

Care Quality Commission

Inspection Evidence Table

Stockwell Lodge Medical Centre (1-540153838)

Inspection date: 16 October 2019

Date of data download: 10 October 2019

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

We rated the practice as requires improvement for providing safe services because:

- The practice's systems, practices and process to keep people safe and safeguarded from abuse were not always comprehensive.
- The practice's systems for the appropriate and safe use of emergency medicines were not always comprehensive.

Safety systems and processes

The practice's systems, practices and process to keep people safe and safeguarded from abuse were not always comprehensive.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence: All the staff we spoke with demonstrated they understood the relevant safeguarding processes and their responsibilities. Staff had completed adult and child safeguarding training to the appropriate level.</p> <p>During our inspection we found some clinical staff members had not completed safeguarding adult refresher training. The practice explained that an external trainer was scheduled to complete this training with staff members in September, however this session had been cancelled by the trainer. Shortly after our inspection, the practice provided us with evidence to confirm that this training session had now taken place and all staff members had completed safeguarding training to the required level.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence: We checked five personnel records and found the practice had an effective system in place to ensure the required recruitment checks had been undertaken.</p>	

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: 20 June 2019.	Y
There was a record of equipment calibration. Date of last calibration: 19 June 2019.	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 17 October 2018 (Checks scheduled for 25 October 2019).	Y
There was a log of fire drills. Date of last drill: 2 October 2019.	Y
There was a record of fire alarm checks. Date of last check: 11 October 2019.	Y
There was a record of fire training for staff. Date of last training: A number of staff had completed online training at various times	Partial

within the previous 12 months.	
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 14 August 2019.	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence: The fire alarm was serviced every three months and the majority of staff members had completed fire safety training. However, we were unable to find evidence of fire safety training for one member of the nursing team.</p> <p>The fire risk assessment included a number of recommendations to reduce fire risk, which the practice had acted on. However, there were six medium to high priority recommendations which had not been completed. The practice was in the process of addressing these and told us that the remaining outstanding actions would be completed by November 2019. During our inspection we found the internal fire exit signage to be inadequate in some areas and one of the fire escape routes was partially obstructed with brambles. Shortly after our inspection, the practice sent us evidence to confirm that they had been attempting to have this work done over the previous months and the fire escape route had now been cleared. The practice had taken steps to ensure there was adequate fire signage throughout the premises.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 15 August 2019.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 15 August 2019.	Partial
<p>Explanation of any answers and additional evidence: At the time of our inspection, the practice did not have an up-to-date action plan in place following a health and safety assessment. Shortly after our inspection the practice provided us with an up-to-date action plan which demonstrated that they had completed all but one of the actions detailed in the assessment. The practice was in the process of obtaining copies of staff driving licences and vehicle insurance.</p> <p>A Legionella risk assessment was in place for the premises and the practice completed regular water temperature checks. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The risk assessment included three high priority and one medium priority recommendations which had not been acted on by the practice. Shortly after our inspection the practice provided us with an up-to-date action plan and told us that the outstanding actions would be completed by November 2019.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met in most cases.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial

Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: September 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: We saw the practice was visibly clean and tidy. The practice completed an IPC audit on a monthly basis. Staff had access to infection prevention and control (IPC) online training. All of the staff we spoke with demonstrated a good understanding of the IPC systems and processes in place. At the time of our inspection, we found two GPs did not have a record of IPC training in place. Shortly after our inspection, we received evidence to confirm that this training had now been completed.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation in most cases.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.08	0.91	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	9.0%	8.8%	8.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	7.11	5.55	5.60	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.67	2.10	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient	Y

