

Care Quality Commission

Inspection Evidence Table

The Acocks Green Medical Centre (1-584619226)

Inspection date: 11 February 2020

Date of data download: 09 February 2020

Overall rating: Good

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

Safe

Rating: Good

The practice was rated as inadequate at the last inspection in June 2019. At this inspection we found the practice had acted on the identified breaches and had implemented processes and procedures to mitigate future risks. This included a complete review of the safeguarding registers, patients on high risk medicines and recruitment processes.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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:	
<ul style="list-style-type: none"> • The practice had implemented a safeguarding spreadsheet to monitor each patient on the safeguarding register to ensure all changes had been actioned and the register was kept up to date. • All patients were discussed regularly at clinical meetings and as part of multi-disciplinary team meetings. • Staff had completed training relevant to their role and this was reviewed on a regular basis by the leadership team. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had strengthened their recruitment procedures to ensure all the appropriate checks were carried out before employment. • Staff vaccination was recorded and maintained in line with Public Health England guidance. All staff had immunisation records in place with the appropriate immunisations relevant to their role. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: February 2020	Y
There was a record of equipment calibration. Date of last calibration: February 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: November 2019	Y
There was a log of fire drills. Date of last drill: January 2020	Y
There was a record of fire alarm checks. Date of last check: November 2019	Y
There was a record of fire training for staff.	Y

Date of last training: Various	
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2020	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: December 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2019	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Actions from the health and safety risk assessment included labelling all bins in the practice and including health and safety and infection control on the agenda for staff meetings. All of the actions had been completed. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Infection control assessments were completed on a regular basis to ensure infection control systems were effective and being monitored appropriately. • The practice had systems in place to manage the risk of Legionella. Legionella is a term given to a bacteria that can contaminate water. Monthly water temperature checks were completed and a Legionella risk assessment had been completed in December 2018. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the last inspection we had identified urgent pathology results that had not been actioned. The practice have now implemented processes to ensure document management was acted on in a timely manner and system changes were shared with staff and monitored regularly to mitigate any future risk. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.68	0.84	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	5.4%	7.4%	8.5%	Tending towards variation (positive)
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)	6.76	5.13	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)	1.83	1.77	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice stocked a range of emergency medicines, however some of the recommended medicines for emergency use were not in place. Risk assessments had been completed for these medicines and the assessments demonstrated that risk was mitigated as the pharmacy that was based within the practice premises was open when the practice was open. • GPs acting in the role as clinical leads had implemented weekly clinical meetings and regular reviews with the nursing team to monitor their prescribing and to offer support. We were provided evidence to demonstrate that formal reviews of the nurses consultations and prescribing had taken place. • The practice had carried out a range of clinical audits to identify patients who required monitoring and medicine reviews and clinical staff were in the process of reviewing each patient. • Systems were in place to monitor patients on high risk medicines and we saw evidence to demonstrate that all patients had been invited in for a review and all prescriptions had been changed from repeat to acute and were issued only on a monthly basis. This ensured patients received regular reviews and their medicines were monitored appropriately. 	

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:	7
Number of events that required action:	7
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had reviewed their processes to ensure changes were embedded to mitigate future risk. • Evidence provided demonstrated that significant events were a standing agenda item for both staff and clinical meetings and learning was shared with the whole team. 	

