

Care Quality Commission

Inspection Evidence Table

Wibsey and Queensbury Medical Practice (1-540224625)

Inspection date: 3 March 2020

Date of data download: 2 March 2020

Overall rating: Good

At the inspection on 2 July 2019 we rated the practice as inadequate overall because:

- The practice did not have clear systems and processes to keep patients safe.
- The practice did not have adequate systems of governance.
- The care and treatment provided to patients living with some long-term conditions and those experiencing mental health difficulties was below local and national standards.

At this inspection on 3 March 2020 we saw that the practice had responded to the issues previously identified and had improved their governance systems. We rated the practice as good overall and for five of the population groups.

We rated the practice as requires improvement for providing well-led services and the population group 'people with a long-term condition' as we found that some of the governance systems had not been fully embedded at the time of our inspection and although the provider had taken steps to improve performance against the Quality and Outcomes Framework (QoF) long term conditions indicators, the validated data was still below average. The practice was able to demonstrate an improvement in the 2019/20 data, however this data had not been validated at the time of our inspection.

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

Safe

Rating: Good

At the inspection on 2 July 2019 we rated the practice as inadequate for providing safe services. This was because:

- There was no central oversight of safeguarding training for clinical staff.
- The safeguarding policy did not confirm the required levels of training and the provider was unaware of guidance published in January 2019 regarding appropriate levels safeguarding of training for staff.
- Staff immunization records were incomplete.
- There were issues with the fire risk assessment and the practice did not have a health and safety risk assessment.
- Arrangements for the management of infection prevention and control, including policy were absent or insufficient.
- There was inconsistent monitoring of emergency equipment.

At the inspection on 22 January 2020 we found that a number of improvements had been made. At this inspection on 3 March 2020 we saw that these improvements had been sustained. However; we identified some areas where oversight of the process was lacking.

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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had comprehensive safeguarding policies in place for both adults and children. The policies contained guidance for staff and details of local safeguarding authorities.</p> <p>We reviewed a sample of training certificates to confirm that staff had received safeguarding training to the appropriate level.</p> <p>We reviewed a statement from a locum GP working at the practice which outlined a situation where concerns had been escalated to the safeguarding team. The statement demonstrated that reception staff had obtained appropriate information and shared this with the GP which supported their decision to escalate.</p> <p>The practice had a system in place to highlight any patient at risk of or suffering from abuse on the clinical system. However; at the time of our inspection there was no formal safeguarding register in place. We were advised that the safeguarding lead worked from the health visitors and community teams registers. We received documentary evidence following our inspection to confirm that a safeguarding register had been implemented.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider had a locum policy in place which outlined the various checks and documentation that should be obtained prior to employment. We reviewed a sample of electronic recruitment files for locum GPs and saw that these contained all relevant information. However; at the time of our inspection we noted that the policy did not make reference to specific checks and documentation required in order to verify the locums identity. The provider submitted evidence following our inspection to confirm that this had been updated to clearly outline the documents to be reviewed in order to confirm identity.</p> <p>The practice had implemented a new work health assessment form which included information about general health, screening and vaccinations. All new staff members were required to complete the form which was then sent to the local occupational health department to undertake screening and risk assessment. The practice had updated this process following our inspection in January 2020 and now requested that all communication sent to the staff member from the occupational health department was shared with the practice manager. Existing staff members had been asked to contact their own GP to obtain up to date status regarding immunisation status and the practice had a spreadsheet containing this information. Any staff member who did not have access to this information would be offered appropriate screening.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 07/12/2019	Yes
There was a record of equipment calibration. Date of last calibration: 06/03/2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 30/10/2019	Yes
There was a log of fire drills. Date of last drill: 20/02/2020	Yes
There was a record of fire alarm checks. Date of last check: 17/07/2019	Yes
There was a record of fire training for staff. Date of last training: Ongoing	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 17/07/2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: All staff members had access to fire training via the eLearning module. We reviewed the staff training matrix which confirmed that all staff were up to date with this training.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 18/07/2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18/07/2019	Yes
Explanation of any answers and additional evidence: The provider had appropriate health and safety risk assessments in place and we were able to review a sample of these. For example; a pregnant worker directive assessment tool and the legionnaire risk assessment. The provider had a system in place to ensure a visual check of the premises was carried out twice daily. This was to identify any issues such as equipment being left out, any light bulbs that required changing and other potential risks to patients.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 15/01/2020 (internal) July 2019 (externa)	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection we reviewed a sample of patient records. We found that the practice did not have individual care plans for patients, however there were systems in place to ensure good communication with community matrons and nurses and the practice had access to care plans produced in the community via the patients' electronic clinical records.</p> <p>We saw records to evidence that all staff had received mandatory training. For example; CPR and sepsis training.</p>	

