# Care Quality Commission

## Inspection Evidence Table

## HMC Health Feltham (1-6340478598)

**Inspection date: 08 January 2020**

**Date of data download: 07 January 2020**

# Overall rating: Requires improvement

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

# Safe Rating: Requires improvement

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

- Risk to patients were assessed and well managed in some areas, with the exception of those relating to the fire safety and infection control procedures, some recruitment checks and staff vaccinations.

**Safety systems and processes**

### The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, some improvements were required.

| Safeguarding | Y/N/Partial |
|---|---|
| There was a lead member of staff for safeguarding processes and procedures. | Y |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |
| Policies took account of patients accessing any online services. | Y |
| Policies and procedures were monitored, reviewed and updated. | Partial |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Partial |
| Staff who acted as chaperones were trained for their role. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |

| Safeguarding | Y/N/Partial |
|---|---|

Explanation of any answers and additional evidence:

- Safeguarding children policy was recently reviewed. However, we noted it had not been updated in line with intercollegiate guidance for all staff working in healthcare settings. All staff had received up-to-date safeguarding and safety training appropriate to their role.
- We noted safeguarding policies did not include the name of a lead member of staff. However, we noted a poster was displayed in the premises which included details of lead members of staff and their key lead areas.
- Disclosure and Barring Service (DBS) checks were mostly undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the practice had recruited an administrative member of staff in November 2019 and allowed to start the work without a DBS check. This meant the provider could not be assured they had up to date and the most relevant information about the individual they had employed to carry out regulated activities. However, the practice informed us that a DBS application was processed, and a DBS certificate was issued on 31 December 2019, but they were still waiting for the DBS certificate to arrive in the post. We noted the practice had taken appropriate steps to mitigate the risks, however, a documented risk assessment was not carried out.
- Staff who acted as chaperones were trained for their role and had received a DBS check.

| Recruitment systems | Y/N/Partial |
|---|---|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | N |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | N |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |

Explanation of any answers and additional evidence:

- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and an ongoing basis. However, the three staff files we reviewed showed that appropriate health checks (satisfactory information about any physical or mental health conditions) had not been undertaken prior to employment and interview notes were not always kept in staff files.
- We found some staff vaccination was not maintained in line with current Public Health England (PHE) guidance, because the practice could not provide assurance that all staff had the requisite blood tests and vaccinations to keep patients safe. The practice's recruitment policy had not included the requirement for the employees to provide evidence of vaccination or certified immunity. This was not in line with PHE guidance regarding staff vaccinations.
- Some staff records were not accessible on the day of the inspection as they were kept at the provider's other location. However, the practice had provided the required documents by email after the inspection.

| Safety systems and records | Y/N/Partial |
|---|---|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: 19 December 2019. | Y |
| There was a record of equipment calibration.<br>Date of last calibration: 19 December 2019. | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| There was a record of fire extinguisher checks.<br>Date of last check: July 2019. | Y |
| There was a log of fire drills.<br>Date of last drill: 29 August 2019. | Y |
| There was a record of fire alarm checks.<br>Date of last check: 2 January 2020. | Y |
| There was a record of fire training for staff.<br>Date of last training: January 2020. | Y |
| There were fire marshals. | Partial |
| A fire risk assessment had been completed.<br>Date of completion: 9 May 2018 (Shared building) & 10 October 2019 (Internal) | Y |
| Actions from fire risk assessment were identified and completed. | Y |

Explanation of any answers and additional evidence:

- The practice informed us they had carried out a fire drill annually. However, we noted the practice was not following their own fire risk assessment which included to carry out fire drills twice a year. We noted the practice had not maintained the list of staff who took part in the recent fire drill as required by their fire risk assessment.
- The practice had not had a documented fire evacuation plan specific to the service and they did not carry out a documented risk assessment to identify how staff could support people with limited mobility to vacate the premises from the third floor.
- We noted access to the disabled toilet was restricted for people with limited mobility or wheelchair users due to some boxes and bin kept in front of the disabled toilet door.
- The practice could demonstrate they had one fire marshal in place who was trained for this role. However, there were no contingency plans in place for when this member of staff was away from the practice. The practice informed us that another trained member of staff had left the job recently and they were planning to appoint and train a new member of staff as a fire marshal.
- Fire system was serviced in July 2019.

| Health and safety | Y/N/Partial |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: 7 August 2019. | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: 14 October 2019. | Y |
| Explanation of any answers and additional evidence:<br>• Health and safety policy was reviewed recently.<br>• The fixed electrical installation checks of the premises had been carried out on 11 April 2018. | |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met. However, some improvements were required.