Medicines management	Y/N/Partial
identity.	
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence: During our inspection, we reviewed how the practice monitored prescribing for uncomplicated urinary tract infections. We found the practice had an effective system in place to monitor their prescribing rates and this included regular audits and performance reviews. The latest audit completed by the practice showed an improvement in their prescribing rate for uncomplicated urinary tract infection.</p> <p>There was a system in place to monitor the use of blank prescriptions, however these were not always securely stored. Blank prescriptions were kept in a filing cabinet which did not have a working lock. The practice told us that they were awaiting the delivery of a replacement key for the cabinet. Shortly after our inspection, the practice told us that they had replaced the filing cabinet and prescription paper was now securely stored.</p> <p>The practice had a system in place to monitor emergency medicine stock levels and expiry dates. During our inspection, we found a number of emergency medicines which had passed their expiry date. The practice explained that these medicines had been ordered and their supplier did not have them in stock. The practice had not taken steps to contact the manufacturer for advice and had not considered the risks in stocking emergency medicines which had passed their expiry date. During our inspection, we found medical swabs which had passed the expiry date recommended by the manufacturer. The practice took immediate action and disposed of the relevant emergency medicines and consumables. Shortly after our inspection, the practice sent us an updated emergency medicines checklist.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Seven
Number of events that required action:	Six
Explanation of any answers and additional evidence: There was an effective system in place for reporting and recording incidents and significant events. The staff we spoke with were clear on the reporting process and we found that lessons learnt were shared to make sure action was taken to improve safety in the practice.	

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

Event	Specific action taken
Historic information was sent to patients.	Staff were reminded to check the results following a system search prior to issuing patient letters.
The two week wait cancer referral pathway was not followed resulting in a delay.	Staff were reminded to follow the referral pathway in place.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw a process was in place and adhered to for the receipt, review and monitoring of action taken in response to safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We saw examples of actions taken in response to recent alerts, including one regarding sodium valproate (a medicine primarily used in the treatment of epilepsy).	

Effective

Rating: Requires Improvement

We rated the practice as requires improvement for providing effective services, and requires improvement for people with long-term conditions population group, families, children and young population group and working age people population group because:

- Not all staff members had an up-to-date record of training relevant to their role.
- Not all staff members had received an appraisal in line with practice's appraisal policy.
- Uptake for cervical screening had declined, rates were below target and the national average.
- Uptake for childhood immunisations had declined, rates were below local and national averages.
- Data from the Quality and Outcomes Framework 2018/2019 showed performance for care provided to patients with diabetes was lower than local and national averages.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: The practice had systems in place to keep all clinical staff up-to-date. Staff had access clinical templates and National Institute for Health and Care Excellence (NICE) best practice guidelines. They used this information to deliver care and treatment that met patients' needs.	

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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	1.02	0.62	0.74	No statistical variation

Older people

Population group rating: Good

- 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: Requires Improvement

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 GPs and nurses 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. Patient medication reviews were carried out on a six-monthly basis.
- 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.
- 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.

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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>	69.0%	78.7%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.6% (22)	10.5%	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>	56.2%	75.4%	78.1%	Variation (negative)
Exception rate (number of exceptions).	3.6% (22)	8.8%	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>	73.0%	81.3%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.7% (23)	11.2%	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>	75.0%	77.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.2% (7)	7.1%	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>	90.1%	91.9%	89.6%	No statistical variation
Exception rate (number of exceptions).	16.5% (32)	13.7%	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)	81.6%	82.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.0% (31)	3.9%	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)	83.7%	90.9%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.3% (2)	4.6%	5.9%	N/A

Any additional evidence or comments

During our inspection, we checked a sample of records for QOF indicators including diabetes and hypertension. We found all of these patients had received appropriate reviews or had been invited for a review. We found the practice had a systematic approach towards managing patient reviews and recalls. Exception reporting was lower than average. (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). Recently published QOF data for 2018/2019 showed the practice had improved their performance in a number of areas. The latest QOF data showed;

- 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, was 69%. This was an increase of 4.7% when compared with 2017/2018 QOF data. Exception reporting remained significantly lower than the local and national average.
- 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, was 56.2%. This was an increase of 8.9% when compared with 2017/2018 QOF data. Exception reporting remained lower than the local and national average.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is five mmol/l or less, was 73%. This was an increase of 7.4% when compared with 2017/2018 QOF data. Exception reporting remained significantly lower than the local and national average.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less, was 81.6%. This was an increase of 7.9% when compared with 2017/2018 QOF data. Exception reporting remained lower than the local and national average.
- Exception reporting for patients with atrial fibrillation with a record of a CHA2DS2-VASc score of two or more, the percentage of patients who are currently treated with anti-coagulation drug therapy was 1.3%. This was a reduction of 10.8% when compared with 2017/2018 QOF data.