The clinicians we spoke with on the day demonstrated that there were aware of how to deal with severe infections.

The practice had a triage system in place which enabled all patients, requiring urgent clinical review, to access a same day appointment.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed a sample of referral letters on the day of inspection and saw that the practice used standard templates which contained specific and adequate information.</p> <p>The practice had implemented a new process for the management of test results. We reviewed the clinical system on the day of inspection and saw all test results had been actioned within a 24-hour period.</p>	

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)	1.02	0.95	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). (01/01/2019 to 30/11/2019) (NHSBSA)	4.8%	5.2%	8.4%	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 (01/07/2019 to 30/11/2019) (NHSBSA)	5.30	5.51	5.56	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2019 to 30/11/2019) (NHSBSA)	2.51	2.43	2.07	No statistical variation

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

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There was a policy in place for monitoring patients' health in relation to the use of medicines including high risk medicines.</p> <p>We saw that the provider had emergency medication on site and there was a system in place to check stock levels and expiry dates. We found that the provider had syringes and needles to administer emergency medication however; we found that some of the syringes and needles were out of date. We discussed this with the provider on the day of the inspection and these were removed immediately.</p> <p>We saw that there was a process in place to carry out weekly checks on emergency equipment. However; at the time of our inspection we found that there was an adult defibrillator pad which had expired in December 2019. We noted that replacement pads were available and the expired pad was removed immediately.</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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: The practice had introduced a new system for recording, reviewing and discussing significant events (SEAs) and incidents. We saw evidence of SEA's and incidents being discussed at practice meetings and saw that this was a standard agenda item. However; there was a lack of oversight of incidents and the provider did not have an overall summary of incidents to review and identify any themes and trends. We discussed this with the provider during the feedback session on the day of inspection and were provided with evidence of a spreadsheet being implemented shortly after the inspection.	

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

Event	Specific action taken
Issue with electronic urgent two-week cancer referral which had resulted in a blank referral form being sent to secondary care.	The practice had implemented a system whereby the referring clinician sent a task to reception when sending an urgent referral. The referral was then logged onto a spreadsheet and regularly monitored until an appointment had been allocated.
Patient transport to secondary care booked for the wrong patient.	As a result, the practice had introduced a diary for transport to enable reception staff to obtain appropriate details regarding the patient once the appointment had been booked. For example; name, date of birth, appointment details and booking reference number.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a system in place for receiving MHRA and safety alerts. These were received via NHS mail, stored on the shared electronic drive and forwarded to the practice pharmacist for review and action. We saw evidence that alerts were discussed in practice meetings. However; there was no process in place to record an overview of searches carried out, number of patients affected by any alerts and dates for review. The provider submitted further evidence following our inspection to confirm that a system had been implemented.</p>	

Effective

Rating: Good

At the inspection on 2 July 2019, we rated the practice as requires improvement for providing effective services. The population groups of people with long-term conditions and people experiencing poor mental health (including people with dementia) were both rated inadequate. This was because:

- The care and treatment provided for patients living with the long-term conditions of asthma, COPD and hypertension was significantly lower than local and national standards, as measured by QoF.
- The care and treatment provided for people experiencing poor mental health (including people with dementia) was significantly lower than local and national standards, as measured by QoF.
- The population groups of Older people, Families, children and young people, Working age people (including students) and People whose circumstances make them vulnerable were rated as requires improvement because although we saw examples of good practice, the issues identified under effective also impacted on all population groups.