| | Y/N/Partial |
|---|---|
| There was an infection risk assessment and policy. | Y |
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: 6 December 2019. | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Partial |
| There was a system to notify Public Health England of suspected notifiable diseases. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |

Explanation of any answers and additional evidence:

- We noted an experienced health care assistant was the infection control lead at the organisation level and a practice nurse was the infection control lead at the practice level. We saw both leads had received relevant infection control training. In addition, the health care assistant had completed a level four professional clinical skills training in 2017 and was enrolled to start level six infection control and prevention training in March 2020.
- We noted the infection control policy was not signed off by a clinician and the handwashing audit was not completed by all nursing staff.
- We noted the sharps injury poster was not displayed in all the consulting rooms.
- On the day of the inspection, the practice had provided a cleaning schedule for the consulting rooms. However, they were unable to provide the cleaning schedule for the rest of the premises including toilets. The practice was unable to provide the evidence of cleaning records and told us they had limited control on the management of premises because the practice was renting space in shared premises and the host was responsible for managing the premises. However, the practice was unable to demonstrate that they had an effective monitoring system to ensure that regular tasks and checks had been undertaken by the hosts who were responsible for managing the premises.
- Clinical equipment was cleaned on a regular basis and records were maintained.
- The practice had up to date legionella risk assessment (February 2018) in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

**Risks to patients**

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

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

**Information to deliver safe care and treatment**

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

| | Y/N/Partial |
|---|---|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referral letters contained specific information to allow appropriate and timely referrals. | Y |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |
| The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | Y |

Explanation of any answers and additional evidence:

- All test results and referrals were managed and checked on a regular basis to ensure all were appropriate and actioned. Any abnormal or concerning test results were actioned by one of the clinicians in a timely manner.
- The practice had maintained a failsafe system to manage and monitor urgent two-week wait referrals.
- The practice had a failsafe system in place to manage and monitor cervical smear screening.

**Appropriate and safe use of medicines**

## The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, some improvements were required.

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA) | 0.48 | 0.71 | 0.87 | Significant Variation (positive) |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA) | 6.8% | 7.6% | 8.5% | 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 (01/04/2019 to 30/09/2019) (NHSBSA) | 4.61 | 5.65 | 5.60 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA) | 0.71 | 1.07 | 2.08 | Significant Variation (positive) |

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

| 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. | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | N/A |
| 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. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |

Explanation of any answers and additional evidence:

- The practice stored prescription stationery in the locked room. We noted the practice had implemented a system on 15 December 2019 to record the use of prescription forms for use in printers. However, on the day of the inspection, we saw blank prescription forms for use in printers were not always recorded correctly and prescription box numbers were not recorded at all. The practice did not have any formal monitoring system in place to assure themselves that records were maintained as intended. The practice informed us they had not had blank prescription handwritten pads in stock.
- Not all staff we spoke with were aware of the location of keys of the medicine cabinet.
- The practice had two oxygen cylinders. However, records of checks were only maintained for one of the oxygen cylinders. We saw both oxygen cylinders were fit for use.
- The practice had an effective system to support vulnerable patients with requesting and collecting prescriptions. This involved checking the prescription box regularly and contacting the patient to check if they still required the medication or if a new prescription was issued.
- The practice had an effective system to identify and monitor who was collecting the repeat prescriptions for controlled drugs from the reception.
- The practice worked closely with the local CCG medicines management team regarding safe prescribing of antibiotics, within national guidance, and medicines optimisation.
- The practice had employed two clinical pharmacists. This had a positive impact to ensure effective management of long-term conditions and medicines safety.
- The practice offered travel vaccination.

**Track record on safety and lessons learned and improvements made**

## The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|---|
| The practice monitored and reviewed safety using information from a variety of sources. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Y |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | 2 |
| Number of events that required action: | 2 |

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

| Event | Specific action taken |
|---|---|
| Information sharing breach | The practice had investigated the incident and reminded all staff to follow information governance and confidentiality guidelines in line with the General Data Protection Regulation (GDPR) before sharing any information with the stakeholders. All staff were advised to complete information governance and GDPR training. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence:<br>• There was an effective system in place to receive and share all safety alerts. If the action was required, this was assigned to an appropriate member of staff and it was recorded when this action complete. | |

# Effective Rating: Requires improvement

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

- The practice was unable to demonstrate that all staff had received annual appraisals and some nursing staff had not received childhood immunisations and travel immunisations training updates in the last 12 months.
- The practice's uptake of the national screening programme for cervical, breast and bowel cancer screening and childhood immunisations rates were below the national averages.

