

# Care Quality Commission

## Inspection Evidence Table

**Dr B Sahota & Dr K Cassam (1-552630076)**

**Inspection date:** 4 February 2020

**Date of data download:** 20 January 2020

## Overall rating: Good

The overall rating has moved to good from a previous rating of requires improvement. This was because, the provider took action to strengthen processes for monitoring patients' health in relation to the use of medicines. The provider took action to ensure joint care planning with secondary care providers were being carried out to support effective management of patients diagnosed with a mental health related illness.

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

## Safe

## Rating: Good

### 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:	
Clinical safeguarding leads attended safeguarding meetings as well as vulnerable adults' meetings. The practice had completed the local Clinical Commissioning Groups (CCG) safeguarding toolkit which enabled the practice to ensure safe and effective systems and processes were in place. The practice had a designated member of the administration team who supported clinicians with non-clinical coordination of safeguarding arrangements such as meetings and maintaining accurate safeguarding registers.	

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

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: December 2019	Y
There was a record of equipment calibration. Date of last calibration: 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. Date of last check: 13/08/2019	Y
There was a log of fire drills. Date of last drill: 17/01/2020	Y
There was a record of fire alarm checks. Date of last check: 03/02/2020	Y
There was a record of fire training for staff. Date of last training: all within the last 12 months	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 15/04/2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 14/07/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14/07/2019	Y
Explanation of any answers and additional evidence:	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 22/03/2019	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: Audits we viewed showed the practice had scored 98% in their Infection Prevention Control (IPC) audit.  We viewed mandate forms for the collection of clinical waste which demonstrated safe disposal of clinical waste.	

## 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
Explanation of any answers and additional evidence:	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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:  At our February 2019 inspection, we found that the practice was in the early stages of implementing a process for managing all incoming clinical correspondence to alleviate pressure on the clinical staff. This involved non-clinical staff summarising clinical correspondence. The practice developed lists and associated workflow charts to enable staff to identify letters which needed to be highlighted for clinicians' attention. During this inspection, we saw that staff had continued to receive support to carry out this extended role safely. There was clear clinical oversight of the entire process and we saw that the process was embedded.	

## 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)	0.97	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)	6.5%	7.4%	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)	4.42	5.13	5.60	Variation (positive)
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)	1.69	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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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> <p>Following our previous inspection, additional time was allocated for staff to run reports and carry out audits to gain assurance that blood monitoring had been carried out in secondary care and results available prior to authorising prescriptions.</p>	

## 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:	16
Number of events that required action:	16
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
Blood pressure (BP) reporting	BP protocol in place; and staff reminded to follow hypertension protocol and to document and pass all relevant information over when referring to another clinician.
Incomplete blood test	<p>The practice provided relevant staff with Continual Professional Development (CPD) training on medicine monitoring to improve their knowledge.</p> <p>The medicine management team reviewed the blood monitoring process and developed a set format of what blood tests were needed and how often.</p>

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> <p>The practice operated a process for receiving and disseminating safety alerts throughout the practice which were all accessible using an electronic information management system. The management team received safety alerts and sent them out to clinicians who were then required to sign to confirm receipt of the alert. We saw evidence of appropriate actions carried out in response to alerts relating to national outbreaks.</p>	



## Effective

## Rating: Requires improvement

The practice has been rated requires improvement for providing effective services because:

Exception reporting rates for patients diagnosed with a long-term condition remained above local and national averages for two consecutive Quality Outcome Framework (QoF) years, the uptake of child hood immunisation and cervical screening was below local and national averages. There was limited evidence of clinical audits to support the monitoring of clinical outcomes of care and treatment.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: The practice demonstrated awareness of their prescribing data and took action to address areas where prescribing was above local and national averages. Staff explained to reduce the quantity of Hypnotics prescribed the practice provided patients experiencing difficulty falling asleep with information such as introducing regular bedtime routines to help patients wind down and prepare for bed sleep. The practice had introduced a new policy as well as working with patients identified as having a long history of being prescribed Hypnotics. Data showed, the quantity of Hypnotics prescribed had reduced in the last two years.	