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

Event	Specific action taken
Blank prescriptions found in printer in unlocked room	<ul style="list-style-type: none"> • The printer was identified as one that is not used by clinical staff. An investigation was completed which demonstrated one of the GPs had used the printer and was unaware that blank prescriptions should not be moved between printers. • The blank prescriptions were removed from the printer and the prescription policy was discussed with the clinical staff to ensure they were aware of the processes in place. • All blank prescription were only signed out by a designated staff member for security reasons. • Signs were added to all printers to remind staff not to return blank prescriptions to the designated staff member once their clinic had finished.
Letter scanned onto the wrong patient record	<ul style="list-style-type: none"> • The letter was found on the patient record and identified as being scanned by mistake. • Once identified the letter was removed and added to the correct patient record. • Discussed with administration team the importance of reviewing each document before adding to patients' records. • Implemented a system that three checks are required before scanning takes place to a patient record, these were patient name, date of birth and address.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had implemented systems to ensure all safety alerts were acted on promptly. Since the last inspection a review of all historical alerts had taken place to ensure they had been actioned. • The practice could demonstrate that alerts had been shared, actioned and discussed by the clinical team and evidence was available to confirm this. We saw examples of actions taken on alerts. For example: An alert had been actioned from the MHRA which highlighted a potential risk relating to a combination of specific medicines for patients of child bearing age. The alert indicated that patients on these medicines should be informed of the risks of foetal abnormalities when pregnant and referred to a specialist for an alternative medicine if they plan to get pregnant. The practice was aware of the alert, had completed an audit which had identified two patients on this medicine, however the female patients were not of childbearing age. 	

Effective

Rating: Requires Improvement

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The current clinical team in place were able to demonstrate they had systems and processes in place to keep themselves up to date with current evidence based guidelines. Performance data was discussed at regular clinical meetings and the practice used the information collected for monitoring and evaluating performance and improving service quality. Following the previous inspection, the clinical team had prioritised reviews of the clinical registers to ensure patients requiring a review were being monitored and cared for appropriately. Evidence provided by the practice demonstrated that patients had been invited to attend the practice for medicine reviews. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	1.17	0.73	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. Evidence provided by the practice showed that 71.8% of patients aged 65 years and over had received the influenza vaccination. This was above the local and national average.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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 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)	77.3%	79.8%	79.3%	No statistical variation
Exception rate (number of exceptions).	17.7% (58)	13.2%	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	91.3%	78.1%	78.1%	Variation (positive)

months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	5.5% (18)	10.1%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	69.8%	81.1%	81.3%	Variation (negative)
Exception rate (number of exceptions).	5.8% (19)	11.2%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.8%	76.5%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.2% (7)	5.7%	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) <small>(QOF)</small>	94.4%	91.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	5.3% (5)	11.0%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.3%	83.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.3% (19)	3.8%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.0%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.8% (1)	7.2%	5.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had not met the minimum 90% for all of the four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had improved 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. Since the last inspection a review of the clinical codes utilised to identify failed attendances had been carried out to ensure the appropriate codes were being used and provided accurate information.
- 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)	59	69	85.5%	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)	63	77	81.8%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	65	77	84.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles,	67	77	87.0%	Below 90% minimum

mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)				
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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 worked with child health department to carry out comparisons of the practice data to ensure it was accurate. Reviews of patients that were due immunisations and who had failed to attend was completed and letters were sent out to all patients encouraging them to attend their appointments.
- Data provided by the practice from Child Health Information Service (CHIS) showed during October 2019 and December 2019 the practice had achieved above the 90% indicator.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Cervical screening rates were below the national target. The practice was aware of the this and were implementing initiatives to encourage patients to attend.
- The practice had been part of a case study practice for the improvement of cancer bowel screening. Joint working had taken place with the bowel screening team to encourage patients to attend their appointments. The practice had seen an increase in the number of patients attending their appointments.
- 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). (01/07/2019 to 30/09/2019) (Public Health England)	54.8%	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)	57.9%	64.3%	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)	36.1%	44.8%	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)	75.0%	73.1%	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)	33.3%	53.2%	53.8%	No statistical variation

