

Care Quality Commission

Inspection Evidence Table

Crook Log Surgery (1-560383996)

Inspection date: 26 November 2019

Date of data download: 18 November 2019

Overall rating: Requires improvement

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

Safe

Rating: Inadequate

We have rated the practice as Inadequate for providing safe services because:

- Medicines management arrangements did not ensure that patients prescribed high risk medicines were not at risk of unsafe care and treatment.
- The practice maintained records of staff training on topics that supported their provision of safety systems and processes. However, we found there were a few gaps in the records of safeguarding training for clinical staff.
- The practice had systems in place to check that clinical staff had the appropriate immunisations. However, we found that the records did not demonstrate that all relevant staff had appropriate immunisations. These gaps were not well highlighted at previous CQC inspections.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However these arrangements were not consistently effective.

| Safeguarding | Y/N/Partial |
|--|----------------------|
| There was a lead member of staff for safeguarding processes and procedures. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Partial ¹ |
| There was active and appropriate engagement in local safeguarding processes. | Yes |

| Safeguarding | Y/N/Partial |
|--|--------------------|
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>1. We found to gaps in the training of clinical staff. One GP and two nurses without recent level three safeguarding training. The practice manager showed us evidence that training was available for the clinical staff to be booked onto in January 2020.</p> | |

| Recruitment systems | Y/N/Partial |
|--|----------------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Partial ² |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>2. Staff immunisations were still not in line with The 'Green Book' Immunisation Against Infectious Diseases. This gives information on immunisation for employees in general practice. Tetanus, polio and diphtheria were not in the list of staff vaccinations checked for, and staff vaccination checks were not completed for reception staff. These gaps were not well highlighted at previous CQC inspections.</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: 25/06/2019 | Yes |
| There was a record of equipment calibration. Date of last calibration: 14/06/2019 | Yes |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks. Date of last check: 19/11/2019 | Yes |
| There was a log of fire drills. Date of last drill: 30/06/2019 | Yes |
| There was a record of fire alarm checks. Date of last check: 19/11/2019 | Yes |
| There was a record of fire training for staff. Date of last training: various dates for individual staff members, all within last 12 months. | Yes |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed. Date of completion: 30/06/2019 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: | |

| Health and safety | Y/N/Partial |
|---|--------------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 30/09/2019 | Yes |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30/09/2019 | Yes |
| 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. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 20/06/2019 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| There was a system to notify Public Health England of suspected notifiable diseases. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: | |

Risks to patients

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

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

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|---|------------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes ³ |
| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | Yes |
| Explanation of any answers and additional evidence: | |
| 3.However, two week wait referral arrangements do not include the practice checking receipt of appointment and attendance. | |

Appropriate and safe use of medicines

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

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA) | 0.96 | 0.83 | 0.87 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA) | 11.2% | 9.9% | 8.6% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA) | 6.69 | 6.30 | 5.63 | Tending towards variation (negative) |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA) | 1.50 | 1.69 | 2.08 | No statistical variation |

| Medicines management | Y/N/Partial |
|--|----------------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | N/A |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Partial ³ |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |

| Medicines management | Y/N/Partial |
|--|-------------------|
| 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. | No ^{4,5} |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | Yes |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 3. We saw evidence that patients prescribed high risk medicines issued prescriptions of these medicines on a repeat basis without appropriate structured medicines reviews being provided to them at recommended intervals. 4. The provider did not have appropriate arrangements for the monitoring and review of patients prescribed high risk medicines (medicines that require additional patient monitoring and review). We reviewed the records for twelve patients receiving high risk medicines. For one of these medicines the practice did not have a process for recall to ensure blood monitoring was completed, for another the surgery system did not adequately record when monitoring was due. For one medicine, where specific information is required to interpret the results of monitoring tests, we found this was not always available. 5. Two days after our inspection, the provider sent us an update of actions they had taken in relation to high risk medicines management. They had reviewed the records of their patients prescribed eight common high risk medicines and identified all those that were due reviews and / or had not had appropriate monitoring at the recommended intervals. All these patients had been contacted and sent blood test forms and requested to get the recommended blood tests done as soon as possible, or they had appointments arranged for them with a doctor for a medication review. | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|--------------------|-------------|
|--------------------|-------------|

| | |
|--|----------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 5 ⁶ |
| Number of events that required action: | 5 |
| Explanation of any answers and additional evidence: 6. This is the total number of events recorded since our last comprehensive inspection, so covers the period from 01 April 2019 to this current inspection being reported on. | |