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>	1.76	0.74	0.74	Variation (negative)

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

**Population group rating: Requires improvement.**

### Findings

- 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.
- The practice demonstrated awareness of Quality Outcome Framework (QoF) indicators where exception reporting rates were not in line with local and national averages. Clinicians explained that there were patients who were on the maximum therapy; therefore, further medical intervention identified as not appropriate. However, clinical staff explained a further review of diabetes and respiratory indicators would be undertaken to improve care for this patient group.
- 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)	86.4%	79.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	20.5% (76)	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 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QoF)	85.4%	78.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	31.4% (116)	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>	92.0%	81.1%	81.3%	Variation (positive)
Exception rate (number of exceptions).	22.4% (83)	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>	80.7%	76.4%	75.9%	No statistical variation
Exception rate (number of exceptions).	28.8% (115)	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>	90.7%	91.3%	89.6%	No statistical variation
Exception rate (number of exceptions).	23.0% (32)	10.9%	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)	83.2%	83.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.2% (30)	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) (QoF)	83.1%	88.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	6.7% (6)	7.2%	5.9%	N/A

#### Any additional evidence or comments

There were clinical areas where QoF exception reporting remained above local and national averages. (Patients can be exception-reported from individual indicators for various reasons, for example if they do not attend appointments or where the treatment is judged to be inappropriate by the GP such as medication cannot be prescribed due to side-effects). Patients could also be exception reported if they declined treatment or investigations. Data taken from the 2018/19 QoF year showed exception reporting rates for diabetes and respiratory clinical indicators showed exception reporting rates had increased since the previous QoF year. Exception reporting rates for mental health related indicators had also increased; however, remained comparable to local and national averages. Clinical leads were unable to demonstrate actions taken to investigate exception reporting; however recognised figures were high and unlikely to be solely down to patients who were on the maximum therapy.

Non-clinical staff described the practice call and recall process which included sending up to three appointment invite letters as well as telephone contact and opportunistically targeting patients. Staff explained that practice had a difficult patient group and provided examples of where patients had refused to engage in interventions despite being provided with information regarding the benefits of engaging in treatment.

Patients had access to two respiratory nurses with one achieving an Association for Respiratory Technology and Physiology (ARTP) certification in Spirometry. Staff explained plans were in place to commence providing access to a designated clinic from February 2020 where patients would be booked in with members of the nursing team on Thursdays between 6.30pm and 8.30pm as well as Saturday mornings between 7.45am and 11am where patients would have access to a respiratory and COPD trained nurse.

#### Families, children and young people

#### Population group rating: Requires improvement

#### Findings

- The practice has not met the minimum 90% target for four of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.

The practice demonstrated awareness of their data and were taking action to improve uptake.

- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	53	60	88.3%	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)	36	41	87.8%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	34	41	82.9%	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)	36	41	87.8%	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

During our previous inspection staff demonstrated an awareness that the uptake of childhood immunisations had declined. Since our previous inspection, the practice had acted to improve uptake with immunisations, however were not able to demonstrate that actions had been effective. The nursing team explained actions taken to identify children whose parent or legal guardian would no longer be contacted by child health services and sent out appointment letters inviting these patients to attend the practice. Non-clinical staff communicated with health visitors in the event of further missed appointments.

Staff explained when parents attended for the eight-week baby check; immunisations were either carried out during this appointment or children were booked an alternative appointment and parents were reminded to present their children in four weeks' time. The practice held designated childhood immunisation clinics as well as carried out immunisations opportunistically.

Television monitors were in patient waiting areas raising awareness about the benefits of child immunisations. Staff received training and demonstrated how they maintained their knowledge of the immunisation schedule. This enabled the nursing team to provide parents with appropriate information so that they can make an informed decision.

The practice used alerts on the clinical system to identify children who had not been vaccinated so that immunisations could be carried out opportunistically or discussions with parents about the importance of

immunisations. Staff ensured during the new patient registration process, child immunisation information were transferred to patients' records. The practice also introduced a spreadsheet to support the tracking of children. There were designated staff responsible for managing the spreadsheet as well as building relationships with families to encourage uptake.

Members of the non-clinical management team attended webinar training to support the management of childhood immunisation.

Following our inspection, members of the management team described work which staff had been carrying out since our inspection to improve the uptake of childhood immunisations.