Findings

- Data from 2016/2017 showed childhood immunisation rates were above the 90% standard across all four indicators. The practice monitored their performance and had a recall system in place. The practice has not met the minimum 90% target for all four childhood immunisation uptake indicators. Data for 2018/2019 childhood immunisation indicators showed a steady decline in uptake rates.
- The practice contacted the parents or guardians of children due to have childhood immunisations. Childhood immunisation was provided during six-week post-natal and child health checks.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, 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)	73	85	85.9%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	75	89	84.3%	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)	77	89	86.5%	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)	74	89	83.1%	Below 90% minimum

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- Uptake for cervical screening had declined, rates were below target and national averages.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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.

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)	71.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	70.5%	72.4%	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)	54.5%	59.3%	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)	54.5%	63.3%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	47.6%	57.2%	53.8%	No statistical variation

Any additional evidence or comments

There was evidence to suggest the practice encouraged its relevant patients to engage with nationally run and managed screening programmes. The practice contacted patients who failed to attend their cervical screening appointment and displayed information in the patient waiting area and on their

website. The practice encouraged uptake by ensuring a female sample taker was available.

QOF data for 2018/2019 showed the percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding five years was 80.53%.

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. The practice had 56 patients on their learning disability register and 40 patients had received a health check and care plan review between 2018/2019.
- 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.
- The practice reviewed young patients at local residential homes.

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.
- Clinical 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) (QOF)	91.8%	92.8%	89.4%	No statistical variation
Exception rate (number of exceptions).	5.2% (4)	12.8%	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)	94.5%	93.9%	90.2%	No statistical variation
Exception rate (number of exceptions).	5.2% (4)	10.6%	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)	75.6%	83.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	6.0% (5)	7.9%	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)	533.3	No Data	539.2
Overall QOF score (as a percentage of maximum)	95.4%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.7%	No Data	No Data

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

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

The practice used information about care and treatment to make improvements. For example, a three-cycle audit was completed to ensure patients receiving medicines for high blood pressure and cholesterol were being managed appropriately. The practice took action to improve the systems in place and the results from the third-cycle audit demonstrated that the practice was effectively monitoring and managing these patients.

All referrals to secondary care services were completed electronically and the practice had a system in place to complete regular audits of referrals. For example, the practice had completed a two week wait cancer referral audit to ensure compliance with the system and process in place.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included role-specific training and updating for relevant staff, the use of an online training package and local Clinical Commissioning Group led training days. The practice had invested in the development of their nursing team and were funding further training and development for one of the nurse practitioners.	

During our inspection, we found some clinical staff members had not completed training relevant to their roles, such as safeguarding adults, fire safety, infection prevention and control and information governance. Shortly after our inspection, we received evidence to confirm that this training had been completed.

At the time of our inspection, three non-clinical staff members had not received an appraisal in the previous 12 months. The practice told us that the outstanding staff appraisals had been delayed due to a change of roles. Shortly after our inspection, the practice sent us evidence to confirm that these appraisals had now been completed.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) <small>(QOF)</small>	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: The practice worked closely with a multi-disciplinary rapid response service in place to support older people and others with long-term or complex conditions to remain at home rather than going into hospital or residential care.	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Explanation of any answers and additional evidence: The practice participated in a local obesity prevention programme. The nursing team provided an in-house smoking cessation service and referred patients to the local stop smoking service.

