

# Care Quality Commission

## Inspection Evidence Table

### Kennet Surgery (1-549951953)

Inspection date: 14 November 2019

Date of data download: 01 November 2019

## Overall rating: Good

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

### Effective

### Rating: Good

#### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
Explanation of any answers and additional evidence: The practice received and circulated new local and national guidance to clinicians and clinicians had access to best practice guidance online. The practice demonstrated they provided care and treatment in line with best practice guidelines through clinical audits.	

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>	0.12	0.56	0.75	Significant Variation (positive)

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

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

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>	69.4%	78.5%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.3% (23)	12.1%	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>	83.9%	78.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	6.4% (28)	8.7%	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>	81.6%	81.4%	81.3%	No statistical variation
Exception rate (number of exceptions).	10.5% (46)	12.4%	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>	72.0%	74.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.1% (5)	5.4%	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>	91.8%	89.4%	89.6%	No statistical variation
Exception rate (number of exceptions).	2.0% (1)	10.7%	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 measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	80.2%	81.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (13)	3.2%	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) (QOF)	96.7%	93.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	6.3% (2)	5.9%	5.9%	N/A

### Any additional evidence or comments

The practice had recognised that it's performance in managing patients with diabetes was an area for further improvement and we saw that the data from 2018/2019 had improved since the previous year, with 2017/2018 data showing the percentage of patients with diabetes in whom the last blood sugar was recorded within the normal range was previously 68.2%.

The practice had the highest diabetes prevalence locally with approximately 8.7% of the practice population and we discussed this with the practice who told us:

- they continued to hold regular discussions with the community diabetes consultant and diabetes specialist nursing team to review performance and discuss further improvements;
- they used care planning and they held virtual groups with the community diabetes consultant to further improve outcomes for patients with diabetes;
- they were involved in a local Nepalese diabetes project to offer group consultations and a translated education course, as the current diabetes programme was not available in different languages;
- they communicated with patients who did not speak English as a first language by using translators, they translated written communication where appropriate and patients' appointments were booked with staff members who spoke the required language; and
- the practice introduced a lead role for an administrative staff member for diabetes recall to ensure all patients were actively contacted on at least three occasions to invite them to attend for reviews.

The 2018/19 Quality and Outcomes Framework (QOF) data highlighted higher than average exception reporting in a number of areas (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). We discussed this with the practice who told us that due to the lower numbers of patients on their condition registers, this data has been skewed.

The 2018/19 QOF data showed that exception reporting for peripheral arterial disease (a condition which causes reduced blood circulation) was 33.3% in comparison to Clinical Commissioning Group (CCG) average of 7.8% and England average of 6.1%. The practice data for peripheral arterial disease showed seven patients on the register and the data demonstrated that two patients had been exception reported.

The 2018/19 QOF data showed that exception reporting for osteoporosis (a condition that weakens bones) was 50% in comparison to CCG average of 17.5% and England average of 20.3%. The practice data for osteoporosis showed four patients on the register and two patients had been exception reported. However, at the time of inspection, all four had now attended for review.

The 2018/19 QOF data showed that exception reporting for cardiovascular disease (conditions affecting the heart or blood vessels) was 50% in comparison to CCG average of 25.9% and England average of 25.6%. The practice data for cardiovascular disease showed two patients on the register and as one patient had been exception reported, the data demonstrated a 50% exception rate.

We spoke to two administrative staff members with lead roles in long term condition recall who told us the protocol for contacting patients on at least three occasions. We were told that when a patient does not respond to three contacts, their information is shared with the lead GP to review and decide to exception report or make further contact with the patient.

The practice policy for exception reporting clearly demonstrated that patients should be contacted on at least three occasions by letters, telephone and text message. We saw three patient records who had been exception reported and all had been appropriately contacted using a combination of communication methods in line with practice policy.