Any additional evidence or comments

- The practice had held three open days to encourage patients to attend for cervical screening. Text messages were sent out to all eligible patients inviting them to attend anytime during the day. The practice had seen positive results from the open days. For example: During October 2019 and December 2019 the practice had completed 44 cervical smears which had increased the practice uptake by 8%. Another open day was planned for March 2020.
- The practice secretary had made contact with the local mosque to discuss the importance of patients attending appointments for screening and immunisations.
- The practice had supported a campaign for the improvement of the number of patients attending bowel cancer screening appointments. A monthly identification search of non responders was carried out in the practice and a letter was sent out encouraging patients to attend appointments. Following the campaign the practice had seen an increase during 2019 to 49.4%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Since the previous inspection the practice has carried out a review of all the safeguarding registers and had implemented processes to ensure all registers were up to date and contained the relevant information.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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) <small>(QOF)</small>	92.7%	92.1%	89.4%	No statistical variation
Exception rate (number of exceptions).	1.2% (1)	9.3%	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) <small>(QOF)</small>	95.1%	92.0%	90.2%	No statistical variation
Exception rate (number of exceptions).	1.2% (1)	7.2%	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) <small>(QOF)</small>	91.3%	86.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	4.2% (1)	5.8%	6.7%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	546.1	546.7	539.2
Overall QOF score (as a percentage of maximum)	97.7%	97.9%	96.7%
Overall QOF exception reporting (all domains)	7.1%	6.4%	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

Following the previous CQC inspection in June 2019, the practice had carried out a range of audits to action the identified breaches. These included:

Patients on ACE Inhibitors

Evidence from clinical trials had demonstrated that patients with heart failure, showed an improvement in symptom control and a reduction in morbidity and mortality when treated with an ACE inhibitor (ACEI). Patients on these medicines should be checked within two weeks of initiation and any change of dose. Reviews should be carried out at one, three and on achieving the appropriate dosage at least every six months. A total of a 116 patients had been identified during the previous inspection as having outstanding blood chemistry and no evidence of blood pressure checks within the previous 12 months. The practice implemented the following actions:

- The practice had sent invite letters for reviews to all patients that had been identified.
- The practice added extra clinics to ensure completion of the reviews.
- Recalls were added to patients records for six monthly reviews upon completion of blood tests.
- A three month audit plan had been implemented to ensure all patients were regularly checked.

Evidence was provided of audits that had been completed between 2019 and 2020. The last audit on 11 November 2019 showed 15 patients were outstanding reviews. Further letters were sent out to patients to invite them in for review.

Patients aged 35 years and above on contraception and smokers

Patients on oral contraception aged 35 years and above who were recorded as smokers required regular six monthly reviews. Blood pressure and weight monitoring were also required. At the previous inspection, a total of seven patients had been identified as not having had reviews in line with evidence based guidance. The practice implemented the following actions:

- Each patient was reviewed and two patients were identified as not requiring review as no longer on the contraceptive pill. The remaining five patients were invited for a review.
- Discussions were held with the clinical team to ensure they were using the appropriate template to record information.
- One of the GPs was assigned as the clinical lead for contraception/gynaecology.

A second audit was carried out in August 2019. A total of six patients were identified. A review of each patient was carried out which showed one patient was under the care of the hospital, four patients had cancelled their appointments and another patient had stopped the medicine. The four patients who had

not attended their appointments had their prescriptions changed to acute and alerts were added to their records to ensure staff advised the patients that a review was required before another prescription could be issued. A further audit was planned for six months time.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Newly employed staff had received regular reviews, including an induction and regular reviews. Regular training of staff was a priority at the practice with both online and face to face training completed regularly. The practice had implemented clinical reviews of the nursing team to ensure they had the appropriate clinical supervision and support. This included reviews of their consultations and prescribing. At the previous inspection we identified one of the clinical team had acted outside of their scope in authorising Statement of Fitness to Work notes (also known as fit notes). The practice had completed an audit to ensure only authorised clinicians were issuing and authorising Fitness to Work notes. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw evidence to support that regular multidisciplinary meetings took place with community services. This included liaison and joint working with health visitors and district nurses. Safeguarding, palliative and end of life care was discussed in these meetings in addition to vulnerable patients and patients with complex care needs. 	

