

# Care Quality Commission

## Inspection Evidence Table

### Northumberland Park Medical Group, Shiremoor Resource Centre (1-569736875)

Inspection date: 6 March 2020

Date of data download: 12 February 2020

## Overall rating: Requires Improvement

The practice was rated as requires improvement at the last inspection in January 2019. While some improvements had been made we saw there were some areas which still needed to be addressed. We also found some additional areas for improvement, some of which the practice took immediate action to address. Therefore the practice continues to be rated as requires improvement.

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

## Safe

## Rating: Requires Improvement

The practice was rated as requires improvement for safety at the last inspection in January 2019. While some improvements had been made we saw there were some areas which still needed to be addressed. We also found some additional areas for improvement. Therefore this domain continues to be rated as requires improvement.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection in January 2019 it was difficult to corroborate that learning took place as part of the multidisciplinary team safeguarding process, because minutes were not formally recorded. At this inspection we saw that safeguarding meetings were minuted and actions were noted.</li> <li>The locum pack did not contain information about local safeguarding procedures. However, we were sent evidence following the inspection to show that these had been added.</li> <li>Policies had been updated. However, we saw that out of date policies had not been deleted or marked to show that they were no longer in use.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection in January 2019 the practice had obtained immunisation histories for clinical staff, as well as for those non-clinical staff handling specimens, but immunisation records were not available for other non-clinical staff. At this inspection we were told that staff had now had required vaccinations and vaccination status had been checked, however not all of the employment records we checked contained this information. We also saw a list which showed staff who had been identified as requiring immunisations but there was no evidence that these had been obtained.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y 17/01/2020
There was a record of equipment calibration. Date of last calibration:	Y 17/01/2020
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:	Y February 2020
There was a log of fire drills. Date of last drill:	Y 10/09/2019
There was a record of fire alarm checks. Date of last check:	Y 06/03/2020
There was a record of fire training for staff. Date of last training:	Y 26/07/2019
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y 30/09/2019
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A fire risk assessment had been completed and areas to follow up had been identified, however there was no evidence that these had been completed. The actions identified were for the building's owners to carry out, but there was no system in place for the practice to be routinely informed once they had been completed.</li> </ul>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment:	Y 15/04/2019
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 15/04/2019
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the inspection in January 2019 there were gaps in the health and safety risk assessment. At this inspection in March 2020 we saw that these had been addressed and appropriate risk assessments had been completed.</li> </ul>	

## 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.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	03/03/2020
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>At the last inspection in January 2019 a comprehensive audit, covering all aspects of infection prevention and control (ICP), had not been carried out. Also, a specific IPC risk assessment had not been completed. At the inspection in March 2020 we saw that these had been carried out.</li><li>While there was an ICP risk assessment and policy, the practice's filing system meant it was difficult to locate. There were two different folders on the practice's shared drive containing information related to infection control – one folder had the most up-to-date policies and risk assessments, while another contained out-of-date information which had not been marked as such.</li><li>Staff had received training on infection prevention and control, however the new lead for infection control at the practice had not yet received the specialist training the role requires.</li></ul>	

## Risks to patients

### There were gaps in 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.	Partial
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.	Partial
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.	Partial
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:	

- There was an informal system for inducting and supporting temporary staff. A locum pack was in place to help locum GPs but information on safeguarding and infection control was missing. This was added after the inspection.
- Clinical staff had been trained to spot the signs of sepsis but reception staff had not. This was additionally concerning as after 9.30am patients who requested an urgent GP appointment were no longer put on the triage list. Instead, patients were asked by receptionists to call back the next day or directed to another service. As well as not having received training in identifying sepsis, the reception staff did not have any clear guidance on when it was safe to ask patients to wait an extra day for an appointment or to attend another service. Since the inspection we were told that training on sepsis and deteriorating patients would be delivered to reception staff in April. We have also seen evidence that patients who call after 9.30am can still be added to the triage list and an evidence-based flowchart is now in place to assist receptionists in deciding where to direct patients.