**Effective needs assessment, care and treatment**

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

| | Y/N/Partial |
|---|---|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |

| 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) | 0.45 | 0.62 | 0.74 | No statistical variation |

## Older people

## Population group rating: Requires improvement

### Findings

The practice is rated as requires improvement for effective key question. The concerns about appraisal and training, which led to these ratings apply to everyone using the practice, including this population group, mean this population group is rated as requires improvement.

- 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. For example, the practice informed us they had completed 100% (of 80 patients at the end of 2018/19) care plans of patients who were living with moderate or severe frailty.
- The practice followed up on older patients discharged from the 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 is rated as requires improvement for effective key question. The concerns about appraisal and training, which led to these ratings apply to everyone using the practice, including this population group, mean this population group is rated as requires improvement.

- 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 the 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 COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| Diabetes Indicators | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF) | 73.5% | 75.0% | 79.3% | No statistical variation |
| Exception rate (number of exceptions). | 5.7% (28) | 6.1% | 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) | 73.2% | 76.7% | 78.1% | No statistical variation |
| Exception rate (number of exceptions). | 6.7% (33) | 6.1% | 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) (QOF) | 81.4% | 81.3% | 81.3% | No statistical variation |
| Exception rate (number of exceptions). | 4.3% (21) | 6.0% | 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) | 72.4% | 77.9% | 75.9% | No statistical variation |
| Exception rate (number of exceptions). | 2.7% (9) | 3.5% | 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) | 97.9% | 89.0% | 89.6% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 4.1% (2) | 9.7% | 11.2% | N/A |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF) | 76.0% | 81.7% | 83.0% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 4.1% (33) | 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) | 73.7% | 90.0% | 91.1% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 13.6% (3) | 4.7% | 5.9% | N/A |

**Any additional evidence or comments**

- The practice had undergone a considerable transition in the last 15 months. The provider took over the practice in October 2018 and completed their CQC registration in January 2019. The provider informed us that the practice had faced challenges and inherited some poor data from the previous provider. We noted the practice had implemented a number of measures to mitigate the challenges and took steps to improve, monitor and review the quality of service.
- According to the QOF year 2019/20 unverified score, the practice had demonstrated improvement. For example, the percentage of patients with hypertension in whom the last blood pressure reading (150/90mmHg or less) measured in the preceding 12 months was 79% (37 out of 47 patients). The practice had planned in place to achieve the targets by March 2020.
- We noted 75% of patients (18 out of 24) with atrial fibrillation (with a record of a CHA2DS2-VASc score of 2 or more) had been currently treated with anti-coagulation drug therapy. The practice had planned in place to achieve the targets by March 2020.
- The practice informed us the National Institute for Health and Care Excellence (NICE) targets of patients with diabetes had increased from 23% (October 2018) to 30% (September 2019).
- The practice offered multidisciplinary diabetes care provided by diabetes trained GPs, clinical pharmacists and practice nurses.
- The practice informed us they were one of the highest prescribers in the locality of a mobile application (an app), which was used to manage diabetes and weight control effectively.
- The practice offered the initiation of insulin in-house as part of the diabetes level two hub.
- The practice had reduced overall exception reporting rates from 10% in 2017/18 to 6% in 2018/19 QOF published results.

## Families, children and young people

## Population group rating: Requires improvement

### Findings

The practice is rated as requires improvement for effective key question. The concerns about appraisal and training, which led to these ratings apply to everyone using the practice, including this population group, mean this population group is rated as requires improvement.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. However, childhood immunisation uptake rates were not in line with the World Health Organisation (WHO) targets for four out of four immunisations measured (in 2018/19) for children under two years of age. The practice explained that this was due to the transient population and known cultural challenges within the practice population. The practice informed us that a number of patients were from a European background and they might have childhood immunisation carried out in their native European countries, but this information was not shared with the practice. The practice had taken steps to improve the childhood immunisation uptake and understood that further improvement was required.
- 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.

| 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) | 197 | 227 | 86.8% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England) | 176 | 223 | 78.9% | Below 80% uptake |
| 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) | 180 | 223 | 80.7% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | 180 | 223 | 80.7% | Below 90% minimum |

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

## Any additional evidence or comments

- The practice had provided us with the recent data (from Open Exeter) which demonstrated some improvements and childhood immunisations rates were 90% (for the quarter to 1 October 2019) and boosters rates were 86% (for the quarter to 1 October 2019). However, the practice was monitoring the uptake and understood that further improvement was required.
- The practice informed us they had increased the uptake of the MMR vaccine from 63% in April 2019 to 81% in September 2019.