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	96.3%	95.8%	95.0%	No statistical variation

smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.3% (3)	0.7%	0.8%	N/A

Consent to care and treatment

The practice always obtained to demonstrate that it 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: Good

Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	18
Number of CQC comments received which were positive about the service.	16
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment Cards	Feedback from patients was positive about the care they received. Comments highlighted how helpful and supportive staff were?.
NHS Choices	The practice had received nine comments in the past 12 months. The comments were mixed. Negative comments related to difficulty in getting appointments. Positive comments included staff were caring and supportive. The practice had responded to all of the comments.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	83.2%	86.8%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very	83.2%	85.5%	87.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2019 to 31/03/2019)				
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)	95.2%	94.4%	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)	60.1%	80.1%	82.9%	Variation (negative)

Any additional evidence or comments

The practice had been going through changes with the absence of the principal GP. The practice was currently not registering new patients and had employed new staff both clinical and non clinical to ensure minimal disruption to services and ensure continuity of care.

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

Any additional evidence

- The practice had implemented a monthly survey process to gather patient feedback. Evidence provided by the practice showed during January 2020 a total of 16 patients had completed an inhouse survey. Results from the survey showed 84% of patients had rated the practice as excellent/good.
- We found all comments on NHS Choices had been responded to by one of the management team. The practice used the comments as part of their discussions at staff meetings to improve customer service and promote learning.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Patients were referred to a range of local services for support in the community. Easy read materials were available to help improve communication with patients. 	

Source	Feedback
CQC Comment cards	Comments received highlighted that the staff took their time, listened carefully to what patients had to say and ensured patients felt supported.

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)	83.1%	91.9%	93.4%	Tending towards variation (negative)

Any additional evidence or comments

- The practice had reviewed the outcome of the national patient survey and had implemented an inhouse survey. Evidence was provided to demonstrate the results of the survey had been discussed with the staff and an action plan had been implemented to improve patient satisfaction.
- Due to the absence of the principal GP, the practice had a new team of staff in place and to capture patients' feedback an inhouse survey had been implemented. At the time of the inspection, patients' responses were still being collected.
- Comments received through the CQC comment cards highlighted the care and treatment received and the support and understanding of all staff at the practice.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a range of information available in different languages to support the practice population. • A check in screen was available, which could be changed into various languages to support patients with their checking in process for appointments. • Interpretation services were available and staff were able to speak some of the languages of the local population. 	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> • The practice had 157 carers on the carers register, which represented 3% of the practice population.

	<ul style="list-style-type: none"> • Since the last inspection, the practice had reviewed their carers register as one of their priorities and had implemented actions to ensure all carers were registered appropriately. The practice had seen an increase in the number of carers from 1% to 3%.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • A carers board was in place with information on local support groups. Carers were supported by ensuring that they were offered influenza vaccinations. The practice website contained links for further sources of support and the waiting room had a Carers' Corner with information. • Evidence provided by the practice showed 39% of patients on the carers register had received an influenza vaccination. All of the carers on the register had been invited and the practice continued to send out further invites to encourage patients to attend.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • A bereavement leaflet was available which gave information on local support groups and services.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

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:	
<ul style="list-style-type: none"> • Interpreters were available for patients who could not speak English. Staff also spoke a range of languages to support the local population. • The practice had a range of clinical staff in place to offer choice and flexibility. These included an advanced nurse practitioner, nurse prescriber and health care assistant. • Patients were also able to access evening and weekend appointments through an extended access hub arrangement, situated approximately 2.5 miles away from the practice. These appointments were available Monday to Friday from 6.30pm to 8pm and on Saturdays from 9am to 1pm. The extended hours service was advertised in the practice and on the practice website. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	9am to 6pm
Tuesday	9am to 6pm
Wednesday	9am to 1pm
Thursday	9am to 6pm
Friday	9am to 6pm
Telephone lines:	Telephone lines were available from 8.30am When the practice was closed for lunch between 1pm and 2pm and on Wednesday afternoons the phones were answered by Badger out of hours services.
Appointments available:	
Monday	9am to 1pm / 2pm to 6pm
Tuesday	9am to 1pm / 2pm to 6pm

