Care Quality Commission

Inspection Evidence Table

Ferryview Health Centre GP Surgery (1-544557602)

Inspection date: 4 December 2019

Date of data download: 04 December 2019

Overall rating: Good

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

Effective Rating: Requires improvement

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

- Two patients prescribed a medicine that required monitoring had not been appropriately managed.
- The practice was below target and the CCG and national average in a number of the performance indicators.

Additional findings:

- Staff were appropriately trained to carry out their duties effectively.
- Quality improvement activity demonstrated improved for patients

Effective needs assessment, care and treatment

In the main, patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. However, this required refinement.

	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.	Partial[1]

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:

1. We reviewed the records of 15 patients prescribed high-risk medicines that required monitoring and found that two patients were prescribed medication without having had the appropriate checks beforehand. In response to this finding, the practice immediately contacted the patients to arrange the tests.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	1.17	0.87	0.74	No statistical variation

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

Findings

- The practice was below the CCG and national average in two of the long-term condition's indicators below. The provider explained that patients with atrial fibrillation (AF) are assessed by the practice pharmacist to check if they are suitable for direct oral anticoagulants. They will then be referred to one of two GPs to initiate and monitor their treatment. They have improved their record of sending patients to be the pharmacist since December 2019. In addition, the practice recognised that expiring AF read codes needed to be updated.

  Following the inspection, the provider informed us the practice had signed up to a local enhanced service to initiate direct oral anticoagulant (DOAC) in primary care since last year. This CCG initiative was in response to patients having to wait more than four months for initiation of DOAC in the hospital anticoagulation clinic. The Practice will also be meeting with a CCG prescribing advisor in January 2020 regarding the NHS England's atrial fibrillation (AF) patient optimisation programme. This programme involves going to all Greenwich practices with the aim of improving the management of people who have been diagnosed with AF.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.
- Induction for all new clinicians included the LTC process and templates, and coding requirements.

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	68.9%	73.0%	79.3%	Tending towards variation (negative)

64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	5.5% (68)	9.1%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	65.6%	73.8%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.3% (41)	6.2%	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) (QOF)	71.6%	77.1%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	6.2% (77)	8.3%	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) (QOF)	72.0%	76.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.5% (19)	2.7%	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) (QOF)	82.5%	89.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	8.3% (28)	7.2%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	75.2%	78.8%	83.0%	Variation (negative)
Exception rate (number of exceptions).	3.3% (92)	3.0%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	79.6%	85.9%	91.1%	Variation (negative)
Exception rate (number of exceptions).	5.6% (9)	7.4%	5.9%	N/A

Any additional evidence or comments

We reviewed the practice's unverified diabetes figures which demonstrated that there was a slight improvement in their 2019/20 outcomes.

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol. Practice: 66%
- 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. Practice: 74%

Following the inspection, the provider told us they are currently ranked 25th out of 33 practices for this indictor in the CCG area.

Families, children and young people Population group rating: Good

Findings

Add findings here, as relevant (the below are examples):

- The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of four childhood immunisation uptake indicators. The practice had not met the minimum 90% target for one (MMR indicator) of four childhood immunisation uptake indicators. Following the inspection, the provider supplied evidence that they had achieved the 90% minimum target for the percentage of children aged 2 who have received an MMR.
- 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)	353	387	91.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	381	417	91.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	378	417	90.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	372	417	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

The practice had three weekly immunisation clinics: Monday 2pm-4pm; Fridays 12pm-4pm and Saturdays 8am -3pm.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

Add findings here (for example):

- 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)	69.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	57.0%	66.1%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	43.4%	47.0%	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)	69.5%	77.2%	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)	50.7%	53.1%	51.9%	No statistical variation

Any additional evidence or comments
Although the practice's cervical cancer coverage level was below the national target their performance was above the CCG and national average. The practice attributed this to their prevention clinic (for adults and children) which runs on Saturdays.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
Add findings here (for example): • 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.

- The practice reviewed all uncollected prescriptions every two months and reviewed the notes of all 'DNA' patients that were booked into a clinic.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The practice was significantly below the CCG and national average for two of the three mental health related indicators and had a negative variation for the remaining. They were aware of this and had introduced a new process to address this. The practice was not yet able to demonstrate a positive impact of this process. However, we did note their improvement in BMI (Body Mass Index) recording and blood pressure monitoring.
- 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.

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	59.6%	85.3%	89.4%	Significant Variation (negative)

31/03/2019) (QOF)				
Exception rate (number of exceptions).	2.4% (10)	5.6%	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)	60.0%	84.9%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	2.4% (10)	4.0%	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)	61.9%	86.2%	83.6%	Variation (negative)
Exception rate (number of exceptions).	13.7% (10)	7.9%	6.7%	N/A

Any additional evidence or comments
Out of an eligible 117 patients on the practice's learning disability register 64% (75) had received and annual health check 4 people (3%) had declined.

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)	473.1	No Data	539.2
Overall QOF score (as a percentage of maximum)	84.6%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.3%	No Data	No Data

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

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

Sodium Valproate (SV) (July 2018) Audit to discover the number of women of reproductive age on the medication within the practice and whether they have been made aware of the associated risks.

