

Care Quality Commission

Inspection Evidence Table

Briton Street GP Surgery (1-4057869524)

Inspection date: 30 September 2019

Date of data download: 10 September 2019

Overall rating: Requires Improvement

We rated the practice as requires improvement overall because the provider had not established systems to ensure test results which prompted any alteration of patients care plans were acted on. In particular, the practice was unable to provide assurance that patients prescribed high-risk medicines were being managed in line with national prescribing guidelines.

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

Safe

Rating: Inadequate

The practice has been rated inadequate for safe because:

Systems and processes to assess, monitor and manage risks to patient safety such as medicines to respond to medical emergencies, and monitoring of high-risk medicines did not provide assurance that safety was routinely maintained. During our inspection, the provider took action in response to the issues we identified.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
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

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	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
Explanation of any answers and additional evidence:	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 10/01/2019	Y
There was a record of equipment calibration. Date of last calibration: 11/10/2019	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: 01/07/2019	Y
There was a log of fire drills. Date of last drill: 15/04/2019	Y
There was a record of fire alarm checks. Date of last check: 27/09/2019	Y
There was a record of fire training for staff. Date of last training: All staff completed training within a three-year cycle	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 25/03/2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: All staff had completed fire marshal training. Fire risk assessment action plans had been completed; for example, door locks had been changed to ensure easy exit and powder fire extinguishers had been removed.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 01/03/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/03/2019	Y
Explanation of any answers and additional evidence:	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 01/07/2019	Y
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: The practice made best use of their resources and effectively managed cleanliness and hygiene. The practice scored 98% overall in their infection prevention and control (IPC) audit; and scored 82% for environmental management. Actions identified such as addressing damp walls, ensuring edges were covered and monitoring of general cleaning to ensure areas were free from dust were being managed and monitored by the IPC lead.	

Risks to patients

There were adequate systems in most areas 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.	Partial
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
Explanation of any answers and additional evidence: All staff had completed Sepsis training; staff we spoke with demonstrated awareness of actions to take if they encountered a deteriorating or acutely unwell patient and there were systems in place to support	

staff in their role. However; at the time of our inspection, some equipment to assess patients with possible sepsis such as a paediatric pulse oximeter (used to check how well the heart is pumping oxygen through the body) was not readily available. During our inspection, the provider ordered a paediatric pulse oximeter.

Information to deliver safe care and treatment

Staff mainly 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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
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: Please see medicines management section below for further details.	

Appropriate and safe use of medicines

The practice had systems which mainly enabled the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.64	0.78	0.87	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	13.1%	8.4%	8.6%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	4.67	4.79	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	5.84	2.14	2.08	Variation (negative)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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:</p> <p>The practice demonstrated awareness of areas of their prescribing where data indicated performance was not in line with local and national averages. Members of the clinical team explained this was mainly due to the practice being a training practice; as a result, the practice strengthened their induction process and provided medical practitioners who were undertaking a two-year, general postgraduate medical foundation training programme with additional training on how to use prescribing formulary embedded in the clinical system to improve prescribing. Clinicians explained the high prescribing of Nonsteroidal anti-inflammatory drugs (NSAIDs) was due to the number of registered patients who were diagnosed with Osteoarthritis.</p> <p>The process for monitoring patients' health in relation to the use of high-risk medicines did not provide assurance that prescribers routinely checked whether blood monitoring carried out in secondary care remained satisfactory before issuing a prescription. For example, a random sample of records we viewed indicated that blood monitoring had been carried out in secondary care; however, results had not been recorded in clinical records. A further check of the clinical system showed prescribers had not checked results and we found evidence of results which would have prompted the practice to review and alter patient management plans which had not been followed up in line with national prescribing guidelines. During our inspection, the practice took action during our inspection, which provided assurance that patients would be safe.</p> <p>In the absence of some emergency medicines recommended in national guidance; the practice had not carried out a risk assessment which demonstrated that this had been considered and potential risks mitigated. During our inspection, the provider ordered additional emergency medicines to enable the</p>	

Medicines management	Y/N/Partial
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practice to respond to a wider range of potential medical emergencies.