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|--|---|
| Patient who attended the practice became verbally aggressive towards the GP during their appointment and was also verbally and racially abusive towards the practice manager who tried to intervene. | <ul style="list-style-type: none"> The incident was reported to the Police The practice initiated immediate removal of the patient from their patient list. The patient further complained to NHS England and the practice has investigated and provided a response on the 11.11.2019 |
| Error made which delayed a two week wait referral being sent. | <ul style="list-style-type: none"> The referring GP had not followed the appropriate administrative procedures and had not used the correct referral form. This error was picked up by the referrals team and they raised the matter with the GP. Following a review, new processes have been put in place to avoid error and referral resent. All referrals are now being sent directly to the referrals team. This provides an audit mechanism for any tasks raised. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Yes |
| Staff understood how to deal with alerts. | Yes |
| Explanation of any answers and additional evidence: | |

Effective

Rating: Requires improvement

The practice is rated as requires improvement for providing effective services because:

- Care and treatment was not consistently delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Whilst child immunisation uptake rates had improved slightly since our last comprehensive inspection, they remained below the national target to achieve herd immunity.
- We found there was a lack of recent completed quality improvement activities on clinical activity.
- We found concerns with the management of high risk medicines that affected patients in some population groups.

Effective needs assessment, care and treatment

Patients' needs were assessed. However, care and treatment was not consistently 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. | Partial ¹ |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Partial ² |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>1. The practice did not undertake ongoing discussions about up to date published clinical guidance and best practice. We found that one clinician was not consistently providing care and treatment in accordance with published guidelines and best practice.</p> <p>2. Patients prescribed high risk medicines did not consistently have appropriate review, monitoring and update of their care and treatment.</p> | |

| Prescribing | Practice performance | CCG average | England average | England comparison |
|--|----------------------|-------------|-----------------|--------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA) | 0.64 | 0.57 | 0.75 | No statistical variation |

Older people

Population group rating: Requires improvement

| Findings |
|--|
| <ul style="list-style-type: none"> • Patients aged over 75 are allocated a named GP. • The practice provided care and treatment to residents in one care home with 76 patients. As part of the service to that home, they carried out planned weekly visits and were involved in a local incentive scheme where they reviewed patients with frailty. • Appropriate patients were added to CMC (Co-ordinate My Care). All these patients had six monthly Care Plan Reviews and Medication Reviews. • The practice were involved in Mental Capacity Assessments and End Of Life (EOL) discussions. They worked with other professionals as part of these discussions, such as the Community Geriatrician, Social Services, Carers and Community District nursing teams. Blood tests or any treatment like dressings and drug administration was arranged with the help of the District Nursing Team. • The practice was actively involved in the monthly virtual Integrated Care Meetings run by their federation. • However, we have rated the practice as requires improvement for the care of older people because the practice did not have safe systems for the management of patients prescribed high risk medicines, which some older people may be prescribed. |

People with long-term conditions

Population group rating: Requires improvement

Findings

- The practice maintained clinical registers of their patients with long term conditions. These include Diabetes, COPD, Asthma, Heart problems, Thyroid disorders, Hypertension, Cancer, Arthritis and Stroke. All patients within these groups were routinely invited to the practice for annual reviews including treatment by intervention or education.
- The practice have assigned lead roles for different aspects of long term conditions. For example, one of the GP partners is the lead clinician in Diabetes.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. The nurses were trained in diabetes, spirometry, asthma and COPD reviews.
- 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 atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.
- However we have rated the practice as requires improvement for the care of people with long term conditions, as the practice did not have safe systems for the management of patients prescribed high risk medicines, who are predominantly people with long term conditions.