## Working age people (including those recently retired and students)

## Population group rating: Requires improvement

**Findings**

The practice is rated as requires improvement for effective key question. The concerns about appraisal and training, which led to these ratings apply to everyone using the practice, including this population group, mean this population group is rated as 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. For example, the practice had offered 309 health checks to date. 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). (31/03/2019 to 30/06/2019) (Public Health England) | 50.5% | N/A | 80% Target | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE) | 57.8% | 69.0% | 71.6% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE) | 44.4% | 50.3% | 58.0% | 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. (01/04/2018 to 31/03/2019) (PHE) | 61.5% | 62.6% | 68.1% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE) | 60.0% | 51.6% | 53.8% | No statistical variation |

**Any additional evidence or comments**

- The practice was aware of these results and explained that this was due to the transient population and known cultural challenges within the practice population, which had an impact on the cervical, breast and bowel cancer screening uptake. The practice had taken steps to encourage the uptake. For example, there was a policy to offer telephone reminders and send text messages to patients who did not attend for their cervical screening test. All non-attenders flagged on the

woman's record so that the clinicians opportunistically encouraged patients to make their appointments. However, further improvements were required to meet the 80% coverage target for the national screening programme.

- On the day of the inspection, the practice had provided current unverified QOF data 2019/20 which was not comparable with the Public Health England published data (31/03/2019 to 30/06/2019) included in this report. The cervical screening QOF indicator used to calculate the payment the practice received, not the number of women screened. It included women who had been invited but who had not attended. In addition, it did not measure whether women had been screened at the appropriate time according to their age.
- The practice had a system to ensure results were received for all samples sent for the cervical screening programme. The practice had established failsafe systems to follow up women who were referred to as a result of abnormal results.
- The practice informed us the patients were able to book cervical screening appointments on Saturdays, which were offered under the Primary Care Network (PCN) arrangement.
- We noted both practice nurses had received specific training for nurses on sample taking for the cervical screening programme.

## People whose circumstances make them vulnerable

## Population group rating: Requires improvement

**Findings**

The practice is rated as requires improvement for effective key question. The concerns about appraisal and training, which led to these ratings apply to everyone using the practice, including this population group, mean this population group is rated as requires improvement.

- 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 is rated as requires improvement for effective key question. The concerns about appraisal and training, which led to these ratings apply to everyone using the practice, including this population group, mean this population group is rated as requires improvement.

- 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 31/03/2019) (QOF) | 79.3% | 87.8% | 89.4% | No statistical variation |
| Exception rate (number of exceptions). | 3.3% (2) | 8.2% | 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) | 71.2% | 91.2% | 90.2% | Variation (negative) |
| Exception rate (number of exceptions). | 1.7% (1) | 6.6% | 10.1% | N/A |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF) | 75.0% | 86.5% | 83.6% | No statistical variation |
| Exception rate (number of exceptions). | 11.1% (1) | 7.1% | 6.7% | N/A |

**Any additional evidence or comments**

- The practice was aware of these results and had taken steps to improve the outcomes. For example, the practice informed us they had completed 73% (58 out of 80 patients) care plans

(joint review clinics with GPs and HCAs) of people experiencing poor mental health. The practice informed us that no care plan was completed when they took over the practice in October 2018.

**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) | 524.2 | 538.1 | 539.2 |
| Overall QOF score (as a percentage of maximum) | 93.8% | 96.3% | 96.7% |
| Overall QOF exception reporting (all domains) | 5.3% | 5.0% | 5.9% |

| | 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

- The practice had carried out repeated clinical audits to review and monitor the appropriateness of antibiotic medicines prescribed. The clinical audits demonstrated that antibiotic medicines were being prescribed appropriately in line with national guidance.
- The practice had carried out repeated clinical audits to review and monitor the appropriateness of controlled drugs prescribed. The aim of the audit was to identify and ensure appropriate documentation and effective monitoring including appropriate dosage, length of supply and clinically appropriate frequency of prescribing. We saw the practice had developed an action plan and advised all clinicians to ensure that prescribing of pain relief was in line with local and national guidelines.
- The practice had carried out repeated quarterly clinical audits to ensure patients with diabetes were receiving care and treatment according to local diabetes guidelines and NICE guidelines. The practice had demonstrated improvement in patients reaching clinical key targets of maintaining blood pressure and monitoring HbA1C and cholesterol targets.