Wednesday	9am to 1pm
Thursday	9am to 1pm / 2pm to 6pm
Friday	9am to 1pm / 2pm to 6pm

National GP Survey results

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%	93.1%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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: Good

Findings
<ul style="list-style-type: none"> 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. Weekly clinical meetings were held to discuss the needs of complex patients and to ensure the appropriate care and monitoring was in place. 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
<ul style="list-style-type: none"> Nurse appointments were available after school 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.
- Due to popular demand the community midwife service offered two days a week at the practice.

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.
- Patients were able to book appointments online and telephone consultations were available for patients who required advice.
- Pre-bookable appointments were available to all patients at an additional location within the area. Appointments were available evenings from 6.30pm to 8pm and Saturday from 9am to 12pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice had a veterans register in place. Information was available in the practice waiting room and staff signposted patients to the appropriate support 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: 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.
- The practice worked with the local Dementia Information for Support for Carers (DISC) team in conjunction with their Patient Participation Group (PPG) to promote and signpost patients and

carers to this service. This provided support and help to those caring for patients with Dementia, Alzheimer's and memory loss.

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)	43.1%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	45.2%	61.4%	67.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	46.7%	61.3%	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)	59.7%	69.0%	73.6%	No statistical variation

Any additional evidence or comments

- The practice had implemented systems to monitor access. The phone system allowed the staff to monitor the number of incoming calls and identify peak times where more staff were required.
- A review of clinical roles had been completed. This included specific clinical roles for the nursing team to offer patients more choice, more appointments and the opportunity to see a range of clinical staff including a pharmacist and nurse prescriber.
- The practice texted patients after their appointment to gather feedback. This was discussed with the practice team to share learning and identify further improvements.

- The results of the friends and family test were discussed on a monthly basis with the practice team and on display in the practice and on the staff noticeboard.
- The practice had started to gather patient feedback through an inhouse survey that was being carried out on a monthly basis. Evidence provided by the practice showed that during January 2020, 16 patients had completed the survey and the findings demonstrated that 47% had rated the practice as excellent for access and 38% had rated the practice as good. The management team planned to gather three months of feedback and analyse the data to implement further actions to improve patient satisfaction scores.
- CQC comment cards completed prior to the inspection were positive about the practice and accessing services, with only two out of 17 commenting on difficulties in getting appointments.

Source	Feedback
CQC Comment Cards	A total of 17 comment cards were completed. Two comment cards commented on the difficulty in accessing appointments via telephone.
NHS Choices	The practice had received a total of nine comments in the past 12 months. Four comments related to access and the difficulty in getting appointments.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice management team were able to demonstrate that complaints were being used to drive continuous improvement. All complaints were documented and responded to in a timely manner. • Complaints were discussed and shared with the team as part of the practice's process of shared learning. • Information about how to make a complaint or raise concerns was available at reception. There was a complaints policy in place. • The practices complaints policy reflected NHS complaints guidelines and provided patients with further information if they wanted to escalate their concerns further. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Waiting time to see GP and dissatisfaction of consultation.	<ul style="list-style-type: none"> • A discussion was held with the GP on the consultation. • A review of patients' medical records was carried out. • A letter of apology was sent to the patient and the GP offered to arrange an appointment with the patient to discuss the complaint.
Patient unhappy about being removed from practice list.	<ul style="list-style-type: none"> • A review of the practice policy was completed to ensure procedures had been followed appropriately. • Letter sent to patient to explain the reason for removal. • Discussion with practice staff to ensure patients are clear on the reasons for removal.