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

## Population group rating: Requires improvement

Findings	
<ul style="list-style-type: none"> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li> <li>The practice's uptake for cervical screening was below local and national targets. Published data showed the update had slightly declined since our previous inspection. Staff explained actions taken such as increased access to screening appointments.</li> <li>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.</li> <li>Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.</li> </ul>	

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)	69.8%	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)	58.1%	64.4%	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)	42.1%	44.9%	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)	80.6%	73.2%	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)	44.4%	53.2%	53.8%	No statistical variation
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### Any additional evidence or comments

The practice operated a call and recall system, identified patients who failed to attend their cervical screening appointment were sent up to three letters as well as telephone contact to discuss reasons for none engagements. Clinicians actively discussed screening during new patient health checks as well as routine consultations. The practice operated a failsafe system which was managed by the nursing team to monitor whether results were received for every sample sent as well as ensuring abnormal results were followed up appropriately.

The practice had a comprehensive cancer awareness promotional board which was located in the patient waiting area. There was a range of supporting information, leaflets which patients were able to take away, information on the benefits of early diagnoses and screening as well as instructions on how to do the bowel screening kit. Posters also encouraged patients to speak to a member of staff in order to book cervical screening appointments as well as what to do if patients failed to attend their screening appointment. The practice had access to information in different languages which staff would access when required.

Patients were able to access screening throughout the day. Staff explained from February 2020 cervical screening would be available at the practice on Saturdays. The practice had Hub arrangements in place which enabled staff to offer additional screening appointments at a neighbouring practice outside of normal working hours.

### 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.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability; there were policies in place which enabled homeless people and travellers to register with the practice.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. The practice followed up patients with alcohol problems following hospital discharge.
- The practice reviewed young patients at local residential homes.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months. There were notices on a television monitor within the waiting area as well as posters promoting dementia awareness.
- 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)	85.3%	92.1%	89.4%	No statistical variation
Exception rate (number of exceptions).	9.3% (7)	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) (QOF)	82.9%	92.0%	90.2%	No statistical variation
Exception rate (number of exceptions).	6.7% (5)	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) (QOF)	91.3%	86.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	8.0% (2)	5.8%	6.7%	N/A

### Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of non-clinical processes to support the care provided. However, there was limited evidence of clinical audits to support the monitoring of clinical outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.2	546.8	539.2
Overall QOF score (as a percentage of maximum)	98.8%	97.9%	96.7%
Overall QOF exception reporting (all domains)	11.0%	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.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice carried out an improvement programme activity to establish whether staff skill mix was being used effectively. The process enabled the practice to allocate staff specific roles; introduce process maps to enable non-clinical staff to signpost patients to the correct clinicians and services. To assess the impact the practice carried out an audit during September 2019 to identify whether patients were being seen by the most appropriate clinical staff. The practice identified 50% of patients booked in with the GPs were minor ailments which could have been seen by a paramedic or nurse practitioner. Actions taken included enabling a member of the reception team to train as a phlebotomist; increase the number of appointments available for pharmacists to see minor ailments. Staff received training to support them when asking questions to enable effective signposting. The practice also developed a crib sheet of different conditions which clinicians were able to see. As a result, the practice was able to increase GPs appointment time from 10 minutes to 15 minutes.

The practice carried out an audit to see whether staff were identifying patients to be placed on the palliative care register and that patients were dying at their preferred place in line with their end of life care plan. Audits carried out in June 2018 and re-audit in March 2019 showed an increased awareness in identifying patients who should be placed on the palliative care register and the number of patients who died at their preferred place.

#### **Any additional evidence or comments**

The practice provided evidence of clinical audits which demonstrated quality improvements. Majority of audits were carried out between 2016 and 2018. The practice was unable to provide a structured programme of clinical audits which demonstrated they were targeting specific areas where performance was not in line with local and national averages such as QoF exception reporting. Clinical staff we spoke with recognised this was an area for further improvement.

## Effective staffing

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

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

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective	Y

processes to make referrals to other services.	
<p>Explanation of any answers and additional evidence:</p> <p>Following our previous inspection, the practice took action to improve coding to reflect that patients had care plans in place. Data from the 2018/19 QoF year showed improvements in the number of patients diagnosed with a mental health related condition who had a care plan in place.</p>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The management team explained that the practice had access to a pharmacist employed by the providers who reviewed quality indicators. The practice had access to two social prescribers, who staff actively referred into. Staff explained whilst looking at reducing the number of Hypnotics prescribing the practice aimed to refer identified patients to the social prescriber. The practice had made arrangements to commence these clinics in February 2020 and we saw evidence of meetings where social prescriber access had been discussed.</p> <p>Clinicians were proactive in promoting healthy eating, exercise on prescription as well as referral to national diabetic programs.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.0%	95.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.2% (3)	0.7%	0.8%	N/A

## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence:	



## Caring

**Rating: Good**

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Training records we viewed showed that staff had completed equality and diversity training.	