**Effective staffing**

## Most staff had the skills, knowledge and experience to carry out their roles. However, the practice was unable to demonstrate that all staff had received annual appraisals and childhood immunisations and travel immunisations training update in the last 12 months relevant to their role.

| | 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. | Partial |
| The learning and development needs of staff were assessed. | Partial |
| 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. | N |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |

Explanation of any answers and additional evidence:

- We saw evidence the practice nurses had undertaken appropriate annual cervical smear training. However, we noted one of the two practice nurses had not received regular annual training updates relevant to childhood immunisations. In addition, we noted both practice nurses had not received regular annual training updates relevant to travel immunisations in the last 12 months. One of the two practice nurses had received last travel health update in June 2018.
- We noted two practice nurses, a health care assistant (HCA) and a phlebotomist had not received a formal appraisal in the last 12 months. The practice informed us they were waiting for one of the practice nurses to complete the mentorship training, so she could appraise the practice nurses and HCA. Most of the non-clinical staff had received formal one to ones.
- We saw relevant staff had completed role specific phlebotomy training.

**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 processes to make referrals to other services. | Y |

**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 |

| 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) | 90.1% | 96.2% | 95.0% | Variation (negative) |
| Exception rate (number of exceptions). | 1.0% (13) | 0.8% | 0.8% | N/A |

| Any additional evidence or comments |
| --- |
| • According to the QOF year 2019/20 unverified score, we saw 91% of patients (1,120 out of 1,237) had smoking status recorded in the last 12 months. Please note this data was not comparable to the above indicator because it was not specific to the people experiencing poor mental health. |

**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 |

# Caring Rating: Requires improvement

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

- Feedback from some patients reflected that they were not satisfied about the way staff treated them and they were not always involved in decisions about care and treatment.
- We saw confidential documents were not always disposed of safely and the computer screen was not always locked when the clinician was not in the consulting room.

**Kindness, respect and compassion**

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

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

| CQC comments cards | |
|---|---|
| Total comments cards received. | 16 |
| Number of CQC comments received which were positive about the service. | 12 |
| Number of comments cards received which were mixed about the service. | 2 |
| Number of CQC comments received which were negative about the service. | 2 |

| Source | Feedback |
|---|---|
| Discussion with the patients, the patient participation group (PPG) members and comment cards | • Eight patients and two members of the patient participation group (PPG) we spoke with said not all staff were helpful, caring and treated them with dignity and respect. Some patients raised dissatisfaction regarding customer services skills of some reception staff and most patients were not satisfied with the access to the service.<br>• Twelve of the 16 patient CQC comment cards we received were positive about the service experienced. Two of the 16 patient CQC comment cards we received were negative and two were mixed, which raised some dissatisfaction regarding waiting for a repeat prescription, long waiting for a referral and poor access to the service. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required. |
| NHS Choices | • The practice had received a number of negative comments (nine out of 11 comments) on the NHS Choices website in the last seven months (between June 2019 and December 2019). Some patients raised dissatisfaction regarding the customer services skills of some reception staff and poor access to the service. |

**National GP Survey results**

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 10365.0 | 467.0 | 80.0 | 17.1% | 0.77% |

| 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) | 72.1% | 83.5% | 88.9% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019) | 69.7% | 81.0% | 87.4% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019) | 98.5% | 92.1% | 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) | 65.8% | 77.8% | 82.9% | Tending towards variation (negative) |

| Any additional evidence or comments |
|---|
| • On the day of the inspection, we observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. We saw a multi-lingual staff (able to speak five languages) helped a patient who was not able to speak the English language fluently. We saw a reception staff had gone an extra mile to help a patient who required an urgent prescription. |

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

| Any additional evidence |
|---|
| • We noted the NHS friends and family test (FFT) results for the last six months (August 2019 to January 2020) and 88% of patients (out of 808 responses) were likely or extremely likely recommending this practice.<br>• The practice had carried out an annual internal patient survey in February 2019 and received 64 responses. The practice had developed an action plan and implemented following changes. For example,<br>• The practice had provided staff customer services training to improve patient satisfaction.<br>• The practice had encouraged patients and staff to use online access and text messages.<br>• The practice had recruited a full-time support practice manager to provide support and mentorship to the administrative staff. |