| 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> | 79.1% | 81.7% | 79.3% | No statistical variation |
| Exception rate (number of exceptions). | 8.2% (37) | 16.3% | 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> | 72.0% | 80.5% | 78.1% | No statistical variation |
| Exception rate (number of exceptions). | 11.0% (50) | 12.1% | 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> | 78.1% | 82.7% | 81.3% | No statistical variation |
| Exception rate (number of exceptions). | 8.4% (38) | 14.5% | 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> | 71.3% | 74.5% | 75.9% | No statistical variation |
| Exception rate (number of exceptions). | 4.5% (18) | 8.9% | 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> | 90.7% | 90.3% | 89.6% | No statistical variation |
| Exception rate (number of exceptions). | 23.2% (26) | 11.8% | 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) <small>(QOF)</small> | 81.3% | 83.2% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 8.0% (96) | 5.9% | 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) <small>(QOF)</small> | 84.8% | 89.4% | 91.1% | No statistical variation |
| Exception rate (number of exceptions). | 4.5% (5) | 6.5% | 5.9% | N/A |

Population group rating: Requires improvement

Families, children and young people

| Findings |
|--|
| <ul style="list-style-type: none"> The practice has met the minimum 90% threshold for one of four childhood immunisation uptake indicators. The practice has not met the minimum 90% target for three of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. Whilst we noted that the practice performance in child immunisation uptake had improved since our last comprehensive inspection, we have rated them as requires improvement for this population group due to their childhood immunisation uptake performance. 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. |

| 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) | 92 | 99 | 92.9% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England) | 65 | 74 | 87.8% | 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) | 64 | 74 | 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) | 66 | 74 | 89.2% | 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

In response to the areas of lower than the target childhood immunisations, the practice responded as follows:

- The practice has a call-recall system for children who are due their vaccinations.
- The practice informed us that they plan to review their system to make it robust and ensure that children are invited 3 times for their vaccinations, including phone calls to parents/guardians

Working age people (including those recently retired and students)

Population group rating: Requires improvement

- 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.

- However, the practice's cervical cancer screening performance was below the 80% target for the year ending 31 March 2018. The latest available cervical cancer screening figure, for the snapshot period covering 31/03/2019 to 30/06/2019 also indicated that the practice performance remained below the national target. We have therefore rated the practice as requires improvement for this population group due to their cervical cancer screening performance.

| 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). (31/03/2019 to 30/06/2019) (Public Health England) | 73.9% | N/A | 80% Target | Below 80% target |

| 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) | 75.6% | 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) | 75.5% | 76.9% | 72.1% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE) | 56.5% | 54.5% | 57.3% | N/A |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE) | 75.0% | 70.2% | 69.3% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE) | 57.4% | 54.1% | 51.9% | No statistical variation |

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

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 training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- We found that patients prescribed Lithium, a medicine used for treating certain mental illnesses, were not all having their treatment appropriately monitored.

| 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) | 91.4% | 85.4% | 89.4% | No statistical variation |
| Exception rate (number of exceptions). | 17.6% (15) | 14.0% | 12.3% | N/A |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) ^(QOF) | 96.1% | 90.1% | 90.2% | No statistical variation |
| Exception rate (number of exceptions). | 10.6% (9) | 12.0% | 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) | 75.2% | 77.6% | 83.6% | No statistical variation |
| Exception rate (number of exceptions). | 4.5% (5) | 8.0% | 6.7% | N/A |

Any additional evidence or comments

For high exception reporting indicators, the provider informed us that for exception reporting in all QOF areas they strictly follow guidelines for exception reporting and it is done for patients who have not responded to three invites/those who have declined intervention or review, or those unsuitable for the intervention on clinical grounds.

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) | 553.8 | No Data | 539.2 |
| Overall QOF score (as a percentage of maximum) | 99.1% | No Data | 96.4% |
| Overall QOF exception reporting (all domains) | 7.3% | No Data | No Data |

| | Y/N/Partial |
|---|----------------------|
| Clinicians took part in national and local quality improvement initiatives. | Yes |
| The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. | Partial ³ |
| Quality improvement activity was targeted at the areas where there were concerns. | Yes |

| | |
|--|-----|
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |
|--|-----|

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

| |
|---|
| The practice had recently started carrying out an HBA1C / type 2 diabetes audit, which they intend to continue carrying out quarterly to ensure newly coded patients continue to be identified for review. |
| The practice had completed an audit of their use of online consultations. The audit was an analysis of the total number of online consultations and the conversion rate to face to face consultations over a four week period, in May 2019. The audit was repeated three months later, in September 2019. The audit found that changes made between the audit's analysis periods led to a 20% increase in use of online consultations and a 7% decrease in face to face appointments. |