Well-led

Rating: Good

The practice was rated as inadequate at the last inspection in June 2019. At the time of this inspection the Principal GP was absent from the practice however the contingency arrangements the leadership team had implemented ensured patients continued to receive appropriate care and treatment. At this inspection we found the practice had acted on the identified breaches and had implemented processes and procedures to mitigate future risks ensuring governance processes had been strengthened.

Leadership capacity and capability

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

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

Explanation of any answers and additional evidence:

- The practice was situated in one of the most deprived areas according to data provided by Public Health England. The practice had a realistic strategy and supporting objectives to respond to these challenges as well as maintaining quality and sustainability.
- Staff we spoke with explained that the GPs and managers were visible and approachable. Staff described the practice team as supportive. The Principal GP was absent from the practice and new GPs were currently leading the practice with the support of the management team. They demonstrated a genuine passion to tackle health inequalities and to improve the practice. There was a systematic approach with improved governance arrangements when working with stakeholders to improve outcomes
- The management team had maintained the sustainability of the practice with the changes in clinical leadership and had ensured that all staff were aware of all new policies and processes that had been implemented. This was confirmed through discussions with the staff who highlighted that regular updates had been received and future plans were discussed at practice meetings.
- Staff reported that they felt well led and part of a team. There was strong collaboration and support across the team and a common focus on improving the quality of care and people's experiences.
- Staff met regularly to discuss any issues or complex cases and regular peer support had been implemented to ensure staff were well supported and to provide the opportunity to share updates with staff and discuss any issues.
- We found at the last inspection that clinical staff were issuing Statement of Fitness to Work notes (also known as fit notes) without the appropriate authorisation. The practice was able to demonstrate that only authorised clinicians were now issuing these notes and policies had been implemented to ensure all staff were aware of their roles and responsibilities and did not act outside of their scope.
- At the last inspection we were informed that the Registered Manager had not been in the country for quite some time. The practice was in the process of changing the partnership and the Registered Manager. We were provided evidence to demonstrate that plans were in place to finalise partnership arrangements.

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: <ul style="list-style-type: none"> • The practice core values was quality care, patient safety and patient satisfaction. This was supported by feedback we received from patients during the inspection. • The practice mission statement was to deliver high quality and effective care to all patients, tailored and responsive to the needs of the local population. • Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy and applied this in their role. 	

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:	

- Quality standards along with other information such as incidents and complaints were discussed at regular clinical and staff meetings
- There was a strong emphasis on the safety and well-being of staff. Due to the significant changes the practice had undergone with the absence of the principal GP, the managers and staff told us that information sharing had been strengthened.
- Staff were very positive about working at the practice. Staff told us they had received constant support from the GPs, managers and team. There was a positive attitude throughout the entire workforce which enabled the smooth running of the practice.
- Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process.
- The practice encouraged staff to report incidents and share learning. Staff told us there was a 'no blame' culture and staff were well supported when reporting incidents.

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

Source	Feedback
Staff	Staff told us that the leadership team were supportive and approachable. With the absence of the Principal GP, staff said they had been kept up to date with all changes and regular meetings were being held to give staff the opportunity to ask questions and clarify any concerns they had.

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:

- The practice had strengthened its systems and processes following the last inspection to ensure appropriate governance arrangements were in place to support the safe and appropriate care for patients.
- Communication was effective and organised through structured, minuted meetings. The management team had positively embraced the challenges identified and ensured governance and performance management arrangements were proactively reviewed and reflected best practice.
- Regular clinical meetings had been implemented to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. There was a good relationship with community teams to ensure patients received effective co-ordinated care.
- The practice had introduced a range of systems to ensure the practice had acted on previous identified breaches and to mitigate further risk. The management team ensured processes were co-ordinated and any changes were implemented through a team approach by regular communication with all staff.