CQC comments cards	
Total comments cards received.	48
Number of CQC comments received which were positive about the service.	42
Number of comments cards received which were mixed about the service.	Six
Number of CQC comments received which were negative about the service.	Nil

Source	Feedback
CQC Comment cards	Patients felt that all clinical staff were friendly, efficient and would recommend this surgery to a friend or family. Comments also showed that patients felt, staff were professional and went the extra mile to respond to their needs.
Patient Participation Group (PPG) feedback	Members of the PPG explained that the practice was very open and honest, and staff were accommodating to patients' needs. PPG felt staff were caring and treated patients with dignity and respect.

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5264.0	451.0	124.0	27.5%	2.36%

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)	91.4%	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 good at treating them with care and concern (01/01/2019 to 31/03/2019)	91.4%	85.5%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	100.0%	94.4%	95.5%	Variation (positive)
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)	93.2%	80.1%	82.9%	No statistical variation

### Any additional evidence or comments

The National GP survey showed patient's satisfaction over time had improved in areas such as how good professionals were at listening to patients, treating them with care and concern as well as patients overall experience of the practice.

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

### Any additional evidence

The practice actively encouraged completion of the friends and family test (FFT). Unpublished data provided by the practice showed FFT completed between January 2019 and December 2019 demonstrated an increase in the number of patients who would recommend the practice to a friend or family from 86% to 96%.

The practice operated a process to receive and record complaints and compliments from various sources such as social media platforms and verbal comments which were shared during practice meetings. Records we viewed showed the practice had received 16 comments. Unpublished data showed 93% of patients had a positive experience. Comments showed patients felt staff were caring, patient and helpful.

### 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:	

Source	Feedback
Completed CQC comment cards	Patients who completed CQC comment cards felt staff proactively responded to their needs and clinicians communicated in a way which enabled patients to understand their conditions and treatment options.

## 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)	96.7%	91.9%	93.4%	No statistical variation

### Any additional evidence or comments

Members of the PPG explained patients were very satisfied with the service being provided and were happy with their engagement with additional clinical staff who had joined the nursing team.

	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:	

Carers	Narrative
Percentage and number of carers identified.	The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 108 patients as carers (2% of the practice list).
How the practice supported carers (including young carers).	Information leaflets and posters regarding support services were available in the reception area. Staff we spoke with explained that carers were provided with advice, offered flu vaccinations and stress level reviews. Those carers who were not registered patients were also able to access general health care as a temporary patient. Unpublished data provided by the practice showed 73% carers received a flu vaccination in the last two years.
How the practice supported recently bereaved patients.	<p>If families had suffered bereavement, their usual GP contacted them, and they were invited in to speak with the GPs or sent a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.</p> <p>The practice had bereavement packs which included information and details of support services available for the family. Information to support families during times of bereavement were also available by accessing the practice website.</p>

## 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
Explanation of any answers and additional evidence:	

# Responsive

Rating: Good

## Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	7.15am – 6.30pm
Wednesday	7.15am – 6.30pm
Thursday	7.30am – 6.30pm
Friday	7.30am – 6.30pm
Appointments available:	
Monday	7.15am to 11am and 3.30pm to 6.30pm Nurse 7.30am – 1pm and 2pm – 6.30pm
Tuesday	7.15am to 11am and 2pm to 3.30pm Nurse 7.30am – 1pm and 2pm – 6.30pm
Wednesday	7.15am to 11am and 3.30pm to 6.30pm Nurse 7.30am – 1pm and 2pm – 6.30pm
Thursday	7.30am to 11am and 2pm to 6.30pm Nurse 7.30am – 1pm and 2pm – 6.30pm
Friday	7.30am to 11am and 3.30pm to 6.30pm Nurse 7.30am – 1pm and 2pm – 6.30pm

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5264.0	451.0	124.0	27.5%	2.36%

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)	100.0%	93.2%	94.5%	Variation (positive)

### Any additional evidence or comments

Extended opening hours were provided at the practice from 7.15am on Mondays, Tuesdays and Wednesdays; and from 7.30am Thursdays and Fridays. Evening and weekend appointments were available as part of a Hub arrangement from 6.30pm to 8pm Monday to Friday, 9am to 1pm Saturdays and 10am to 1pm Sundays.