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>	93.0%	95.3%	95.0%	No statistical variation
Exception rate (number of exceptions).	1.0% (25)	0.7%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: The practice had clear systems in place for the appropriate assessment of capacity and recording of consent.	

Caring

Rating: Requires Improvement

We rated the practice as requires improvement for providing caring services because:

- The results from the latest National GP Patient Survey results published in July 2019 showed the practice was performing significantly lower than local and national averages for several indicators.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: During our inspection we observed that staff members displayed a kind and caring approach towards patients. Staff members had completed equality and diversity training.	

CQC comments cards

Total comments cards received.	43
Number of CQC comments received which were positive about the service.	42
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
Patient interviews	Feedback from patients was positive about the way staff treated them. Patients described staff as friendly, professional and caring.
Patient Participation Group (PPG) members	Feedback from PPG members was positive about the way they were treated by staff.
CQC comment cards	Patient comments were positive about the caring nature of all staff members.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10,984	287	105	36.6%	0.96%

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)	74.2%	88.9%	88.9%	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)	73.9%	86.4%	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)	89.1%	95.9%	95.5%	Tending towards 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)	49.2%	80.5%	82.9%	Significant Variation (negative)

Any additional evidence or comments

The practice had reviewed the latest National GP Patient Survey results published in July 2019 and had obtained feedback from the NHS Friends and Family Test (FFT) and Patient Participation Group (PPG). (The FFT asks people if they would recommend the services they have used and offers a range of responses). The practice had taken steps to make improvements in areas where performance was below the local and national average and monitored their progress by completing patient surveys and audits on a regular basis.

The practice had reviewed feedback from patients and had made a number of changes in order to improve the patient experience. For example, the practice had re-arranged the reception and waiting area. The practice had installed a partition which enabled staff answering the telephone during busy periods to do so away from the front desk. Staff had received customer service training.

Feedback from patients on the day was positive about the quality of their consultation and overall experience of the practice.

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

Any additional evidence
The PPG had completed a patient survey in October 2019 and had received 50 responses. Patients were asked about their consultation and all 50 patients stated that they were satisfied with the service they had received. Patients were also asked to rate their overall experience of the practice and all but two patients stated that they were satisfied or very satisfied with their overall experience of the practice.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The practice displayed information about local services and support available to patients. The practice website offered a range of information for patients to access. Easy read materials were available.	

Source	Feedback
Interviews with patients, PPG members and CQC comment cards.	Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	90.2%	93.5%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice held a register of carers, with 269 carers identified, which was approximately 2.4% of the practice list.
How the practice supported carers (including young carers).	The practice's computer system alerted staff if a patient was also a carer. The practice had a dedicated carers noticeboard in the patient waiting area and a carers lead who provided information to patients about local services offering support to carers.
How the practice supported recently bereaved patients.	Staff told us that if families had experienced bereavement a sympathy card would be sent to the family and the practice would provide information on services available to support them. Patients experienced a bereavement were also given the opportunity to access support from a local social prescriber. (Social prescribing is when health professionals refer patients to support in the community, in order to improve their health and wellbeing).

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: Staff recognised the importance of patients' dignity and respect. Staff made efforts to maintain privacy and confidentiality. The practice displayed a notice in the reception area to promote patient confidentiality. The reception desk and patient waiting area had been re-organised to promote patient confidentiality. A private room was available to patients and the practice had an electronic check-in kiosk available to patients.	