## 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

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.90	1.03	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)	7.0%	7.7%	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)	4.64	4.97	5.60	Tending towards 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)	2.73	2.79	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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Prescription stationary for use in printers was kept in a locked cupboard in a room in the surgery which could also be locked. A log was kept of the serial numbers to track stationary when it came into the practice and as it was used. However, we also saw four handwritten prescription pads which were not logged and which some staff did not realise were part of the stock. We were told following the inspection that these pads had now been logged in line with other stationary in the practice and would be kept in case of need in an IT outage.</li> </ul>	

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

**The practice learned and made improvements when things went wrong but this could be improved.**

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.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	5



Number of events that required action:	5
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the inspection in January 2019 the arrangements for summarising patients' medical records did not include a system for sampling and carrying out peer reviews, to help ensure consistency and accuracy. At this inspection we saw that this system had been put in place and was being used effectively.</li> <li>The practice was not sharing learning from significant events externally using the Safeguard Incident and Risk Management System (SIRMS).</li> <li>There appeared to be a delay in the review of some significant events. For example, a miscommunication about a patient's medication was discovered in January 2019 but was not discussed at a significant event meeting until February 2020.</li> <li>Learning from significant events could be improved. For example, a patient who was not put on the triage list for a same-day appointment with a GP was given a nurse appointment for later that day instead, but when presented at the practice their condition was severe enough for staff to call 999 for an ambulance. Despite this, no changes to the appointment system were investigated or made, nor were reception staff given training in identifying deteriorating patients as a result of the significant event.</li> </ul>	

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

Event	Specific action taken
A patient was found to still be taking a medication which should have been stopped.	The medicines manager at the practice now runs a search of patients' notes every two months to ensure that medication requests are correct.
Vaccines needed to be reordered after the temperature of the refrigerator increased due to being accidentally unplugged from the mains..	Labels were attached to the plugs to warn people not to remove them. National guidance was followed to ensure the vaccines were safe to use.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was a system for recording and disseminating safety alerts to staff in the practice. However, on the day of inspection we saw that this system did not include a process to ensure all staff had seen and read relevant alerts. We saw evidence following the inspection to show that this process had been added.</li> <li>We saw examples of actions taken on recent alerts for example, regarding sodium valproate.</li> </ul>	



## Effective

## Rating: Good

At the last inspection in January 2019 the practice was rated as requires improvement for providing effective care. They had made improvements in this area when we inspected the practice in March 2020.

### 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: <ul style="list-style-type: none"> <li>Each clinician had access to the latest guidelines to keep up to date with evidence-based practice, however these guidelines were not routinely discussed at team meetings.</li> </ul>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.53	0.61	0.74	No statistical variation

## Older people

## Population group rating: Good

### Findings

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

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	74.4%	79.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.0% (21)	14.0%	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)	75.8%	77.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	5.5% (23)	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) (QOF)	74.5%	82.1%	81.3%	No statistical variation
Exception rate (number of exceptions).	9.4% (39)	15.5%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	76.4%	76.5%	75.9%	No statistical variation
Exception rate (number of exceptions).	3.6% (20)	8.1%	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) (QOF)	85.4%	91.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	4.1% (7)	11.7%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	75.1%	84.7%	83.0%	Variation (negative)
Exception rate (number of exceptions).	3.7% (36)	4.2%	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	79.8%	90.0%	91.1%	Variation (negative)

currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	5.7% (6)	8.4%	5.9%	N/A

### Any additional evidence or comments

While the practice was below average for the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less and the percentage of relevant patients who are currently treated with anti-coagulation drug therapy, their exception reporting for these areas was also below average. The practice were aware of these scores and felt that vacancies among their nursing staff had been a contributing factor. A new member of the nursing team had recently been appointed. Following the inspection, we were sent an action plan showing how the practice intended to address these areas.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- 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)	109	113	96.5%	Met 95% WHO based target
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)	104	107	97.2%	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)	103	107	96.3%	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)	103	107	96.3%	Met 95% WHO based target

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). (01/07/2019 to 30/09/2019) (Public Health England)	77.8%	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)	64.0%	73.4%	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)	58.4%	59.6%	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)	67.6%	66.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a	60.5%	54.8%	53.8%	No statistical variation

two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)				
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#### Any additional evidence or comments

The practice continued to work towards meeting the 80% target for cervical screening. They sent letters to patients to encourage them to attend for screening and telephoned those who did not. Again it was felt that nursing vacancies had contributed to the score.