A search was done of all female patients under 50 years of age on SV. They were checked to ensure they had: (I) Been reviewed by a specialist within the last year; (II) Given contraception advice within the last year; (III) A documented discussion about the risks of SV, (IV) Been on long acting contraception.

Results:

- Twenty-three patients under 50 were identified as being on SV
- Five were not of reproductive potential and two were excluded as they were inactive
- Nine (56%) of the remaining 16 patients had a documented discussion regarding contraception, though only 2 (12%) were within the last year and had been done by their specialist team.
- Eleven (69%) of the patients had specialist review within the last year
- Three of the 11 were on contraception, only one (6%)

A letter was sent to all patients inviting them to attend the practice for a medication review, when the effects of SV would be explained. The practice re-audited after 6-8 weeks of patients attending.

Re-auditing results:

- Four (25%) attended for a medication review and a further one was discussed in psychiatry clinic
- Two (40% had the risks of SV discussed (though MHRA leaflet not given, nor risk form filled out)
- One person had changed to an alternative medication
- No change to contraception
- Twelve (75%) remain under or had been re-referred to secondary care

The practice recognised that they needed to improve in this area and took a number of steps to raise GP awareness and compliance with guidance.

Audit of Urinary Albumin: Creatinine Ratio requests amongst diabetic patients on diabetes register.
The purpose of this audit was to determine if NICE guidance was being followed.

The first cycle of the audit showed the:

- No. of Diabetic Patients -1225
- No. of patients with Urine Albumin: creatinine ratio – 949 (77%)
- No. of patients without Urine Albumin: creatinine ratio – 275 (23%)

The second cycle of audit s (following advice given to clinicians)

- No. of Diabetic Patients -1241
- No. of patients with Urine Albumin: creatinine ratio – 1009 (81%)
- No. of patients without Urine Albumin: creatinine ratio – 232 (19%)

Overall a 4 % increase in screening levels was noted with a brief intervention.

Any additional evidence or comments

The practice also carried out quality improvement activity such as:

- Audit of B12 deficiency
- Mortality Audit - May 2019 (1st Cycle)
- Inadequate smear audit – July 2019 (1st Cycle)

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
• The lead nurse had weekly supervision with the other nurses • The practice had a comprehensive induction programme in place for new staff. This included, staff training, confidentiality agreement and building requirements. • All staff had undergone an appraisal within the last 12 months.	

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)	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	Y

processes to make referrals to other services.	

Helping patients to live healthier lives

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

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

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) (QOF)	92.2%	93.0%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (22)	0.6%	0.8%	N/A

Any additional evidence or comments
The practice implemented NICE guidance on hypertension diagnosis encouraging patients to engage in 24-hour blood pressure monitoring.

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

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:

- To ensure continuity of care for patients, clinical staff are grouped into clinical micro teams which are smaller sub-groups of GPs, nurses and clinical assistants who work closely together on dedicated patient lists and provide cover in the event of staff absences.
- The practice had a plan in place to introduce phone & video appointments.

Practice Opening Times	
Day	**Time**
Opening times: Ferryview Health Centre	
Monday	8.00am – 8.00pm
Tuesday	8.00am – 8.00pm
Wednesday	8.00am – 8.00pm
Thursday	8.00am – 8.00pm
Friday	8.00am – 6.30pm
Saturday	9.00am – 3.00pm
Opening times: Holburne Road Surgery (branch site)	
Monday	8.00am – 6.30pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 8.00pm
Thursday	8.00am – 6.30pm

Friday	8.00am – 6.30pm
2nd Saturday of the month (only)	9:00am – 1:00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
26025	444	109	24.5%	0.42%

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)	88.8%	91.1%	94.5%	Tending towards variation (negative)

Any additional evidence or comments

The practice had developed a walk-in clinic which ran daily between 8am and 11am daily.

The practice carried out a patient survey in 2019 which showed the overall percentage of patient satisfaction with services provided:

- 35% of respondents were very satisfied
- 58% of respondents were quite satisfied
- 5% of respondents were quite dissatisfied
- 2% of respondents were very dissatisfied

The results also showed that the highest percentage of dissatisfaction related to information provided about delays (11% of respondents considered this 'poor').

As a result of the survey the practice created and displayed a "You said, we did" poster to demonstrate that they take feedback seriously and had taken action. In response to patient feedback the practice created a children's waiting area in a separate room, established clearer communication around the availability of the walk-in clinics and which clinicians will be holding them, and increased the seating capacity with the waiting area.

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, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

- There was a medicines delivery service for housebound patients.

People with long-term conditions (LTC) 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.

Families, children and young people Population group rating: Good

Findings

- Additional nurse appointments were available until 8pm between Monday and Thursday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- 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.
- The practice was open until 8pm between Monday and Thursday and until 6:30pm on Fridays and from 9am to 3pm on Saturdays. 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. Appointments were available Saturday and Sunday 10am until 1pm.
- The practice hosts services such as a sexual health clinic, social prescriber which their patients can attend.