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:	Three
Number of events that required action:	Three
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
Vaccination fridge outside of recommended temperature range and the practice cold chain policy was not followed promptly.	Staff were reminded of the importance of following up any cold chain breaches in a timely manner. Additional training and support provided.
Staff noticed a box of prescription in the back office which should have been stored securely	The management team reminded staff regarding the importance of ensuring all prescription stationary were stored securely.
Sharps bin not clicked down properly	Management team reminded all staff of the practice protocol regarding replacing sharps bins.

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 reviewed the system for receiving and sharing safety alerts within the practice and saw examples of actions taken to ensure patient safety. For example, actions had been taken in response to a Hormone replacement therapy alert (HRT) as well as alerts relating to an adrenaline auto-injector. Members of the management team explained alerts were discussed during clinical meetings as a standing agenda item and then were added as a batch report which were carried out monthly.	

Effective

Rating: Requires improvement

The practice has been rated as required improvement for effective because:

Quality Outcomes Framework data shows areas of significant variation where data was below local and national averages for the management of patients diagnosed with a long-term condition. The uptake of childhood immunisations was below the minimum 90% as well as below national target of 95% for all four childhood immunisation indicators.

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:	

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>	0.34	0.96	0.75	Tending towards 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: Requires Improvement. This is because data showed clinical management of patients' conditions was below local and national averages.

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. However, QOF data showed performance was below local and national averages.
- The 2017/18 Quality Outcomes Framework data showed areas of negative variation as well as significant negative variations compared to the local and national averages for the management of patient's conditions. At the time of our inspection the 2018/19 QOF had not yet been published and there was some data which the practice was unable to access. However, data which the provider was able to supply during our inspection, showed a mixed picture. For example, there were areas of improvement as well as areas which showed little to no significant change.
- 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 signposted to the local pharmacy for ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	59.3%	77.4%	78.8%	Variation (negative)
Exception rate (number of exceptions).	2.2% (4)	8.4%	13.2%	N/A
The percentage of patients with diabetes, on	52.6%	75.8%	77.7%	Significant

the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QoF)</small>				Variation (negative)
Exception rate (number of exceptions).	7.0% (13)	7.6%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	69.5%	80.1%	80.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.8% (9)	8.7%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	84.6%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.7% (2)	3.5%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	71.4%	88.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	9.5%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	73.0%	82.5%	82.6%	Variation (negative)
Exception rate (number of exceptions).	4.4% (13)	4.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	50.0% (4)	7.0%	6.7%	N/A

Any additional evidence or comments

Quality Outcomes Framework (QOF) indicators for long-term conditions:

The practice demonstrated awareness of performance which was below local and national averages. Staff explained deprivation coupled with health inequalities within the area presented challenges in engaging patients in their treatment. The clinical team also explained during the 2017/18 QOF year the practice did not have enough nurses to enable effective management of long-term conditions. To address the issues the practice carried out a successful recruitment campaign. The practice operated a call and recall system, maximised every patient contact such as carrying out treatment reviews opportunistically as well as providing patients with information to enable them to make informed decisions regarding their health and treatment. The clinical team explained they carried out home visits for patients who experienced difficulties accessing the practice for several reasons such as financial hardship. The practice worked with community specialist nurses to manage patients with complex needs, specifically those diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and diabetes. Nurses explained the community specialists' nurses supported them to develop treatment plans specifically for patients with complex needs. The practice was involved in local initiatives such as the diabetes prevention programme. Unpublished data provided from the 2018/19 QOF year showed little to no improvement in the QOF points achieved; except for the percentage of patients with diabetes, on the register, whose last measured total cholesterol was within recommended range which was 75% and exception reporting rates were zero. Data published since our inspection, showed the percentage of patients whose last measured total cholesterol was within recommended range had not improved and remained below local and national averages.

Since our inspection, the 2018/19 QOF data was published. Data showed areas where performance had declined in clinical indicators such as diabetes, mental health and other long term conditions. For example;

- 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 50%, CCG average of 75% and national average of 78%.
- 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 68%, compared with CCG and national average of 83%.
- 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 anticoagulation drug therapy was 75%, compared with CCG average of 93% and national average of 91%.

- 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 was 20%, compared with CCG average of 91% and national average of 90%.