## 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 contacted the parents or guardians of children due to have childhood immunisations. However, on the day of inspection we were told by a member of staff that following up of failed attendance for childhood immunisations was not always carried out consistently with a telephone call in line with the practice protocol. We discussed this with the practice who implemented a new process to ensure that if the practice nurse had been unable to follow up by telephone during the day, then the senior administrator would contact the parents. Following inspection, the practice told us they had carried out a search on all failed attendances in the past six months and confirmed that all had been consistently followed up with a telephone call at the time by the practice nurse.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice offered joint baby and post-natal clinics with a GP and practice nurse.
- 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, 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)	69	74	93.2%	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)	55	60	91.7%	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)	55	60	91.7%	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)	56	60	93.3%	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>

## 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. The patient waiting area had information for patients to access information cards about NHS health checks, what they included and how to book them.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.



Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	65.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	68.4%	72.1%	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)	45.7%	57.5%	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)	66.7%	73.9%	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)	55.6%	54.1%	51.9%	No statistical variation

Any additional evidence or comments
<p>We saw unverified data from the practice that indicated cervical screening had improved since March 2018. The practice provided the most recent clinical commissioning group's (CCG) quality improvement unverified data which demonstrated that in March 2019 the practice's cervical screening performance for the last three and a half years for those aged 25-49 years was 63% and cervical screening performance for the last five and a half years for those aged 50-64 years was 77%. The CCG data showed that this unverified data was currently above local averages but still demonstrated being below the national target. At the time of the inspection, the most recent 2018/19 verified data for cervical screening was not available to confirm the practice's current figures.</p> <p>To further improve its uptake of cervical screening, the practice had taken the following actions:</p> <ul style="list-style-type: none"> <li>• Translated posters were displayed in the waiting area to ensure patients that did not speak English as a first language had access to relevant information to encourage uptake;</li> <li>• Alerts had been added to patient records for patients who had not attended or had not booked an appointment;</li> <li>• Clinical and non-clinical staff members continued to discuss cervical screening opportunistically with patients when record alerts indicated that the patient had not booked an appointment or had not attended;</li> <li>• A dedicated staff member carried out three monthly searches to identify all patients who had not attended or booked their appointment;</li> <li>• Search results were divided between five reception staff members to contact patients to discuss cervical screening; and</li> <li>• The practice sent translated letters to patients that did not speak English as a first language to advise of cervical screening and how to book an appointment.</li> </ul>

The practice was aware of their lower than average uptake of bowel screening and told us they had taken the following actions to improve this:

- The practice had access to a new bowel screening kit and staff had been informed of how to use the kits, to ensure they felt confident explaining this to patients;
- The practice met with the local cancer team to discuss further ideas on how to improve uptake; and
- The practice recognised that bowel screening uptake was lower in patients who did not speak English as a first language and were in discussions to obtain translated posters to provide information to the local population. In the interim, the practice provided pictorial posters in the waiting room to highlight the new kit and improve understanding of bowel screening.

The 2018/19 Quality and Outcomes Framework (QOF) data highlighted higher than average exception reporting in cancer at 50%, in comparison to CCG average of 22.4% and England average of 26.3% (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The practice provided unverified data from November 2019 which demonstrated that out of the nine patients that required a review within six months of diagnosis, eight of these had been completed. This demonstrated a current 89% achievement. In addition, 2018/19 QOF data demonstrated a lower than average exception report rate for cervical screening at 4.4% in comparison to CCG average of 7.2% and England average of 6.8%.

The practice policy for exception reporting clearly demonstrated that patients should be contacted on at least three occasions by letters, telephone and text message. We saw three patient records who had been exception reported and all had been appropriately contacted using a combination of communication methods in line with practice policy.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.



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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services and we saw appropriate services were displayed in the patient waiting area.

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>	93.8%	90.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	7.7% (4)	10.1%	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) <small>(QOF)</small>	93.8%	91.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	7.7% (4)	8.7%	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) <small>(QOF)</small>	80.0%	85.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.4% (2)	5.9%	6.7%	N/A

## Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	536.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	96%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.8%	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 completed a two-cycle audit to review patients with confirmed e-coli (a type of bacteria common in human intestines) from analysis of urine to find trends in results and treatment and minimise ongoing infections. The first cycle audit was carried out in February 2019 and identified four patients, and all had been found to be treated appropriately. A repeat audit was carried out in September 2019 and identified two patients who were found to be treated appropriately. This demonstrated a 50% reduction from the previous audit and all patients with primary care contact and clear symptoms of a urinary tract infection were treated appropriately. In addition, the practice had sent the audit to the Infection Prevention and Control lead for additional feedback which had not been received at the time of inspection.