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, Travellers and those with a learning disability. People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. However, we noted that these patients were not offered a hepatitis b vaccination.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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.

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

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)	76.0%	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)	76.0%	65.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	72.1%	62.6%	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)	69.2%	66.4%	73.6%	No statistical variation

Source	Feedback
For example, NHS Choices	*26 comments (April 2018 – December 2019)* Eight positives – themes included: ○ Pleased with GPs and reception staff ○ Welcoming staff ○ Thorough diabetic review Eighteen negatives – themes included: ○ Difficulty getting a routine appointment ○ Poor consultation with GP

	○ Appointments running late The practice had responded to all negative comments.
Patient interviews	During the inspection we spoke to four patients. Comments included: • Two patients said they have difficulty getting a routine appointment and experience long waiting times (up to an hour) for the walk-in clinic (WIC). • One patient was not aware of the out-of-hours service. • One patient said that they found the manner of receptionists impolite. • One patient said they found staff very helpful and polite.

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 since April 2018.	94
Number of complaints we examined.	8
Number of complaints we examined that were satisfactorily handled in a timely way.	8
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: 1. In response to complaints relating to staff attitudes the practice organised customer service training for the reception team and complaints training for all staff groups. The former has been added to the yearly training schedule for all the reception team for refresher. Practice manager performs weekly audits on customer service by listening to telephone calls and discussing their findings during 1:1 meetings. Complaints are also discussed during team meetings and 1:1s.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Refusal to prescribe	Letter of explanation forwarded to patient explaining that the practice had followed prescribing best practice.
High risk patient not offered medication	• Letter forward to patient from GP involved. • Clinicians to be aware of clinical complexities and the need to seek guidance on management of patients from published guidelines like NICE and also colleagues within and external to the practice (be able to recognise

	when need to seek advice).
Patient interview (not included in written complaint figure): Patient not given option to speak with a duty doctor and given personal advice.	• Receptionist re-trained on the correct procedures

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- A clear leadership structure was in place. The partners at the practice demonstrated a commitment to driving improvement in the quality of care and patient experience. We were told there was an open and transparent culture at the practice and all staff were engaged in the direction of the practice.
- Staff were encouraged to participate and feedback through practice meetings or direct to the managers or one of the GPs.
- Partners were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. There was evidence that future changes and requirements were acted on immediately or a plan put in place in readiness for changes. For example, the change of coding on the electronic patient record system.
- The practice held clinical meetings, palliative care meetings all staff meetings, reception meetings, complaints meetings and PPG meetings.
- We saw that all meetings were appropriately minuted and actions were logged.

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 strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. They demonstrated a determined attitude to overcome the barriers the practice and the population faced.

Culture

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

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

Explanation of any answers and additional evidence:

- Staff said leaders were approachable and listened if they raised concerns. They felt respected, supported and valued.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff reported there was an open-door policy, and they could contact managers and GPs whenever they had a concern.
- The practice had introduced well-being incentives for staff, such as:
    - Monthly photography competition
    - Salaried GP support programme
    - Desk yoga

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

Source	Feedback
Staff interviews	• Staff told us that they were well supported by management at the practice

	and they felt able to approach managers for support. • Staff we spoke with told us that the whole practice worked as a team and that all the GPs and management were very approachable. Staff told us they found there was a supportive environment both clinically and non-clinically.

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:
• Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. Staff were clear on their roles and accountabilities.
• There were named clinical and non-clinical leads. Namely:
  ○ Safeguarding adults and children
  ○ Complaints lead
  ○ Infection control	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	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: • The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.	

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- Practice partners reviewed all MHRA alerts, incidents, and complaints.

Appropriate and accurate information

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

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

- The practice had a patient participation group with 30 members who met quarterly. Meeting minutes and the date of the next meeting were advertised on the practice's website.
- Peer review of prescribing was carried out with other primary care network practices.

Feedback from Patient Participation Group (PPG).

Feedback
Members of the spoke highly of the practice and said that they felt listened to. For example, the practice invested in a glass barrier to separate the waiting area from the reception desk in response to feedback from the PPG. In addition, members were invited to attend the practice's clinical governance meeting twice a year. There were areas where the group felt further development was needed, such as: • A telephone system that informs patients of their position in the queue • More practice related information on the JX screen in the waiting area • Photo of clinicians on the wall with details of their specialism(s)

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: • There was clear evidence that staff at the practice drove continuous improvement using a wide range of information as well as their own knowledge and skills. The practice was passionate about ensuring they always provided their patients with the best care possible. Staff knew about improvement methods and had the skills to use them. The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements across sites.	

Examples of continuous learning and improvement activity
The practice had implemented several executive projects to drive improvements: • Audit of and 'lost opportunities' for long-term conditions reviews • Revising of staff induction to emphasise and review adherence to practice policies for safety and effectiveness. • All staff development sessions to review the processes for responding to QOF alerts. • Mapped processes from call & recall to clinical encounter for QOF domains.

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.