Families, children and young people

Population group rating: Requires Improvement. This is because childhood immunisation uptake was below minimum target

Findings

- Briton Street Surgery had not met the minimum 90% target for each of the four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The practice demonstrated awareness of this and discussed contributing factors as well as actions to improve uptake.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- Bi-weekly midwife lead clinics were available at the practice.
- Where appropriate children were identified and enrolled onto child obesity programmes.

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)	14	17	82.4%	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)	18	21	85.7%	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)	18	21	85.7%	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)	18	21	85.7%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice operated a call and recall system to enable effective follow up of children who had not received their childhood immunisation. Staff explained they engaged with the National screening service who provided the practice with a list on a weekly basis of patients who were due their immunisation. Non-clinical staff contacted parents and legal guardians to arrange appointments with the nursing team. Members of the nursing team explained that they provided parents and legal guardians with information to enable them to make an informed decision regarding the uptake of childhood immunisation. We saw information available in up to five different languages; staff were multilingual, and the practice also requested that the screening service send appointment letters out in various languages. The practice worked with health visitors to engage with patients who missed multiple appointments. The nursing team explained some patients refused MMR for various reasons, the practice had a growing migrant population and there was a high percentage of missed appointments.

Working age people (including those recently retired and students)

Population group rating: Requires improvement. This is because the uptake of cervical screening was below target.

Findings

- 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)	70.1%	N/A	N/A	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)	75.1%	63.1%	69.9%	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)	42.4%	42.7%	54.4%	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)	80.0%	60.2%	70.2%	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)	50.0%	53.2%	51.9%	No statistical variation

Any additional evidence or comments

Staff explained there were patients who were reluctant to engage in national screening programmes. Staff explained they actively signposted identified patients to walk-in screening clinics held in secondary care. The management team contacted Public Health England (PHE) who produced recall letters in various languages for patients who failed to attend their screening appointments. We were told the local Clinical Commissioning Group (CCG) identified issues such as diversity which hindered the uptake of cervical, breast and bowel cancer screening for patients who have gone through a gender change. Staff explained

the CCG were running a screening pilot which involved a drop-in clinic where patients would receive awareness of the needs of having the screening as well as access to the tests. Staff explained the clinics were held at the local Genital-urinary Medicine and Sexual Health Clinics as well as secondary care and staff were actively promoting the service. The pilot commenced 10 weeks prior to our inspection and at the time of our inspection, the practice was unable to provide data regarding the uptake rates.

The practice clinical system enabled staff to identify women who required cervical screening and invitation letters were sent out to patients. The clinical staff discussed screening during consultations and screening was also carried out opportunistically. Staff we spoke with were trained and aware of appropriate read codes such as verbal smear test reminder discussion and recall codes. Female sample takers were available as well as appointments at different times. The practice was part of a Hub arrangement which enabled patients to access appointments outside of normal working hours as well as weekends, this included access to cervical screening.

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.
- 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.
- All staff had received dementia friendly 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 (01/04/2017 to 31/03/2018) (QOF)	92.3%	90.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	18.8% (3)	11.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.9%	93.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (2)	9.5%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.0%	83.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	6.5%	6.6%	N/A

Any additional evidence or comments
<p>The practice provided unpublished data from the 2018/19 QOF year which showed exception reporting for mental health indicators was less than 5%. The 2018/19 data published since our inspection showed zero percent exception reporting for mental health indicators. However, data also showed a significant decline in patients who had a comprehensive, agreed care plan documented in the record. For example:</p> <ul style="list-style-type: none"> 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 was 33%, compared to CCG average of 87% and national average of 89%.

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)	474.1	526.8	537.5
Overall QOF score (as a percentage of maximum)	84.8%	94.2%	96.2%
Overall QOF exception reporting (all domains)	5.8%	5.8%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The management team described several audits which were carried out quarterly such as summarising medical records onto the clinical system and mortality audits. The summarising medical records audit looked at whether incoming documents were being scanned onto the clinical system and read coded. The first audit showed 100% records were scanned and coded appropriately. The second audit showed some shortfalls and actions were taken to address identified issues. A further audit carried out showed following actions taken 100% of records viewed were appropriately summarised. The mortality audit showed all patients records included do not attempt resuscitation (DNAR) forms and end of life medication (EOL) was added to patient records home screen for easy access.