Staff explained to further improve patient access; from February 2020 the practice would be providing Hub appointments which patients could access at the practice; Monday to Thursday from 6.30pm to 8.30pm; as well as Saturday appointments from 7.45am to 11am. Virtual appointments with GPs and Pharmacists were scheduled to commence in March 2020.

National GP survey data over time showed patients satisfaction with appointments had improved from 92% to 100%.

The practice provided a phlebotomy service which enabled the practice to collect blood samples from patients to help diagnose illnesses. Staff explained this eliminated the need for patients to access secondary care for this service. This benefited all six population group.

## Older people

## Population group rating: Good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.



## People with long-term conditions

Population group rating: Good

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- Staff received Gold Standard Framework (GFS Going for Gold) training and were actively using these skills to ensure patients receive the right care at the right time in the right place. Staff were using this knowledge to support open conversations with patients and their families at an early stage about their advanced end of life care planning.

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- Additional nurse appointments were available until 6.30pm Monday to Friday and at a local Hub until 8pm Mondays to Fridays as well as weekends until 1pm for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.
- The practice provided long acting reversible contraception. The practice website promoted self-care and signposting to community sexual health services.

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

**Population group rating: Good**

### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6.30pm Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday 9am until 1pm and Sunday 10am until 1pm.
- Virtual appointments with GPs and Pharmacists were scheduled to commence in March 2020.
- Patients had access to on-line appointments and prescription ordering service. The practice was able to send electronic prescriptions to any pharmacy signed up to the service.
- Depression questionnaires were available on the practice website; the practice used this to monitor the severity of depression and response to treatment as well as make tentative diagnoses of depression.
- The practice provided a phlebotomy service which enabled the practice to collect blood samples from patients to help diagnose illnesses. Staff explained this eliminated the need for patients to access secondary care for this service. This benefited all patients including this population group.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including 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.
- The practice had processes in place which enabled staff to refer patients to social prescribers. There were information leaflets in patient waiting areas advising them of this.
- The practice provided a phlebotomy service which enabled the practice to collect blood samples from patients to help diagnose illnesses. Staff explained this eliminated the need for patients to access secondary care for this service. This benefited all patients including this population group.

**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 nursing team carried out physical health reviews for patients diagnosed with a mental health related illness and followed up non-attenders. Records showed that care plans which covered patients physical and mental health were being carried out as part of the review.
- The practice provided a phlebotomy service which enabled the practice to collect blood samples from patients to help diagnose illnesses. Staff explained this eliminated the need for patients to access secondary care for this service. This benefited all patients including this population group.

## 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
Explanation of any answers and additional evidence:	

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)	79.2%	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)	77.4%	61.4%	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)	75.6%	61.2%	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)	77.8%	69.0%	73.6%	No statistical variation

Source	Feedback
CQC comment cards	Patients who completed the CQC comment cards felt they were able to get through to the practice by telephone without difficulty, get an appointment when needed and were satisfied with the appointment waiting times.
PPG Feedback	Members of the PPG felt that the recruitment of additional clinical staff within the nursing team and changes made within the practice has increased the practice ability to provide timely services.

	PPG felt that the online booking service was very useful, they were able to get an appointment when needed and found the phlebotomy service held at the practice was very convenient.
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## 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.	Two
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Nil

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	

Example(s) of learning from complaints.

Complaint	Specific action taken
Communicating test and investigation results	Complainant received an apology. The practice advised clinical staff to be more specific when making comments on reports, results or secondary care letters.