At this inspection on 3 March 2020 we found that performance against the 2019/20 QoF indicators had significantly improved. However; at the time of our inspection this data had not been validated or published. In addition; the practice had recruited a new practice nurse to increase capacity and ease of patient access for reviews. Therefore, we have rated the practice good for providing effective services and for five of the population groups. However; we have rated the population group 'people with long term conditions' as requires improvement as the validated data available at the time of inspection was still below average.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice held a weekly clinical meeting during which any new guidance was reviewed and discussed. In addition, the practice received updates via the Bradford Clinical Commissioning Group (CCG) Forum. We were informed about a new pathway for patients diagnosed with autism that was to be introduced at the end of March 2020.</p> <p>We reviewed three patient records and found that these contained evidence of a full assessment of the patient and detailed notes regarding the consultation.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2019 to 30/11/2019) <small>(NHSBSA)</small>	0.64	0.51	0.72	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 had regular monthly meetings with the community matron to review the caseload of elderly patients identified as having complex needs and intensive, proactive healthcare input. This enabled them to adopt a holistic approach rather than identification using tools or codes alone.
- 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.
- 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.
- The practice was proactive in primary and secondary cardiovascular prevention, adopting the Bradford Health Hearts recommendations on statins and local guidelines on blood pressure management.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The nursing team worked with patients to provide asthma management plans, COPD reviews and spirometry/reversibility testing as appropriate.
- COPD rescue packs were offered to eligible patients and this was coordinated by the practice pharmacist.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	69.8%	81.2%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.4% (30)	13.4%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.5%	80.7%	78.1%	No statistical variation
Exception rate (number of exceptions).	5.0% (34)	10.6%	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>	73.6%	82.0%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	8.4% (57)	16.4%	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>	56.9%	75.9%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	12.9% (121)	7.1%	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>	57.7%	90.9%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	8.4% (22)	11.6%	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)	73.9%	84.5%	83.0%	Variation (negative)
Exception rate (number of exceptions).	2.3% (35)	4.9%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QoF)	97.9%	91.5%	91.1%	Variation (positive)
Exception rate (number of exceptions).	13.9% (23)	8.1%	5.9%	N/A

Any additional evidence or comments

We discussed the Quality and Outcomes Framework (QoF) areas where the practice had been identified as achieving lower than the Clinical Commissioning Group (CCG) and national average and were advised that this was due to nursing capacity issues which had now been addressed. The practice had recruited a new nurse in May 2019, and this had a positive impact on QoF performance.

We were able to review current performance against the 2019/20 indicators. There had been changes to some of these indicators. However, we noted the following:

At the time of our inspection the practice had achieved 45 out of a maximum of 54 points against the diabetes indicators which equated to 83%.

The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months had increased from 56.9% to 73.2%.

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 had increased from 57.7% to 79.8%.

The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less had increased from 73.9% to 81.7%.

However; at the time of our inspection the 2019/20 QoF period was still ongoing and as such the data had not yet been published or validated.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) targets. The practice had a system in place to encourage parents to bring their child for immunisations, any parent wishing to opt out of the immunisation schedule was required to actively dissent and sign a form to confirm this.