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services, including the population groups, because:

- The results from the latest National GP Patient Survey results published in July 2019 showed the practice was performing significantly lower than local and national averages for several indicators.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: The practice participated in a local CCG led annual winter resilience scheme and offered more appointments between October 2018 and April 2019. This service had given patients the opportunity to attend the practice for an urgent appointment rather than travel to the local A&E department. The practice had also provided additional visits to a local care home during this period.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7.30am – 6.30pm
Tuesday	8am – 8pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	7.30am – 1pm and 2pm – 6pm
Tuesday	8.30am – 1pm and 2pm – 8pm
Wednesday	8.30am – 1pm and 2pm – 6pm
Thursday	8.30am – 1pm and 2pm – 6pm
Friday	8.30am – 1pm and 2pm – 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10,984	287	105	36.6%	0.96%

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)	87.3%	94.8%	94.5%	Tending towards variation (negative)

Older people

Population group rating: Requires Improvement

Findings

- 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.
- GPs provided a weekly visit to a local residential care home. We spoke to a staff member at the home who told us that there was good communication between the two services and improvements had been made over the previous six months.
- The practice was able to offer home visits via the Acute In-Hours Visiting Service. This is a team of doctors who work across East and North Hertfordshire to visit patients at home to provide appropriate treatment and help reduce attendance at hospital.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients available via a local pharmacy.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice held monthly meetings with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Practice staff worked with PPG members and held coffee mornings for patients with long-term conditions.
- The practice had a blood pressure monitoring machine available to patients to use in a private room.

- 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: Requires Improvement

Findings

- Additional nurse appointments were available until 6pm 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 a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- A community midwife held regular clinics in the building next to the practice.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

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.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- A community phlebotomy service was available to patients locally seven days a week for the required testing.
- A social prescriber held a monthly clinic at the practice. This service offered patient referrals to a range of local, non-clinical services.
- An electronic prescribing service (EPS) was available which enabled GPs to send prescriptions electronically to a pharmacy of patients' choice.
- The practice offered extended opening hours on Monday mornings and Tuesday evenings. Additional appointments were also available to all patients at a local GP practice within the area daily, as the practice participated in a local Extended Access scheme. Appointments were available from 6.30pm to 8pm weekdays and from 9am to 1pm during weekends.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice had carried out extensive work in identifying and supporting people with a learning disability. This work resulted in the practice receiving a Purple Star Award in March 2019. This locally developed quality kite mark had been developed by service users, carers, the University of Hertfordshire Business School and the Community Learning Disability Service in Hertfordshire, to award services for providing good quality, accessible health care for adults with a learning disability.
- The practice had re-organised their waiting area and had created a private room available to vulnerable patients and patients wanting to discuss sensitive issues.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

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

Timely access to the service

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

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: The practice provided a telephone triage service. All requests for an urgent appointment or home visit were clinically assessed by a duty doctor.	

National GP Survey results

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)	21.8%	N/A	68.3%	Significant Variation (negative)
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)	38.7%	62.2%	67.4%	Variation (negative)
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)	47.6%	57.8%	64.7%	Tending towards variation (negative)
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)	57.9%	70.9%	73.6%	Tending towards variation (negative)

Any additional evidence or comments

Following our previous inspection in August 2018, the practice had taken a number of steps to improve access and the patient experience. For example, the practice had increased the number of online appointments available and had introduced a quarterly newsletter to keep patients up-to-date. The practice had increased the number of nursing staff members and clinical pharmacists. A new telephone system had been installed. The practice undertook regular monitoring and audits on the telephone and

appointment booking system and data provided by the practice demonstrated that they were offering more appointments when compared with the previous year. Results from the latest National GP Patient Survey showed improvements when compared with the 2018 survey results.

Patient feedback we received on the day of our inspection was positive. Patients commented on the positive changes made by the practice and described access and overall experience as much improved.

The PPG had completed a patient survey in October 2019 and had received 50 responses. Patients were asked about their experience of contacting the practice by telephone and 45 patients (90%) stated that they had found it easy. Patients were asked if they would recommend the surgery to family and friends and 39 patients (78%) stated that they would recommend the surgery. Patients told us that they were able to get to the through to the practice on the telephone and were offered an appointment convenient to them.

The latest National GP Patient Survey results showed performance was below the local and national average. For example, 21.8% of patients responded positively to how easy it was to get through to someone at their GP practice on the phone. This was an improvement of 4.8% when compared to the National GP Patient Survey results published in 2018. The number of patients who described their overall experience of making an appointment as positive was 38.7%. This was an improvement of 7.7% when compared to the National GP Patient Survey results published in 2018.