The clinical team carried out an audit to assess the monitoring of patients diagnosed with Coeliac disease (an autoimmune condition affecting the small intestine). The first audit identified patients did not routinely have their bloods reviewed regularly. The practice acted to improve screening of patients and clinician's awareness were raised during clinical meetings regarding the implementation of national guidance. The practice repeated the audit which showed improvements in the clinical management of patients diagnosed with Coeliac disease.

The practice proved two audits looking at the use of antibiotics and dipsticks in urine infection; the use of a clinical severity grading system as well as antibiotics in patients with sore throat. Both audits had set targets for improvement and demonstrated improvement in the second cycle of the audit. While the numbers were small and further improvement could not be demonstrated these showed the practice were actively looking at clinical effectiveness and appropriate use and stewardship of anti-microbials.

Despite the practice explaining involved in local initiatives such as the diabetes prevention programme; data from the 2018/19 QOF year showed little to no improvement in some clinical indicators and the practice did not demonstrate an effective plan targeting areas where there were concerns.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Members of the management team explained appraisals were carried out in relaxed environments' away from the practice and staff we spoke with welcomed this approach and felt appraisals were positive and supportive.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff actively signposted patients to social prescribing schemes. For example, staff explained patients were signposted to the local care navigation service who looked at patients' needs such as social aspects, access to social services and befriending services. Frail patients at risk of trips and falls were supported to obtain aids such as hand rails installed in their home to reduce risk. The practice received an award for being the highest referrer to the care navigation service. The management team monitored referral rates which were discussed during practice meetings.</p> <p>Staff explained the practice held annual open days where they invited services such as Age UK and offered flu vaccinations; the 2019 open day was scheduled to take place during November.</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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	96.9%	96.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.8% (3)	0.9%	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:	

Caring

Rating: Good

Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	35
Number of CQC comments received which were positive about the service.	34
Number of comments cards received which were mixed about the service.	One
Number of CQC comments received which were negative about the service.	Nil

Source	Feedback
CQC comment cards	Patients described staff as being understanding, professional and patients felt they were treated with respect and dignity. Patients felt staff listened, made them feel comfortable and met their needs. Staff were described as friendly, helpful and welcoming.
Patient interviews	Patients we spoke with during our inspection felt their needs were being met and staff were understanding. Patients explained they had recommended the surgery to family and friends.
NHS Choices	Comments placed on NHS Choices showed patients felt staff were friendly, helpful and did their best to meet their needs.

National GP Survey results

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1820	444	98	22.1%	5.38%

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)	83.3%	84.7%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	76.4%	82.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	91.7%	91.6%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	71.5%	75.0%	82.9%	No statistical variation

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

Any additional evidence
The practice carried out internal surveys and unpublished data provided by the practice showed patients were satisfied with the care they received. For example; data from the 2018 practice survey showed 50 forms had been handed out and returned, 100% would recommend the practice to a family or friend and 90% felt the healthcare practitioner told them about their treatment. The practice carried out a repeat of this audit during August 2019 where they handed out and received 50 completed survey forms and data showed patient satisfaction remained positive.

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: Easy read and pictorial materials were available.	

Source	Feedback
The 2019 national GP patient survey	The survey results indicated that patients felt involved as much as they wanted to be in decisions about their care and treatment during their general practice appointment.
Interviews with patients.	Patients we spoke with during our inspection felt involved in decisions about their care and treatment; they also felt nurses clearly explained treatment plans and medicines.

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)	80.0%	90.5%	93.4%	Tending towards variation (negative)

Any additional evidence or comments

The management team demonstrated awareness of areas where the national GP survey showed patient satisfaction to be below local and national averages. Staff explained the practice had identified the possible causes and raised clinical staffs' awareness during clinical meetings. Data from the practice 2019 internal survey showed 100% felt during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: There were staff members who were multi-lingual and able to speak up to five different languages.	

Carers	Narrative
Percentage and number of carers identified.	The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 78 (4%) patients as carers and 89 (4%) had a carer.
How the practice supported carers (including young carers).	The practice had a carer lead who signposted patients to local support services as well as local authority assessments.
How the practice supported recently bereaved patients.	If families had suffered bereavement, their usual GP contacted them, and they were invited in to speak with the GPs as well as sent a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice had bereavement packs which included information and details of support services available for the family.