**Involvement in decisions about care and treatment**

## Most staff helped patients to be involved in decisions about care and treatment. However, some patients said they were not always 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. | Partial |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |
| Explanation of any answers and additional evidence:<br>• Easy read and pictorial materials were available. | |

| Source | Feedback |
|---|---|
| Discussion with the patients, the patient participation group (PPG) members and comment cards.<br>NHS choices. | • Feedback from most patients demonstrated they felt involved and that their personal decisions were taken into account. However, some patients told us they did not feel being listened to during the consultation by some doctors. For example, a patient we spoke with informed us that a doctor had already printed the prescription before the conversation was ended and they did not feel involved in decisions about their care and treatment. |

**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) | 88.3% | 89.0% | 93.4% | No statistical variation |

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

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified 41 patients as carers (0.4% of the practice patient list size). |
| How the practice supported carers (including young carers). | The practice's computer system alerted GPs if a patient was also a carer. They were being supported by offering health checks and referral for social services support. |
| How the practice supported recently bereaved patients. | Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. |

**Privacy and dignity**

## The practice did not always respect patients' privacy and dignity.

| | Y/N/Partial |
|---|---|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Y |
| Consultation and treatment room doors were closed during consultations. | Y |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Y |
| There were arrangements to ensure confidentiality at the reception desk. | Y |
| Explanation of any answers and additional evidence:<br>• We found the recycling bin used to dispose of confidential documents was overflowing in the communal area and confidential documents were accessible to the public.<br>• We saw one of the computer screens was not locked while a clinician was not in the consulting room. | |

# Responsive Rating: Requires improvement

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

- Patients were not always able to access care and treatment in a timely way.

**Responding to and meeting people's needs**

## The practice organised and delivered services to meet patients' needs. However, some improvements were required.

| | 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. | Partial |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |

Explanation of any answers and additional evidence:

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice was proactive in offering online services, which included online appointment booking; an electronic prescription service and online registration.
- The practice was sharing space with other health services in a modern health centre with excellent facilities. However, the provider informed us that the practice did not have sufficient space for the list size. We noted the practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services. For example, the practice was in discussion with the CCG and the host to rent the additional administrative room to address the issues related to lack of space. The practice was also considering a centralised approach to its administration and back office functions to the provider's another location in the local area.
- The practice made some reasonable adjustments when patients found it hard to access services. For example, there were accessible facilities, which included a disabled toilet and lifts. However, a hearing induction loop and baby changing facilities were not available on the premises.
- The practice website was well designed, clear and simple to use featuring regularly updated information. The practice website included a translation facility.
- The practice sent text message reminders of appointments.
- The practice had installed a touch screen self check-in facility to reduce the queue at the reception desk.
- Patients were offered an intrauterine contraceptive device (IUCD) and implant insertions appointments at the provider's two other locations in the local area. (IUCD is a small device made from plastic and copper which sits inside the womb/uterus. It is also known as 'the coil').
- Patients were offered joint injection clinics appointments at the provider's two other locations in the local area.

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| **Opening times:** | |
| Monday | 8am-6.30pm |
| Tuesday | 8am-6.30pm |
| Wednesday | 8am-6.30pm |
| Thursday | 8am-6.30pm |
| Friday | 8am-6.30pm |
| | |
| **Appointments available:** | |
| Monday | 8am-5.50pm |
| Tuesday | 8am-5.50pm |
| Wednesday | 8am-5.50pm |
| Thursday | 8am-5.50pm |
| Friday | 8am-5.50pm |
| | |
| **Extended hours opening:** | |
| Saturday (at the practice) | 8am-4pm (GP) & 12.30pm-4pm (HCA) |
| Monday to Friday (at local GP hubs) | 6.30pm-8pm |
| Saturday and Sunday (at local GP hubs) | 8am-8pm |
| Saturday one of the local hubs was opened at the practice's premises (Funded by Primary Care Network). | 8am-12pm (HCA) |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 10365.0 | 467.0 | 80.0 | 17.1% | 0.77% |

| 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) | 92.2% | 91.2% | 94.5% | No statistical variation |

## Older people

## Population group rating: Requires improvement

### Findings

The practice is rated as requires improvement for responsive key question. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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.

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

The practice is rated as requires improvement for responsive key question. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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: Requires improvement

**Findings**

The practice is rated as requires improvement for responsive key question. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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.