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.	19
Number of complaints we examined.	Seven
Number of complaints we examined that were satisfactorily handled in a timely way.	Seven
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Information about how to make a complaint or raise concerns was available and it was easy to do. The practice offered apologies to patients, lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Negative patient feedback relating to the quality of patient consultations with a	The practice carried out an investigation which resulted in a decision to stop using a particular locum GP at the practice.

locum GP.	
Patient complaint in relation to confidentiality.	Staff were provided with additional training and the practice completed regular checks to ensure the process for managing confidentiality was effective.

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led services because:

- The provider had not established a governance framework to ensure adequate oversight of systems and processes across all areas.
- The provider did not have a comprehensive process to identify, understand, monitor and address risks to patient safety in all areas.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The practice had a stable leadership team and had taken a number of steps to manage patient demand. For example, the practice had recruited additional clinical and non-clinical staff members and had introduced a workflow management system.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a clear vision and strategy in place. The practice manager had joined in September 2018 and had implemented a practice-wide programme of system reviews and improvements.	

Culture

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

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

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

Source	Feedback
Staff interviews.	The staff members we spoke with told us that there was a good relationship with managers and they could raise concerns and report when things went wrong. Staff were positive about the improvements made within the previous months and they told us they felt respected, valued and well supported.

Governance arrangements

The provider had not established a governance framework to ensure adequate oversight of systems and processes across all areas.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice had a regular schedule of meetings	

in place for all staff members including multi-disciplinary teams. Clinical oversight and accountability within the practice had been established. There was an overarching governance framework in place and staff had access to practice specific policies. At the time of our inspection, we found the practice did not have an adequate system in place to ensure all staff members had completed the appropriate training relevant to their roles. Not all staff members had received an appraisal within the previous 12 months.

Shortly after our inspection, the practice provided us with evidence which demonstrated that they had taken the required action in response to the areas identified.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice monitored their performance and had made changes where required. For example, the practice had introduced nurse led clinics for the review of patients with long-term conditions and this had improved their QOF performance. The practice regularly reviewed and audited their clinical systems and processes to ensure they were effective and operating as intended.	
The practice had a detailed overarching risk register which was aligned to the business continuity plan. The practice did not have clear and effective processes for managing risks in some areas. At the time of our inspection, we found the practice had not taken adequate actions to address the recommendations identified in the fire, health and safety and Legionella risk assessments. The practice had not considered the risks of stocking emergency medicines which had passed the expiry date recommended by the manufacturer. The system of checking the expiry dates of medical consumables was not adequate. Blank prescriptions were not always stored securely.	
Shortly after our inspection, the practice provided us with evidence to confirm that they had taken immediate action where possible and were taking steps to address all of the areas identified.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice regularly reviewed patient feedback and staff members told us that their feedback was always considered. The practice obtained and reviewed patient feedback in order to make improvements where required. Recent changes introduced by the practice in response to feedback included a new telephone system, a refurbishment and re-design of both patient and staff areas and changes to the staffing structure.	

Feedback from Patient Participation Group.

Feedback
The practice worked closely with the PPG and held regular meetings. The PPG had supported the practice in securing approval for the development of a wellbeing and sensory garden. PPG members had supported the practice in holding engagement events for patients with long-term conditions. The PPG liaised closely with the local CCG and undertook regular patient surveys with the support of practice staff.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice worked closely with other practices within the locality and a GP federation. The practice participated in a Primary Care Network (PCN). (A Primary Care Network is a group of practices working together to provide more coordinated and integrated healthcare to patients). The senior GP and practice manager were the research leads for the PCN. The senior GP was also the GP tutor for the locality and organised regular educational sessions and updates. The practice had signed up to the international GP recruitment scheme and a new GP was scheduled to join the practice in January 2020.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.