Privacy and dignity

The practice respected respect 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: The management team explained the implementation of pass cards which enabled patients who presented upset, distressed and unable to get their words out to hand a card to receptionists which alerted them that the patient wanted to speak in a confidential area. Staff explained this system was introduced following learning from an incident.	

If the practice offered online services:

	Y/N/Partial
Patients were informed, and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 7.30pm
Appointments available:	
Monday	GPs 9am to 1pm and 4pm to 6.20pm Health Care Assistant (HCA) 8am to 3pm, Practice Nurses (PN) 8.30am to 2pm
Tuesday	GPs 9am to 1pm and 4pm to 6.20pm HCA 8am to 3pm and PN 11am to 6pm
Wednesday	GPs 9am to 1pm and 4pm to 6.20pm HCA 8am to 3pm
Thursday	GPs 9am to 1pm and 4pm to 6.20pm
Friday	GPs 9am to 1pm and 4pm to 6.20pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1820	444	98	22.1%	5.38%

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)	82.0%	91.5%	94.5%	Tending towards variation (negative)

Any additional evidence or comments

The practice had an action plan to improve patient satisfaction. Actions included reminding the clinical team to continue to provide the best care for patients and ensure needs are being met before ending the consultation. During clinical meetings GPs were made aware of the importance of ensuring patients were satisfied with consultation outcomes. GPs were also reminded to ask patients whether there were any other needs they would like to address. Results from the practice internal patient survey carried out August 2019 showed 100% felt during their last general practice appointment, their needs were met.

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- Enhanced services for patients at risk of hospital admission and staff explained contact were made if patients were admitted or seen by out of hours (OOH) services.
- There was a designated phone line provided to care homes and residents at increased risk of hospital admission.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was

coordinated with other services.

- The practice worked with specialist nurses to manage complex patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD), asthma or diabetes to support patients to improve control of their condition.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available until 6pm on a Tuesday for school age children so that they did not need to miss school.
- Staff discussed healthy eating with parents or guardians and actively encouraged enrolment onto child obesity programmes.
- Staff explained to improve the uptake of childhood immunisation they held dedicated immunisation clinics as well as carried out home visits if necessary when parents or guardians found it difficult to present their child for their immunisations.
- 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.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice made use of phone applications and patients could be called at their place of work.
- The practice was open until 7.30pm on a Friday and patients could be seen by a clinician up to 6.20pm Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice had Hub arrangements in place. Appointments were available Monday to Sunday 8am until 8pm at a neighbouring practice.
- Patients were able to access pre-booked cervical screening appointments 8am to 8pm Monday to Sunday as part of the Hub arrangements.
- The practice carried out healthy lifestyle checks for patients over the age of 45 years old and offered advice and support with lifestyle changes.
- The practice provided a range of appointments focused on lifestyle; for example, smoking cessation, weight management and alcohol counselling.
- Meningitis vaccines for 18-year olds and students going to university were available at the practice

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people 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. Staff explained joint visits were carried out when required with other healthcare professionals.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice was proactive in understanding the needs of the patients, such as people who may be approaching the end of their life and people who may have complex needs, such as housebound patients. Staff had received training in Gold Standards Framework (GSF) (an evidence-based guideline to deliver high quality end of life care) and were using GSF to coordinate end of life care with other health care professionals.
- The practice actively engaged and signposted patients to local services who provided support such as the homeless Hub, support for asylum seekers, Lesbian, Gay, Bisexual and Trans (LGBT); we also saw a range of leaflets in patent waiting areas in a range of languages.
- Vulnerable patients were allocated an admin tracker who acted as a single point of contact. Staff explained this enabled admin staff to build a therapeutic relationship; gain a comprehensive understanding of patients' needs which they then discussed with GPs and the nursing team ahead of their appointments. This also enabled staff to carry out well-being calls as well as improve the coordination of patients care.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Clinicians carried out dementia screening including annual blood tests. There were referral processes in place where identified patients were referred to secondary care memory clinics. Dementia medicine prescribing were taken over from secondary care for patients who were assessed as stable.