Any additional evidence or comments

3. We found there was a lack of recent completed quality improvement activities on clinical activity.

Effective staffing

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

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

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|--|------------------|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF) | Yes ⁴ |
| We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Yes |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>4. We found that it was unclear if there is enough clinical input / attendance from members of the practice team at multidisciplinary team meetings. The provider informed us that a GP from the practice usually dialled in to these meetings, but on some occasions when they were not available the practice manager was informed of the outcomes of the discussions.</p> | |

Helping patients to live healthier lives

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

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

| 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> | 98.2% | 94.4% | 95.0% | Variation (positive) |
| Exception rate (number of exceptions). | 0.8% (15) | 0.9% | 0.8% | N/A |

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance. However, there was a lack of monitoring of the process for seeking consent.

| | Y/N/Partial |
|--|-----------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| The practice monitored the process for seeking consent appropriately. | No ⁵ |
| Policies for any online services offered were in line with national guidance. | Yes |
| Explanation of any answers and additional evidence: | |
| 5. The provider was not able to demonstrate that they monitored the process for seeking consent. | |

Caring

Rating: Good

Kindness, respect and compassion

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

| CQC comments cards | |
|--|---|
| Total comments cards received. | 2 |
| Number of CQC comments received which were positive about the service. | 1 |
| Number of comments cards received which were mixed about the service. | 1 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|--|---|
| CQC comments cards | Two patient comments cards received and were positive about staff but mixed about the service provision. |
| NHS choices | <p>There have been 12 reviews of the practice in the last six months; four were positive and the remaining eight were negative. Themes reported in the positive comments included good care and treatment experiences, and helpful staff and doctors. Themes reported in the negative comments included difficulties getting appointments, inefficiencies getting answers to non-clinical queries, and rude and unhelpful reception staff.</p> <p>The practice had responded to all the comments received, with people posting negative reviews being invited to book an appointment to speak with the practice manager to discuss their concerns.</p> <p>We saw evidence that the practice team discussed and took action in response to patient feedback.</p> |
| Observations of staff / patient interactions | We observed that staff treated patients with kindness and respect in their interactions with them. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 7845.0 | 304.0 | 110.0 | 36.2% | 1.40% |

| 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) | 84.3% | 88.0% | 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) | 81.2% | 85.6% | 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) | 94.9% | 95.8% | 95.5% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019) | 69.2% | 80.6% | 82.9% | Tending towards variation (negative) |

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

| Any additional evidence |
|---|
| <ul style="list-style-type: none"> The practice had carried out its own in-patient survey since our last comprehensive inspection. They received comments from 87 patients. Some of the actions taken in response to the survey results included: <ul style="list-style-type: none"> -better communication with patients wanting to see a regular GP that the wait time may be longer -informing patients of service change that the practice does not offer walk-in surgery anymore. -A new telephone system has been introduced to help manage calls that come through reception. -There is also new management in place from the 1st May 2019 that were looking into all the policies, processes and procedures. |

Involvement in decisions about care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |
| Explanation of any answers and additional evidence: | |

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) | 87.5% | 92.0% | 93.4% | No statistical variation |

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

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 1.7% of the patients have been identified as having caring responsibilities. |
| How the practice supported carers (including young carers). | People with caring responsibilities were referred to external organisations for additional support. |
| How the practice supported recently bereaved patients. | The practice had updated their arrangements in responding to deaths, and issuing death certificates in response to a recent patient complaint. They had now set out clear responsibilities with full administrative support in the preparation of death certificates rather than it being a GP led process alone. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|--|-------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Yes |
| Consultation and treatment room doors were closed during consultations. | Yes |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |
| Explanation of any answers and additional evidence: | |

If the practice offered online services:

| | Y/N/Partial |
|--|-------------|
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice was actively using eConsult, an online advice and consultation service, to improve access to the service. Patients registered to use the service would get access to advice and administrative help within one working day.</p> | |

Responsive

Rating: Requires improvement

We rated the practice as requires improvement for providing a responsive service because:

- Data from the national GP patient survey showed patients rated the practice lower than others for responses relating to timely access to the service. We saw evidence that the practice had taken action in response to these results, but there was a lack of evidence of impact of their actions.
- Extended hours appointments were available on Monday evenings.
- Complaints were managed in line with the practice's complaints policy and were used to improve the quality of care.