- There was an open culture within the practice, the systems for reporting and investigating incidents and complaints had been improved to ensure changes were embedded and learning was shared effectively with the team. The practice encouraged the reporting of incidents, however small, to identify ways in which the practice could continually improve.

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:	
<ul style="list-style-type: none"> • Due to the concerns identified at the previous inspection, the practice had implemented a risk stratification process to review and act on each breach and concern and prioritise those areas most at risk first. • Incident reporting was integral to learning and improvement. The practice used all safety concerns including incidents and complaints as a base to review and manage all possible risks. The management of risk was demonstrated as a team effort and all the staff were proactive in ensuring risks were mitigated. • The management team with the support of the new and existing clinical team had completely reviewed all their systems and processes to ensure quality and sustainability were assessed and embedded across the whole practice. • The practice had a system to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place. • Performance and risk were managed by the leadership team. Regular meetings were held to review quality standards were being met and quality and risk was being managed appropriately. These were monitored along with complaints, significant events, safety alerts and governance management processes. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Due to the concerns identified at the previous inspection, the practice had reviewed patients records to ensure clinical coding was appropriate. • A range of safety mechanisms had been implemented to ensure risks were mitigated. This included regular reviews of all information to ensure to was accurate and timely and a comprehensive range of risk assessments to ensure patient safety. • The practice used clinical data to drive performance and demonstrate improved outcomes for patients. This included clear roles for the clinical team. This enabled the team to assess and monitor the care and management of patients to ensure they received a co-ordinated care approach and were receiving the appropriate reviews. • The practice had introduced a messenger application to share information. This included safety alerts, updates and any other relevant information. • Regular monthly meetings were held to discuss incidents and significant events and share learning to mitigate future risks. • Weekly clinical meetings were held to discuss clinical guidelines and updates and these were shared with the wider team to ensure changes were actioned. 	

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:	
<ul style="list-style-type: none"> • The practice had accessed peer support through the Clinical Commissioning Group (CCG) . The peer support programme gave the new clinical team guidance on how to address the identified breaches and prioritise improvements. • Staff meetings had been strengthened to ensure all learning outcomes were shared with the practice team. • Following concerns identified at the previous inspection of no clear safeguarding registers being in place, the practice had carried out a review of all the safeguarding registers and implemented processes to ensure the registers were maintained. The practice had invited the CCG lead for 	

safeguarding to review the safeguarding process and to offer support in ensuring the registers were effective.

- All comments received on the friends and family test were reviewed and shared with staff. The outcome of the national patient survey was discussed at staff meetings and on display on the staff noticeboards.
- The practice had an active patient participation group that met on average every three months. The group had supported the practice in organising events and raising money for local charities, including carers of dementia patients.

Continuous improvement and innovation

There was evidence of 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:	
<ul style="list-style-type: none"> • Following the previous inspection the practice had acted on the identified breaches and concerns and had implemented a programme of improvement and learning which was shared with the practice team. This included regular peer support of the nursing team, weekly clinical meetings and structured staff meetings. • Identified risks had been acted on, these included a review of the safeguarding registers to ensure they were being maintained appropriately and patients on high risk medicines had been invited for review. • Continuous monitoring of training and development was carried out by the management team and learning from events, complaints and compliments was shared to enable lessons to be learnt and improvements to services were acted on. The practice continued to develop and implement processes for learning from incidents and reviews of patients with complex care needs to ensure patients were receiving appropriate care and treatment and risks were minimised. • A monthly inhouse survey had been introduced to gather patient feedback on the changes to services that were being implemented. This included improvements made to accessing the practice. • A programme of audits was in place to monitor service provision and quality outcomes. 	

Examples of continuous learning and improvement

One of the new GPs to join the practice and the advanced nurse practitioner had enrolled on a leadership course. The practice had plans in place to strengthen the leadership team and ensure the systems and processes put in place continued to be effective to mitigate risk and demonstrate quality improvement.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. 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.