- 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.
- Women of child bearing age prescribed sodium valproate were referred for mandatory counselling to the local epilepsy service.
- 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)	125	134	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	129	133	97.0%	Met 95% WHO based target
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)	130	133	97.7%	Met 95% WHO based target
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)	126	133	94.7%	Met 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>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	72.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	72.0%	67.0%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	60.4%	54.0%	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)	66.7%	68.2%	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)	56.7%	62.7%	53.8%	No statistical variation

Any additional evidence or comments

The practice had taken steps to increase uptake of cervical screening by offering additional clinics on Monday afternoons. In addition, the practice were able to refer patients to a local practice, operating within the Primary Care Network, where they could access evening or weekend appointments for cervical screening. We reviewed the practice's current uptake during our inspection and found that this had increased to 73.1%. However; at the time of our inspection this data had not been validated.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice had a system in place to record the requirements of vulnerable patients on the clinical system. They offered a same day and longer appointments when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances and patients identified were referred to the appropriate local services.
- The practice reviewed young patients at local residential homes.
- The practice used the Royal College of General Practitioners (RCGP) Veterans toolkit to support management of ex armed forces patients who may have complex psychological and medical needs.

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.
- The practice offered flexibility with appointment booking including same day, longer appointments and appointments when the surgery was quiet to avoid unnecessary waits.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.9%	92.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	14.3% (6)	11.6%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	69.4%	93.1%	90.2%	Variation (negative)
Exception rate (number of exceptions).	14.3% (6)	10.2%	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>	76.3%	86.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	14.5% (10)	7.2%	6.7%	N/A

Any additional evidence or comments

We discussed the areas with negative variation during our inspection and reviewed current performance data for 2019/20. This demonstrated that the practice had achieved 15 out of a maximum of 18 points against the mental health indicators, which equated to 85%.

However; at the time of our inspection the 2019/20 QoF period was still ongoing and as such the data had not yet been published or validated.

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)	465.9	549.4	539.2
Overall QOF score (as a percentage of maximum)	83.3%	98.3%	96.7%
Overall QOF exception reporting (all domains)	3.8%	6.1%	5.9%

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

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

The practice had carried out a full cycle audit to review the management of cow's milk protein allergy (CMPA) in new born babies. The first audit cycle was carried out from September until December 2018 and this showed that the practice were following appropriate local Clinical Commissioning Group (CCG) guidelines in the majority of cases. A further audit was carried out between March and June 2019 and this demonstrated that the practice had 100% adherence to local guidelines.

Any additional evidence or comments

The practice could demonstrate a commitment to quality improvement and had made a number of changes since the last Care Quality Commission inspection. This included addressing the issues around nursing capacity by recruiting a new practice nurse; which had resulted in an improvement in performance against the Quality and Outcomes Framework indicators.

The practice had reviewed and improved governance systems such as overview of staff training and the process for documenting, sharing and learning from significant events.

The practice had introduced a policy and process to support staff when dealing with results and correspondence. All documents were scanned onto the patient records on the clinical system on the day of receipt. The correspondence was then sent to the document management group to be date stamped and actioned by the coding team. Dependent on the content of the correspondence, this would either be passed to a clinician to action, passed to the in-house pharmacists for action, a task would be sent to reception to make an appointment for the patient to see a GP or no action required, in which case the correspondence would be filed.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: The practice had an electronic record of all staff appraisals and a record of the date of renewal. There was a system in place to ensure this was checked on a monthly basis and any appraisals due were acted upon. Staff members were sent a letter two weeks prior to their appraisal with a pre-appraisal form complete in preparation for the meeting.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

Helping patients to live healthier lives

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

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

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>	91.7%	95.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (14)	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: During the inspection we reviewed documented consent for a joint injection procedure. We also noted that the records contained a record of any side effects having been discussed.	

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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: Reception staff had been trained in care navigation and could signpost patients to other services such as health and wellbeing and counselling services.	

CQC comments cards	
Total comments cards received.	46
Number of CQC comments received which were positive about the service.	30
Number of comments cards received which were mixed about the service.	12
Number of CQC comments received which were negative about the service.	4

Source	Feedback
CQC Comment Cards	Words used to describe the practice included 'friendly, caring, brilliant and feel listened to'. Less positive comments related to accessing appointments.