## Working age people (including those recently retired and students)

## Population group rating: Requires improvement

**Findings**

The practice is rated as requires improvement for responsive key question. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered extended opening hours Saturday from 8am to 4pm for working patients who could not attend during normal opening hours.
- In addition, the patients at the practice were offered extended hours appointments through the local GP access hubs Monday to Friday between 6.30pm to 8pm, Saturday and Sunday between 8am to 8pm.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

## People whose circumstances make them vulnerable

## Population group rating: Requires improvement

**Findings**

The practice is rated as requires improvement for responsive key question. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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

## Population group rating: Requires improvement

| Findings |
| --- |
| The practice is rated as requires improvement for responsive key question. The concerns which led to these ratings apply to everyone using the practice, including this population group.<br>• Priority appointments were allocated when necessary to those experiencing poor mental health.<br>• Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.<br>• The practice was aware of support groups within the area and signposted their patients to these accordingly. |

**Timely access to the service**

## People were not always 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 |

Explanation of any answers and additional evidence:

- The practice had identified patients who were vulnerable or who would have difficulties accessing the service and had flagged them on their computer system. They would offer those patients home visits as a priority.
- Appointments were available to book online.
- In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

| 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) | 48.4% | 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) | 52.0% | 65.0% | 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) | 61.1% | 64.3% | 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) | 65.8% | 69.7% | 73.6% | No statistical variation |

| Any additional evidence or comments |
|---|
| • The provider took over the practice in October 2018 and took steps to improve access to the service. The practice had carried out an annual internal patient survey in February 2019, developed an action plan and implemented changes. For example, the practice had changed the |

telephone provider and increased the telephone lines (from two to three) and increased the number of staff answering the telephone calls during the peak hours (from two to three).

- However, feedback from patients reflected that they were not able to get through the practice via the telephone in a timely manner.
- The practice was in discussion with the telephone provider and planning to monitor the telephone calls data in the future.
- The practice informed us they had recruited regular salaried male and female GPs to promote continuity of care.
- The practice had increased the number of clinical appointments. For example, the practice informed us they had offered 7,225 (weekdays) and 300 (weekend) appointments during the quarter January 2019 to March 2019, compared to the 5,648 (weekdays) and 196 (weekend) appointments offered by the previous provider during the quarter July 2018 to September 2018.
- The practice had 10,340 patients registered with the practice. On the day of the inspection, we found the practice offered 25 GP clinical sessions per week on average.
- The practice offered extended opening hours on Saturday from 8am to 4pm.
- We checked the online appointment records and noted that the next pre-bookable face to face appointment with any GP was available within two weeks.
- The practice informed us they offered 30 same day appointments for emergencies with the GP. However, most of the patients we spoke with informed us they were not satisfied with the availability of same day appointments.
- The practice offered 35 practice nurse clinics hours per week (increased from 19.5 hours in October 2018). In addition, an advanced nurse practitioner (ANP) offered clinic one day (10 hours) per week and a clinical pharmacist offered clinic two days (10.5 hours) per week.
- We noted 17% of patients were registered to use online services.
- The practice had introduced 20 minutes catch up sessions for GPs. However, some patients we spoke with raised dissatisfaction regarding the long waiting time in the waiting area.
- The practice had taken steps to improve access to the service. However, further improvements were required to review and monitor the telephone system, availability of same day appointments and long waiting time in the waiting area.

| Source | Feedback |
|---|---|
| Discussion with the patients, the patient participation group (PPG) members and comment cards. | • Most patients we spoke with and some comment cards we received highlighted dissatisfaction regarding the poor telephone access, long waiting times in the waiting area and availability of same day appointments.<br>• They were satisfied with online access provided by the practice. |
| NHS Choices | • The practice had received a number of negative comments (nine out of 11 comments) on the NHS Choices website in the last seven months (between June 2019 and December 2019). Most patients raised dissatisfaction regarding the poor telephone access and lack of appointments. |
| Staff | • Some staff we spoke with raised dissatisfaction regarding the telephone access during the peak hours and lack of same day appointments. However, they said the availability of pre-bookable appointment was satisfactory. |

**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. | 8 |
| Number of complaints we examined. | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| 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:<br>• The complaint policy and procedures were in line with recognised guidance.<br>• The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Ineffective communication | The practice had reminded all staff to answer the telephone calls promptly and politely explain the repeat prescription request protocol and advised the patients to request the repeat prescription by email if they were unable to log in online on the practice's website. |

# Well-led Rating: Requires improvement

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

- There was a lack of good governance in some areas.

**Leadership capacity and capability**

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

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

Explanation of any answers and additional evidence:

- The provider informed us that the practice had faced challenges and changes within the staff team in the past 15 months. We noted the practice had implemented a number of measures to mitigate the challenges, addressed the staffing and leadership issues and took steps to improve, monitor and review the quality of service.
- Staff we spoke to were complimentary about the leadership at the practice. We were told that the leaders were approachable, supportive and inclusive. Staff told us this made them feel motivated.
- On the day of the inspection, we noted the practice's CQC registration was not up to date because they were required to remove one partner and add one partner. Two partners were managing the practice. The practice assured us they would submit appropriate application forms to the Care Quality Commission to resolve the registration issues.