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The management team were aware of challenges faced within the local community due to deprivation and health inequalities. The providers had a realistic strategy and supporting objectives to respond to these challenges. For example, the providers were aware of areas which they needed to improve such as becoming more efficient with specific clinical codes, consistency amongst staff and managing confidentiality within reception which they were actively addressing. To address challenges members of the management team attended and completed a Quality Improvement (QI) programme around implementing change within the work environment.</p> <p>Leaders explained the QI programme enabled them to identify leadership skills which helped when chairing meetings and involving staff in improvement activities. For example, staff were involved in developing a process map to identify work flow as well as identified staff's strengths and weaknesses. Staff explained they felt more empowered and included in changes within the practice and staff were allocated lead responsibilities which complimented their strengths. Data from the 2019 national GP patient survey showed actions carried out by the practice had a positive impact on patient satisfaction in questions relating to confidants and trust and meeting patients' needs which was above local and national averages.</p> <p>Staff we spoke with explained that the partners and management team were visible and approachable. Staff described the practice team as a family and very supportive.</p>	

### 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	Y

them.	
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy which they applied to 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
<p>Explanation of any answers and additional evidence:</p> <p>Staff explained they felt a valued member of the practice team. Members of the practice management team demonstrated how they used skills gained following the completion of a QI programme in meetings to better involve and actively engage staff in discussions regarding changes within the practice.</p> <p>Records we viewed showed that patients who were affected by an incident or were unsatisfied with the service provided received an apology.</p>	

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

Source	Feedback
Staff	Clinical and non-clinical staff explained that the management team was very supportive and promoted equality and diversity for all staff members.
Policies	Practice policies were in place which supported leaders to act on behaviours and performance inconsistent with the vision and values of the practice.
Policies and staff interviews	The practice had processes which enabled the management team to take action to promote equality and diversity. For example, flexible working options were available, managers were aware of options available to ensure staff maintained a work life balance and staff were confident that they would receive support if they needed time off to care for a child or family member.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Structures, processes and systems of accountability were clearly set out, understood and effective. These included management of environmental risks, monitoring of training needs as well as management of partnership and joint working arrangements.</p> <p>The management team had an understanding of performance and there were proactive actions taken to improve and streamline workflow within the practice to enhance the quality and efficiency of service delivery. In particular, the QI programme undertaken by the management team enabled leaders to review workflow as well as identify whether the practice was effectively using staff skill mix. This resulted in non-clinical staff being allocated lead roles in areas such as coordinating childhood immunisation, clinical correspondence, managing safeguarding registers and ensuring staff were competent in signposting patients to the correct clinician. The practice found that this resulted in ensuring patients were booked in with the most appropriate clinician to deal with their clinical needs which in turn increased GP availability. The practice developed a range of process maps to support staff in their role and staff felt involved in changes and practice development. National GP patient survey results showed areas where patient satisfaction was above local and national averages.</p>	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks. There were some processes to manage issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
We saw evidence of clinical audits which had been carried out, between 2016 and 2018, there were some audits carried out after this time, however we found audits were not used to target specific areas where performance was not in line with local and national averages such as QoF exception reporting. During our previous inspection, the practice was unable to demonstrate a clear and structured approach to exception reporting or provide evidence of an action plan aimed at addressing high exception reporting rates. At this inspection, staff demonstrated awareness of some of the root causes which impacted on exception reporting; however, there was limited evidence to demonstrate whether clinical leads had developed an action plan to address this area.	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
There was limited evidence to demonstrate that the practice used data effectively in areas such as cervical screening, childhood immunisations and QoF exception reporting to improve performance in these areas.	

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

## Engagement with patients, the public, staff and external partners

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

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

Feedback from Patient Participation Group.

Feedback
Members of the PPG we spoke with during our inspection, felt involved in any discussions regarding any proposed changes and provided examples such as Hub arrangements and introduction of social prescribers. The PPG explained the practice responded to feedback. For example, the patient waiting area had been improved by updating notice boards to increase the amount of information about local support services. Door stops were placed on entrance doors to enable better access to patients with a disability.

Any additional evidence
Staff we spoke with felt that the management team was accessible and explained that their opinions regarding the running of the practice were valued and had been taken seriously. The management team had an open-door policy which encouraged timely interaction with clinical and non-clinical staff.

## Continuous improvement and innovation

**There were some systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: Oversight of systems for managing significant events and complaints showed that these were investigated and responded to in a timely manner with clear evidence of shared learning.	

### Examples of continuous learning and improvement

The management team had used a general practice improvement leads programme to review workflow as well as identify whether the practice was effectively using staff skill mix. This enabled the practice to place non-clinical staff in designated lead roles in areas such as coordinating childhood immunisation, clinical correspondence, managing safeguarding registers and ensuring staff were competent in signposting patients to the correct clinician.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.