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)	87.6%	88.8%	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)	94.1%	87.7%	87.4%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	98.5%	94.2%	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)	84.2%	80.2%	82.9%	No statistical variation

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

Any additional evidence
The practice carried out an in-house patient satisfaction questionnaire in December 2019 to review patient satisfaction following the implementation of a telephone triage service.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Easy read information and pictorial materials were available for patients who required them.	

Source	Feedback
Patient comment book	Words used to describe the practice included, brilliant service as always and staff are polite and doctors very caring.

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)	90.0%	92.0%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	316 patients (2.9% of practice population)
How the practice supported carers (including young carers).	The practice had a dedicated carers lead who had good knowledge of the practice registered list. The practice had posters in the waiting area which provided information for young carers.
How the practice supported recently bereaved patients.	The practice had a system in place to ensure all communication regarding a recently deceased patient was stopped. The practice sent a bereavement card to relatives of recently deceased patients and, where appropriate, offered an appointment to provide further support.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes

A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: All incoming calls were answered in an office located to the rear of the reception desk to ensure that conversations were not overheard. The practice had a notice at the reception desk requesting that patients stand back to respect the privacy of patients speaking with a member of the reception team at the reception desk.	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	Yes

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am until 6pm
Tuesday	8am until 6pm
Wednesday	8am until 6pm
Thursday	8am until 6pm
Friday	8am until 6pm
Appointments available:	
Monday	8.10am until 12pm and 1pm until 5.50pm
Tuesday	8.10am until 12pm and 1pm until 5.50pm
Wednesday	8.10am until 12pm and 1pm until 5.50pm
Thursday	8.10am until 12pm and 1pm until 5.50pm
Friday	8.10am until 12pm and 1pm until 5.50pm

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)	96.2%	93.7%	94.5%	No statistical variation

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.

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.

Families, children and young people

Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Clinicians opportunistically discussed domestic violence concerns and referred to appropriate resources and services. For example; Bradford Women's Aid and the Adult Safeguarding Team.

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. For example; the practice had introduced a telephone triage service to enable patients to access clinical advice without having to take time out of work.
- The practice had increased the number of appointments available to book on line and these included book in advance appointments.
- The practice was in the process of implementing e-consults to offer patients the option to ask for advice via email.
- Patients could access extended hours appointments at three local hub sites from 6.30-9pm Monday to Friday and from 10am until 1pm on Saturday and Sunday.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice took steps to support the needs of patients who were considered vulnerable. For example; priority reminders were added to the clinical record to ensure staff were aware of their needs and make individual adjustments to support those patients.
- The practice worked closely with district nurses and palliative care services to offer patient centered end of life care.

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

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: The practice offered a telephone triage which enabled patients to speak with a GP on the day and their needs would be assessed as to whether a face to face appointment, or home visit was necessary.	

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)	43.0%	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)	60.7%	61.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	59.0%	60.5%	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)	70.6%	71.4%	73.6%	No statistical variation

Any additional evidence or comments

The practice had undertaken a full review of the appointment system and considered feedback from patients and the patient participation group when updating the system.

As a result of the review, the practice had introduced a telephone triage system which enabled patients to speak with a GP on the day and their needs would be assessed as to whether a face to face appointment, or home visit was necessary.

Results from a patient survey, conducted after the implementation of the telephone triage system, showed an improvement in patient satisfaction:

50% of respondents found it easier to contact the practice by telephone for an appointment.

90% of respondents found it easier to contact the practice by telephone for any other queries.

56% of respondents reported that the receptionists had offered care navigation.

The practice had also encouraged patients to sign up to online services, where they could book and cancel appointments; at the time of the inspection 32% of patients were signed up to use this service.

The practice offered appointments on line from 7am and offered a mixture of book on the day or book in advance.

In addition, the practice had been monitoring the volume and quality of calls in order to audit the type and time of calls and plan the workforce to respond to demand.

Source	Feedback
CQC Comment Cards	Words used to describe the practice included 'since having the online system it's a lot better service and service is ok'.