Responding to and meeting people's needs

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

| | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |
| Explanation of any answers and additional evidence: | |

Practice Opening Times

| Day | Time |
|-------------------------|---------------|
| Opening times: | |
| Monday | 08:00 - 20:00 |
| Tuesday | 08:00 - 18:30 |
| Wednesday | 08:00 - 18:30 |
| Thursday | 08:00 - 18:30 |
| Friday | 08:00 - 18:30 |
| | |
| Appointments available: | |
| Monday | 08:00 - 20:00 |
| Tuesday | 08:00 - 18:30 |
| Wednesday | 08:00 - 18:30 |
| Thursday | 08:00 - 18:30 |
| Friday | 08:00 - 18:30 |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 7845.0 | 304.0 | 110.0 | 36.2% | 1.40% |

| 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) | 92.1% | 94.2% | 94.5% | No statistical variation |

Any additional evidence or comments

Older people

Population group rating: Requires improvement

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.
- Residents of one local care home were registered with the GP practice and the GPs conducted weekly visits to the care home.
- However, we have rated this population group as requires improvement, as patient survey responses indicated patients rated the practice lower than others for responses relating to timely access to the service.

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 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.
- However, we have rated this population group as requires improvement, as patient survey responses indicated patients rated the practice lower than others for responses relating to timely access to the service.

Families, children and young people

Population group rating: Requires improvement

Findings

- 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 prioritised appointments when necessary.
- However, we have rated this population group as requires improvement, as patient survey responses indicated patients rated the practice lower than others for responses relating to timely access to the service.

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.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.
- However, we have rated this population group as requires improvement, as patient survey responses indicated patients rated the practice lower than others for responses relating to timely access to the service.

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, 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.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- However, we have rated this population group as requires improvement, as patient survey responses indicated patients rated the practice lower than others for responses relating to timely access to the service.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

| Findings |
|---|
| <ul style="list-style-type: none"> • 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. • However, we have rated this population group as requires improvement, as patient survey responses indicated patients rated the practice lower than others for responses relating to timely access to the service. |

Timely access to the service

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

National GP Survey results

| | Y/N/Partial |
|--|-------------|
| Patients with urgent needs had their care prioritised. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| Appointments, care and treatment were only cancelled or delayed when absolutely necessary. | Yes |
| Explanation of any answers and additional evidence: | |

Yes

| 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) | 55.4% | 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) | 45.8% | 61.4% | 67.4% | Tending towards 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 | 45.4% | 60.6% | 64.7% | Tending towards variation (negative) |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|----------------------|
| 31/03/2019) | | | | |
| 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) | 50.6% | 68.2% | 73.6% | Variation (negative) |

Any additional evidence or comments

The provider has taken the following actions in response to their patient survey results.:

- In response to the low levels of satisfaction with the types of appointments offered, the practice have increased the number of book in advance and on the day appointments.
- They have promoted online consultations and telephone consultations to improve access.

| Source | Feedback |
|-------------|---|
| NHS Choices | There have been 12 reviews of the practice in the last six months; four were positive and the remaining eight were negative. Themes reported in the positive comments included good care and treatment experiences, and helpful staff and doctors. Themes reported in the negative comments included difficulties getting appointments, inefficiencies getting answers to non-clinical queries, and rude and unhelpful reception staff. |

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. | 24 |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • We reviewed staff meeting minutes, and the review of recent complaints was a standing item on the staff meeting agenda. • We saw examples of changes in the practice that had been made as a result of complaints. | |

Examples of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Complaint regarding a delay in the issuing of a death certificate. | <ul style="list-style-type: none"> • Practice manager spoke with the complainant on the telephone, apologised and the matter was resolved. • Duty doctor was advised of the complaint • A new process was put in place to ensure future delays were avoided and death certificates would be issued in time. |
| Patient made a verbal complaint about their appointment being cancelled due to the GP being off sick. | <ul style="list-style-type: none"> • Practice Manager called and spoke with the patient and apologized as the GP's sickness was unexpected and the practice could not rearrange appointment on time. • The complainant was offered other options to get access, including having a telephone consultation and using eConsult. • The practice was able to agree a suitable appointment and the patient was satisfied with it. |

Well-led

Rating: Requires improvement

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

- There have been recent changes in the leadership and management of the practice. The new team have implemented systemic changes and improvements in the governance of the service.
- There were clear roles and responsibilities to achieve effective management arrangements. However, some systems to support good governance were ineffective.
- There were clear and effective processes for managing risks, issues and performance. However, the practice did not have a systematic programme of clinical audit.
- The practice did not always act on appropriate and accurate information.

