The practice had worked with the local homeless population and charities to improve the care for homeless patients. The practice was a member of the Faculty for Homeless and Inclusion Health. They attended the annual conference in order to continue to learn from national and international expertise. The practice provided training opportunities for specialist trainee doctors, medical and nursing students and offered apprentice schemes to potential reception and administration staff. The practice website had been updated to provide appropriate and up to date information and education for patients. The practice has been leading the development of at scale working with the primary care network and GP provider organisation. A GP based at Nelson, Chairs the GP provider organisation.

## 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.