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.	10
Number of complaints we examined.	0
Number of complaints we examined that were satisfactorily handled in a timely way.	Unknown
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Unknown

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a complaints policy in place and details of how to complain were available for staff and patients. However; on the day of the inspection we were unable to review any paperwork relating to complaints or audit trails of complaints. The practice had recorded all complaints received on a spreadsheet with an outline of action taken as a result of complaints and communication with the complainant. We discussed this with the practice manager who told us that the practice tried to resolve complaints by contacting the patients upon receipt of a complaint.</p>	

Example of learning from complaints.

Complaint	Specific action taken
Complaint received regarding a delay in reauthorisation of long-term medication.	Upon investigation the practice identified that the delay had been caused due to duplicate tasks being raised on the clinical system when requested, rather than the original task being updated. The practice discussed this with relevant staff members and provided additional training to support future requests.

Well-led

Rating:

Requires Improvement

At the inspection on 2 July 2019 we rated the practice as inadequate for the provision of well-led services. We found that the systems and processes which were in place did not support high quality sustainable care.

At this inspection on 3 March 2020 we found that the provider had responded to the concerns raised and had reviewed and improved the governance systems in place to ensure leaders had access to appropriate information. However; we noted that some of these systems had yet to be fully embedded.

We found that the provider had taken steps to improve performance against the Quality and Outcomes Framework (QoF) long-term condition and mental health indicators. However; at the time of the inspection the validated data available was still below average.

We also noted that the provider did not consistently following the complaints procedure and we saw no audit trail of complaints having been investigated and responded to in line with the policy. Therefore, we have rated the practice as requires improvement for providing well-led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: Following the Care Quality Commission inspection in July 2019, the practice could demonstrate that they had acted upon the concerns identified and implemented new systems and processes to support these actions. Interviews with staff confirmed that the partners were approachable and had been proactive in making changes to improve the service. For example; the partners and practice manager had reviewed the practice structure and created a new role of patient services manager to provide additional support to the management team, reception team and patients.	

Vision and strategy

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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: The practice had an internal Freedom to Speak up Guardian. However; there were no arrangements in place for an independent Freedom to Speak up Guardian in the event that staff wanted to raise concerns with someone outside of the practice.	

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

Source	Feedback
Staff interview	Words used by staff included, really do like the new manager and it is now a nice atmosphere to work in.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw that the practice had reviewed and improved the governance structures and systems following the last Care Quality Commission inspection in July 2019. For example; the practice had implemented a programme of staff and clinical meetings which clearly outlined standing agenda items including complaints and significant events. They had also implemented systems to ensure management had clear oversight of all staff training.</p> <p>However; we found that although governance systems had improved, general oversight of these systems needed to be embedded. For example:</p> <p>The provider had reviewed and updated the system in place to check stock levels and expiry dates of emergency medication. However, during the inspection we found that some of the syringes and needles to administer emergency medication were out of date. This was rectified immediately by the practice nurse.</p> <p>The practice had reviewed and improved the process for emergency equipment checks. However; at the time of our inspection we found that one of the adult defibrillator pads had expired. This was replaced immediately.</p> <p>The practice had a system in place for receiving MHRA and safety alerts. However; there was no process in place to record an overview of searches carried out, number of patients affected by any alerts and dates for review. We received additional evidence following our inspection to confirm that a system had been implemented.</p> <p>The practice had a complaints policy in place and details of how to complain was available for staff and patients. However; on the day of our inspection we were unable to review any paperwork or audit trails of complaints. We discussed this with the practice manager who told us that the practice tried to resolve any complaints informally as they were generally 'grumbles'. Upon receipt of a complaint (whether verbal or in writing) the practice manager would contact the patient to address any issues raised. This was not in line with the practice's complaints policy.</p>	

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.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

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

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
At the time of our inspection the Patient Participation Group (PPG) had eight members and regular meetings took place. The PPG had been actively involved in the in-house patient surveys that the practice had undertaken to review the changes to the appointment system.	

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

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.