Leadership capacity and capability

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

| | Y/N/Partial |
|--|------------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes ¹ |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| Explanation of any answers and additional evidence: | |
| 1. This practice has a history of fluctuating performance. The patient list has been in decline in recent years. The practice is under ongoing performance review and support from the local clinical commissioning group (CCG). As part of the arrangements to improve the practice performance, there have been changes in the leadership and management of the practice. The new team have implemented systemic changes and improvements in the governance of the service. From 1 May 2019, there has been a new lead GP (who is also now the registered manager), changes in the practice partnership membership, and a new practice manager. The new management team had made good progress in addressing the most recent regulatory breaches at the practice, which were found at our last comprehensive inspection in March 2019. | |
| | |
| | |

Vision and strategy

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

| | Y/N/Partial |
|---|-------------|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Yes |
| There was a realistic strategy to achieve their priorities. | Yes |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |

| | |
|---|------------------|
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes ² |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: 2. The new practice management team have recently completed a mission statement and values development exercise. The whole staff team were engaged and involved in the exercise and the practice team agreed their mission statement as: 'To provide our patient population with high quality, accessible care in a responsive & courteous manner in a way we wish our family & friends to be treated'. The practice values are quality, respect, support, promote best practice and respond to change. | |

Culture

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

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

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

| Source | Feedback |
|------------------------------------|---|
| Staff records and staff interviews | We spoke with four members of non-clinical staff during our inspection. They told us they felt supported by the new practice management team. Staff records indicated that staff were supported with supervision and appraisal meetings and discussions. They received training and development opportunities for their roles. These support arrangements had been put in place since the new management team joined the practice. |

Governance arrangements

There were clear roles and responsibilities to achieve effective management arrangements. However some systems to support good governance were ineffective.

| | Y/N/Partial |
|--|----------------------|
| There were governance structures and systems which were regularly reviewed. | Partial ³ |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| Explanation of any answers and additional evidence: 3. The practice had a range of policies and procedures in place to govern activity, and these were subject to regular review. However, we found that the practice's governance around high risk medicines management was ineffective. The provider sent us an updated high risk medicines management policy on 11 December 2019, which included a comprehensive range of medicines the practice clinical team had identified as high risk. However we do not have evidence of the demonstrated impact of the updated policy we were provided. | |

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. However, the practice did not have a systematic programme of clinical audit.

| | Y/N/Partial |
|---|----------------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Yes |
| There was a systematic programme of clinical and internal audit. | Partial ⁴ |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: 4. The practice had one recent example of clinical audit activity, which was on identification of adults with type 2 diabetes. | |

Appropriate and accurate information

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

| | Y/N/Partial |
|---|-----------------|
| Staff used data to adjust and improve performance. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Our inspection indicated that information was accurate, valid, reliable and timely. | No ⁵ |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>5. We found that the practice was not ensuring patients prescribed high risk medicines were having suitable information (test results and records of reviews) confirmed for them, to allow the practice to provide them with appropriate care and treatment.</p> <p>The practice has moved to a new patient records system as of 4 October 2019. We found that they were still experiencing teething problems with the system. For example, searches to identify specific groups of patients did not always provide accurate results, so the practice was at risk taking inappropriate action or not undertaking necessary actions.</p> | |

If the practice offered online services:

| | Y/N/Partial |
|---|------------------|
| The provider was registered as a data controller with the Information Commissioner's Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes ⁶ |
| Any unusual access was identified and followed up. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>6. The practice offered eConsult, to patients who registered to use the service, which allowed patients online access to advice and consultations from the practice, and to make administrative requests.</p> | |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|---|------------------|
| Patient views were acted on to improve services and culture. | Yes |
| The practice had an active Patient Participation Group. | Yes ⁷ |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| Explanation of any answers and additional evidence: 7. The new practice leadership team that had been in post since 1 May 2019 had taken active steps to re-establish the patient participation group (PPG). We saw the new practice management team had hosted a PPG meeting since being in post, and they have introduced virtual participation to offer flexibility and increase attendance and engagement. | |

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. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: | |

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.