#### People whose circumstances make them vulnerable

**Population group rating: Good**

#### Findings

- Longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The practice had carried out reviews for 35 of the 44 patients on their learning disability register (79.5%). This was the second highest rate in the clinical commissioning group area.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

**Population group rating: Good**

#### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.1%	92.8%	89.4%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.1% (2)	14.5%	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>	76.0%	93.8%	90.2%	No statistical variation
Exception rate (number of exceptions).	10.7% (3)	12.2%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.7%	85.0%	83.6%	No statistical variation
Exception rate (number of exceptions).	4.0% (1)	7.4%	6.7%	N/A

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	530.1	550.3	539.2
Overall QOF score (as a percentage of maximum)	94.8%	98.4%	96.7%
Overall QOF exception reporting (all domains)	3.8%	6.2%	5.9%

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



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

- An audit of patients on vitamin B12 had been carried out to ensure patients were being prescribed the medication appropriately.
- An audit of patients taking antipsychotic medication improved monitoring of this group from 76% of patients being appropriately monitored to 95%.
- An audit of patients being prescribed dual antiplatelets (medication which reduced blood clotting) found that 100% had a stop date in place.
- Audits were carried out to ensure appropriate consent had been gained for treatment.

#### Any additional evidence or comments

The practice did not have a systematic programme of quality improvement at the time of the last inspection in January 2019. This had been improved when we visited in March 2020.

### 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.	Partial
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.	Partial
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:	
<ul style="list-style-type: none"> <li>• At the last inspection in January 2019 none of the staff, including the GPs, had received an internal appraisal during the previous two years. At this inspection in March 2020 we saw that all non-clinical staff and most of the clinical staff had had an appraisal. There were plans in place for the clinical staff who had not yet been with the practice for 12 months to receive theirs. All staff we spoke to told us they felt supported.</li> </ul>	

- At the inspection in January 2019 the nurse lead for infection control told us they had not completed more advanced training in infection control to help them carry out this role. At this inspection there was a new infection control lead, however they had also not yet completed the advanced training in infection control.

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the last inspection in January 2019 one of the GP leaders told us there were no formal systems in place for sharing information with social services and community services professionals. We saw this was in place at the inspection in March 2020.</li> </ul>	

## Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	97.0%	96.2%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.8% (14)	1.0%	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.	N/A

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	11
Number of CQC comments received which were positive about the service.	11
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comments cards, NHS Choices, patient interviews	Patient feedback about care at the practice was positive. Comment cards gave examples of times when patients had been treated with kindness, respect and compassion. All 11 cards reported positive feedback about care at the practice.

### 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%	91.4%	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)	86.1%	90.6%	87.4%	No statistical variation

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 had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	97.9%	96.9%	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)	85.3%	86.4%	82.9%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> <li>The practice had carried out its own survey since the last inspection, however it had not yet taken any actions as a result of the responses.</li> <li>An independent company had been commissioned to carry out a patient satisfaction review. This found that 85% of responses to the survey rated the practice as good, very good or excellent. The practice scored above the national average for questions related to care, such as “warmth of greeting”, “respect shown”, and “ability to listen”.</li> </ul>

### 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

Source	Feedback
Patient comment cards, patient interviews, NHS Choices.	Patients said they were involved in decisions about their care and treatment and were able to give examples of when this had happened.

## 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)	95.3%	94.9%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 137 patients as carers (approximately 1.6% of the patient population).
How the practice supported carers (including young carers).	Patients were asked if they had or were a carer when they joined the practice. Leaflets in reception area promoted carers' groups. Any carers who were identified were signposted to the local carers' organisations and offered early flu vaccinations. The practice's carer's lead had recently left and a new one had been appointed.
How the practice supported recently bereaved patients.	Bereaved patients received a call and/or a card from a GP. They were signposted to support groups.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

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

## Responsive

## Rating: Requires Improvement

At the last inspection in January 2019 we rated the practice as good for providing responsive services. At this inspection we found some concerns which have changed the rating to requires improvement.