As a result of the medical secretary highlighting an increase in workload and request for referrals by the locum GPs, the practice carried out a two-cycle audit to review all referrals made during locum sessions. The first audit in July 2019 identified that out of 54 patients seen by the locum in one week, 18 referrals were made, a total of 33%. Out of the 18 referrals made and reviewed by the lead GP, 39% were considered appropriate. The practice discussed the audit with the locum GPs, advised of alternative management options and it was agreed that the lead GP would monitor and review all referrals made by locums. In addition, the practice set a target to reduce locum referral rates to 20%. A re-audit in October 2019 highlighted a significant reduction in referrals and out of 54 patients seen by the locum in one week, 10 referrals were made, a total of 19%. This demonstrated an improvement in referrals made and had reached the practice target. The practice planned to continue to monitor the appropriateness of referrals and would carry out a further audit in three months.

## 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
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
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: The practice promoted a culture of learning and development across the staffing team and we saw reception staff had been upskilled, for example to a practice manager role. In addition, four administration staff members now had lead roles, for example, in long term conditions recall and workflow optimisation (a process to manage incoming correspondence) to lighten GP administrative workload.	

## 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 (01/04/2018 to 31/03/2019) (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
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: The practice held a number of regular meetings with the district and community nurses, health visitors and the community matron to discuss patients on the safeguarding registers and patients on the palliative care register. We saw evidence of minutes from these multidisciplinary meetings.	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>Clinicians used motivational interviewing techniques to improve patient's motivation to make positive changes to live healthier lifestyles and to manage their own health. In addition, a dedicated staff member would send information to patients prior to their condition reviews to help patients to better understand their condition. For example, information explaining diabetic values would be sent to patients with diabetes before they attended for their review to help patients to understand the different ranges of blood sugar levels.</p> <p>Staff were aware of local initiatives to improve patient's health and would signpost patients to appropriate services. We also saw the practice waiting area held information in a variety of languages regarding health promotion, weight loss clinics, heart health clinics, smoking cessation and there was a self-monitoring blood pressure machine for patients to use.</p> <p>To improve engagement and health outcomes within the local community, the practice provided a defibrillator (a device to provide emergency treatment to someone who is in cardiac arrest) and defibrillator training to local religious groups including a local Mosque, Mandir (Hindu temple) and Gurdwara (Sikh temple).</p> <p>The practice had attended a local nursery to promote self-care to children, for example the use of antibacterial hand gel, and to provide education on what to expect in a GP consultation and what the medical equipment was used for to reduce any fears about seeing a doctor. For example, to understand the use of a stethoscope.</p>	

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>	93.7%	94.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (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
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence that formal written consent was obtained for minor surgery procedures at the practice and staff we spoke to on the day were clear on the requirement to obtain consent and provided clear examples to demonstrate their understanding of mental capacity.</p> <p>All staff who currently worked at the practice had completed Mental Capacity Act training.</p>	



## Well-led

Rating: Good

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
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:	
<p>The practice told us they had challenges in communicating care and treatment services to patients who did not speak English as a first language as this was a large percentage of their practice population. To improve this, the practice installed a noticeboard in the waiting area highlighting 11 staff members at the practice who could speak languages including Hindi, Punjabi, Urdu, Konkani and British Sign Language. In addition, the reception desk clearly displayed NHS contact cards translated in Nepalese to ensure patients were able to request a Nepalese speaking interpreter and the practice's telephone answer machine message was recorded in both English and Hindi to communicate to patients how to access out of hours health services.</p> <p>The practice was aware of a decrease in their patient feedback and had closely monitored feedback and reviewed the Friends and Family Test results, shared concerns with the Patient Participation Group (PPG) and had installed a 'You said, we did' board in the practice to inform patients of improvements made as a result of feedback.</p> <p>For example:</p> <ul style="list-style-type: none"><li>• a new telephone system had been installed to improve access by the telephone;</li><li>• additional telephone consultations and on the day appointments were introduced;</li><li>• the practice installed a larger television screen to make information easier to read;</li><li>• the lead GP monitored and addressed issues with clinicians running late with appointments; and</li><li>• additional education was provided to patients about which staff members could be seen to treat certain illnesses to reduce demand for GP appointments.</li></ul> <p>In addition, appointment availability had been monitored by the practice and on the day of inspection we saw that the next available routine appointment for one GP was 21 November 2019 and the next available blood test appointment was available at 11am on 20 November 2019.</p> <p>Patient feedback from comment cards received on the day of inspection was positive and highlighted that staff were friendly, helpful and caring. Three comment cards had mixed reviews and said that although they were happy with the care and treatment at the practice, it could be difficult to get an appointment with a GP.</p>	