- Staff explained there were designated appointment slots kept as well as VIP appointments to ensure were not missed on follow up.
- Improving Access to Psychological Therapies (IAPT services provides evidence-based psychological therapies to people with anxiety disorders and depression) as well as a counselling service was available at the practice. Staff explained the practice had referral processes for patients who required cognitive behavioural therapy (CBT).

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were Hub arrangements in place which enabled the practice to offer extended access appointments between 8am and 8pm Monday to Sunday at a neighbouring practice.</p>	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	59.0%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	63.5%	58.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	59.8%	60.6%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	71.6%	65.9%	73.6%	No statistical variation

Source	Feedback
NHS Choices	Comments showed patients were mainly satisfied with the appointment system.
CQC comment	Completed comment cards showed patients were satisfied with the appointments

cards	system and were able to get an appointment in a timely manner.
Patient interviews	Patients we spoke with felt they were able to get an appointment when they needed one, they had not requested a home visit or telephone consultation; however, they were aware this was an option if required.
Staff interviews	Non-clinical staff demonstrated clear understanding of the appointment system; as well as systems in place for triaging and prioritising home visits. Staff had completed care navigation training to support them in their role.

Listening and learning from concerns and complaints

The provider had a system in place to ensure complaints were listened and responded to and used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N/A
Explanation of any answers and additional evidence: Records we viewed showed the practice had not received any complaints in the last 12 months and staff we spoke with confirmed this. However, staff described actions they would take to ensure complaints were managed in a timely manner and learning shared with all staff. There was information in patient waiting areas to support people who wished to make a complaint and patients were encouraged to complete suggestion slips to enable the practice to identify any areas for potential improvement.	

Well-led

Rating: Requires improvement

The practice has been rated requires improvement because:

The system for managing test results did not provide assurance that patients were always protected, and the system did not demonstrate that clinicians routinely reviewed results to ensure results which prompted alteration of patient's management plans were acted upon. During our inspection, the provider acted to gain assurance that patents medicines were being managed safely. There was limited evidence to demonstrate a systematic programme to monitor quality or a holistic understanding of performance.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels. Leaders could demonstrate that they had the capacity and skills; however, unable to demonstrate that this routinely supported delivery of effective and high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Dr Shafiq Shafi and Partners operated an overarching leadership and governance framework for all contracts managed by the providers. The management team supported service delivery and provided leadership for all contracts held by the providers, and clinical as well as non-clinical staff worked across both all services when required. The provider and management team demonstrated awareness of the challenges within the local area such as impact of deprivation, culture and health inequalities. However, despite involvement in local initiatives to improve patient care the 2018/19 QOF year showed areas where the management of some clinical indicators had declined and there were areas of significant decline. For example, the management of patients diagnosed with COPD showed a 51% decline and the number of patients with a mental health related condition who had a care plan showed a 59% decline. The management team explained, for business continuity the provider had a silent partner who was not directly involved in the day to day running of the service. However, in the event the principle GP is unable to work then the silent partner would be appointed as clinical lead.	

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 which reflected compassion, dignity, respect and equality. Staff we spoke with demonstrated clear understanding of the practice vision and strategy; we saw that this translated into the actions of the practice.	

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
<p>Explanation of any answers and additional evidence:</p> <p>Staff demonstrated a variety of processes they had embedded to ensure that staff were involved and actively engaged in discussions regarding changes within the practice. For example, the practice held a range of meetings such as clinical and admin team huddles. There was opportunity for staff feedback through suggestion boxes and the practice operated an open-door policy. Staff we spoke with explained the management team communicated with them daily exploring ways to support their continued development as well as checking whether they were equipped with the necessary resources to carry out their duties effectively. The partner shared thoughts and views about the future of the practice including any identified risks. They also shared the business plan with staff.</p> <p>There was a lead person responsible for managing and monitoring complaints and significant events. Staff were able to demonstrate systems that were in place to enable the practice to respond to complaints in a timely manner. We saw that incidents were investigated, and learning shared throughout the practice. Patients who were affected by an incident or were unsatisfied with the service provided received an apology.</p>	