**Vision and strategy**

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

| | Y/N/Partial |
|---|---|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |

Explanation of any answers and additional evidence:

- The practice had a mission statement which stated 'each and every patient matters'. This included to provide high quality healthcare in a responsive, supportive and courteous manner.

**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 |

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

| Source | Feedback |
|---|---|
| Staff interviews | • Staff told us they felt involved in decisions on how the practice was managed.<br>• We were informed that the practice culture was one of being open and supportive of one another.<br>• Clinical staff said they had prompt access to the senior GP when they needed clinical advice.<br>• Staff felt they were treated equally. |

**Governance arrangements**

## There were clear responsibilities, roles and systems of accountability to support good governance and management. However, some improvements were required.

| | Y/N/Partial |
|---|---|
| There were governance structures and systems which were regularly reviewed. | Partial |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |

Explanation of any answers and additional evidence:

The practice had a governance framework, however, monitoring of specific areas required improvement, in particular:

- The practice had not assured that confidential documents were disposed of safely and computer screens were locked when the staff was away from their desks.
- The practice had established proper policies and procedures. However, we noted safeguarding policies did not include the name of a lead member of staff and infection control policy was not signed off by a clinician.
- The practice was unable to demonstrate that all staff had received annual appraisals and some training relevant to their role.

**Managing risks, issues and performance**

## There were processes for managing risks, issues and performance. However, some improvements were required.

| | Y/N/Partial |
|---|---|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Partial |
| There were processes to manage performance. | Y |
| There was a systematic programme of clinical and internal audit. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |

Explanation of any answers and additional evidence:

- There were processes to ensure risks to patients were assessed and well managed in most areas, with the exception of those relating to the fire safety and infection control procedures, some recruitment checks and staff vaccinations.
- The practice's uptake of the national screening programme for cervical, breast and bowel cancer screening and childhood immunisations rates were below the national averages.
- The practice had implemented excellent processes to monitor clinical performance and quality of care within the practice.
- The practice had a business continuity plan in place.

**Appropriate and accurate information**

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

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

**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. However, some improvements were required.

| | Y/N/Partial |
|---|---|
| Patient views were acted on to improve services and culture. | Partial |
| 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:

- Patients had a variety of means of engaging with the practice all of which were effective: text messages, emails and complaints/comments.
- Staff feedback highlighted a strong team with a positive supporting ethos.
- Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered.
- The practice had promoted health awareness in three sessions held at the local charity premises. They informed us approximately 160 people attended the sessions.
- The practice held the patient engagement day at the premises on 22 June 2019, which was attended by 14 patients.

Feedback from Patient Participation Group.

| Feedback |
|---|
| • The practice was in the process of establishing the patient participation group (PPG) and two meetings were held in the last six months. We spoke with two PPG members and they were positive about the care and treatment offered by the practice, which met their needs. They said the doctors were caring and receptionists were friendly and helpful. They said staff treated them with dignity and respect, and they felt involved in decisions about care and treatment.<br>• They were satisfied with online access provided by the practice. However, they were not satisfied with telephone access.<br>• They reported they felt they were not always kept informed by the practice and would appreciate better communication and engagement. They said they were willing to work with the practice to address the challenges. |

**Continuous improvement and innovation**

## There were evidence of systems and processes for learning, continuous improvement and innovation. However, some improvements were required.

| | Y/N/Partial |
|---|---|
| There was a strong focus on continuous learning and improvement. | Partial |
| Learning was shared effectively and used to make improvements. | Y |
| Explanation of any answers and additional evidence:<br>• Staff has received mandatory training. However, some nursing staff had not received role specific training and all nursing staff had not received annual appraisals. | |

| Examples of continuous learning and improvement |
|---|
| • The practice was forward thinking and planning to address the lack of space issue.<br>• The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.<br>• We saw the clinical staff were supported to develop in advanced lead roles. For example, one of the practice nurses (at the provider level) was supported to complete leadership and mentoring programme.<br>• We noted the infection control lead (at the provider level) was supported to enrol in a level six infection control and prevention training course.<br>• The practice was supporting a practice nurse to complete a non-medical prescriber course.<br>• We saw one of the administrative staff was supported to grow and develop as a business manager.<br>• The practice was planning to offer e-consultations in the future. |

**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.