## 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

## 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
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke to told us they felt able to raise any concerns with the leadership team and felt confident issues would be addressed.</p> <p>The practice had encouraged staff to use a mindfulness app and had introduced a mental health champion role within the practice for the purpose of recognising staff who may need additional support and to support and advocate for staff members if they did not feel able to raise concerns.</p> <p>Staff we spoke to were clear on the practice whistleblowing policy and was aware of how to contact the external Freedom to Speak Up Guardian.</p>	

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

Source	Feedback
Staff interviews	<p>Feedback from staff we spoke to was positive and told us they felt able to raise any concerns with management. Staff told us they felt supported, listened to and said they were encouraged by leaders to carry out additional training to further support them in their roles.</p> <p>Staff we spoke to told us they enjoyed working at the practice and felt leaders were approachable.</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
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice held a number of regular meetings throughout the year for staff to attend to discuss issues affecting the practice and the service patients received. These included clinical meetings, full practice meetings, management meetings, reception staff meetings and multidisciplinary meetings.</p> <p>Staff we spoke with on the day were clear about their own roles within the practice as well as the roles and responsibilities of other staff members.</p>	

### Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
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
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:	
The practice had effective systems in place for managing safety alerts, incidents and complaints and these were appropriately reviewed, actioned and discussed at clinical or practice meetings.	
Clinical audits had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.	

### 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
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:	
The practice had a proactive approach to improving the service for patients and staff. For example, having regular meetings to discuss significant events, complaints, audits and the practice used data to inform performance targets for clinical staff.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

### 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:  
 The practice had regular contact with their PPG and the practice told us they were trying to improve the attendance. We saw evidence of information shared with the PPG including discussions on areas for improvements, current targets of achievement (such as flu vaccination uptake) and themes of patient feedback.

### Feedback from Patient Participation Group.

**Feedback**

We spoke to a member of the PPG who spoke positively about the practice. Members of the practice attend the PPG meetings twice a year and listen to any concerns or ideas to improve the service for patients. In addition, the PPG felt the practice was open and honest about areas for improvement and suggestions from them would be actively encouraged and implemented where possible. For example, the PPG was involved in the installation of a new telephone system in response to patient feedback about getting through to the practice by telephone.

The PPG also told us that the practice had been proactive in offering advice and support to identified carers and told us the practice had good knowledge of local support services.

The PPG and practice told us they had discussions about how to increase attendance at their meetings. To improve this, the practice introduced a virtual PPG group which approximately 40 patients are signed up to receive information and can offer suggestions using email. We were told that the PPG and practice had discussions within the Primary Care Network (PCN) to decide whether a PCN-wide patient participation group would be more appropriate.

## 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
Explanation of any answers and additional evidence:	
<p>All staff had access to a range of training to support them to undertake their role and continue to support the needs of the practice. For example, a clinician recently attended a gang awareness training course in response to local crime concerns to improve awareness of risks to young people and recognise early intervention opportunities.</p> <p>The practice actively encouraged staff to report on both positive and negative significant events and outcomes would be discussed and addressed at staff meetings. For example, a positive significant event was the introduction of a new leaflet to advise parents of signs to look out for when a child is unwell, what they can do to support the child and when to seek medical support.</p> <p>The practice was currently working within their PCN to improve and increase services to the local population. The practice was involved in an overflow hub project to increase access for patients across the locality and further improve collaborative working with other practices in their PCN.</p>	



## 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.