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

Source	Feedback
Staff	Individuals we spoke with explained staff at all levels within the team were very supportive, listened to staff ideas and were happy to try new ways of working as well as implement suggestions from the teams to help improve service delivery. Staff explained there was a strong learning culture and clear lines of communication. Staff were encouraged to share any ideas as well as discuss any

	areas of concern and they felt the management team responded to maintain staff well-being and a positive working environment.
Management team	Felt supported in their role; induction processes were comprehensive and there were opportunities to raise concerns without fear of retribution.
Policies	Practice policies were in place which supported leaders to act on behaviour and performance inconsistent with the vision and values of the practice.
Policies and management interviews	The practice had processes which enabled leaders to take action to promote equality and diversity. For example, flexible working options were available, leaders were aware of options available to ensure staff maintained a work life balance and staff received support if they needed time off to care for a child or family member.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>Dr Shafiq Shafi and Partners held a total of two separate GMC contracts against delivered across two locations. All contracts were operating as one service with an overarching leadership and governance framework for both contracts. The management team supported service delivery and provided leadership as well as oversight of the governance framework for both contracts. Clinical as well as non-clinical staff also worked across both services when required.</p> <p>The management team provided examples of structures, processes and systems in place to support the delivery of safe care. For example, systems for managing safeguarding concerns, clinical and environmental risks, recruitment and the effectiveness of care provided were monitored through regular audit cycles. The practice operated a process for ensuring policies and procedures were reviewed and updated in line with local and national guidance updates.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
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:	
<p>The practice operated a programme of clinical audits; however, unable to demonstrate that quality improvement activities systematically identified where actions should be taken to improve areas where performance was below local and national averages. For example; QOF data showed areas where performance had declined over time and there was limited evidence to demonstrate a clear structured process for escalating performance issues.</p> <p>Records we viewed showed clear arrangements for managing environmental and most clinical risks. For example, the practice carried out fire safety, health and safety, legionella and Control of Substances Hazardous to Health (COSHH) risk assessments. We also saw arrangements in place to enable staff to respond to most medical emergencies. During our inspection, the provider ordered equipment to enable staff to assess patients with possible sepsis as well as additional emergency medicines to enable staff to respond to a wider range of clinical emergencies. The practice had a recruitment policy which ensured all appropriate checks were carried out prior to commencing employment.</p> <p>The system for managing test results did not provide assurance that prescribing remained safe and effective. For example, blood monitoring results were not routinely documented in the clinical system, clinicians were unable to demonstrate that they routinely reviewed results to ensure those which prompted alteration of patient's management were acted on. During our inspection, the provider acted to gain assurance that patients' treatment and prescribing plans remained safe.</p> <p>The practice had a business continuity plan which would enable the practice to continue delivering services with minimum disruption.</p>	

Appropriate and accurate information

There was a demonstrated commitment in most areas to using data and information proactively to drive and support decision making. However, there was limited evidence to support how leaders used data to drive improvements in some clinical areas.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
The decline in QOF performance between the 2017/18 and 2018/19 QOF years did not provide assurance that the management team had a holistic understanding of performance or using data effectively to measure as well as drive improvement.	

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
The practice had a Patient Participation Group (PPG) which was combined with two neighbouring practices; three PPG members from Briton street attend the joint meetings. Members of the management team also attends PPG meetings and outcomes were shared within the practice. For example, patients felt the appearance of the building could do with decorating. The provider took action and identified work was carried out.	

Feedback from Patient Participation Group.

Feedback
Members of the PPG explained the practice was proactive in following up queries raised by the PPG and were always available when required. PPG members were aware of actions taken by the practice to improve access and have noticed improvements in getting through to the practice by phone as well as appointment availability. PPG explained they felt that this was partly due to the practice publicising the number of misused appointments and the impact this was having on appointment availability. Patients received appointment text reminders to reduce the risk of them missing their appointment.

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:	
Oversight of systems for managing significant events showed that these were investigated and responded to in a timely manner with clear evidence of shared learning. The practice had a system in place for managing complaints in a timely manner.	

Examples of continuous learning and improvement

The practice operated a system to enable the management team to disseminate learning as well as share updates regarding future plans and feedback from stakeholders.

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)	≤ -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.
- 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.

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>

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.