### 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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 6pm
Tuesday	7am to 6pm
Wednesday	8.30am to 6pm
Thursday	7am to 6pm
Friday	8.30am to 6pm
Appointments available:	
Monday	8.30am to 11.30am and 2.30pm to 5.30pm
Tuesday	7am to 11.30am and 1pm to 5.30pm
Wednesday	8.30am to 11.30am and 2.30pm to 5.30pm
Thursday	7am to 11.30am and 1pm to 5.30pm
Friday	8.30am to 11.30am and 2.30pm to 5.30pm



## 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)	96.9%	95.9%	94.5%	No statistical variation

### Older people

### Population group rating: Requires Improvement

#### Findings

This key question has been rated as requires improvement due to reasons which affect all the population groups. Therefore, this population group has been rated as requires improvement.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice offered home visits.
- The practice provided effective care coordination to enable older patients to access appropriate services.

### People with long-term conditions

### Population group rating: Requires Improvement

#### Findings

This key question has been rated as requires improvement due to reasons which affect all the population groups. Therefore, this population group has been rated as requires improvement.

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

### Families, children and young people

### Population group rating: Requires Improvement

#### Findings

This key question has been rated as requires improvement due to reasons which affect all the population groups. Therefore, this population group has been rated as requires improvement.

- 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.

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

**Population group rating: Requires Improvement**

**Findings**

This key question has been rated as requires improvement due to reasons which affect all the population groups. Therefore, this population group has been rated as requires improvement.

- 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 from 7am on a Tuesday and Thursday. Extended access appointments at evenings and weekends could also be booked through the practice.

**People whose circumstances make them vulnerable**

**Population group rating: Requires Improvement**

**Findings**

This key question has been rated as requires improvement due to reasons which affect all the population groups. Therefore, this population group has been rated as requires improvement.

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

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

**Population group rating: Requires Improvement**

**Findings**

This key question has been rated as requires improvement due to reasons which affect all the population groups. Therefore, this population group has been rated as requires improvement.

- We did not see evidence that 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 not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	N
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:	
<p>At this inspection we had concerns with the way the appointment system was operated, which meant that patients with urgent needs were not always given a same-day appointment.</p> <ul style="list-style-type: none"><li>Patients who requested a same-day appointment were placed on a list to be triaged by the practice nurse if they telephoned the practice between 8.30am and 9.30am. We were told that patients who telephoned the practice after this time would be asked to call back the following day between 8.30am and 9.30am or they would be signposted by reception staff to another service. Receptionists at the practice had not received any training in triage, nor any other training which might support them in making decisions as to whether it was safe for a patient to be signposted to another service or wait 24 hours before calling back to be triaged. We were also told that there was no written proforma or flow chart in use at the practice to help to inform decision making around triaging. We were told that reception staff used local knowledge or leaflets from other services to guide their decision making around where to direct patients.</li><li>A copy of a significant event analysis (SEA) sent to us prior to the inspection showed that a patient had not been triaged for a same-day GP appointment by the triage nurse as they had telephoned the practice in the afternoon and therefore triage had ended. The patient was instead offered an appointment with a practice nurse on that same day. The SEA showed that when the patient was seen by the nurse they were displaying symptoms of shortness of breath and they reported they had been struggling to use their nebuliser for the past three days. The on-call doctor was summoned and following a review of the patient they called 999 for an ambulance. The patient was taken by paramedics to hospital. The analysis of this event acknowledged that a same-day appointment was required for this situation and that the appointment should have been with a doctor. It also highlighted a 'possible' need for reception staff to have training to identify this. Further training in identifying signs and symptoms of life-threatening illness for reception staff or a review of the appointment system to ensure it was safe were not recommended. We were told that no review of the appointment system had been carried out to ensure it was safe.</li></ul> <p>However, since the inspection, the practice had:</p> <ul style="list-style-type: none"><li>Changed the appointment system so that people who called after 9.30am could still be triaged for a same-day appointment if they met certain criteria;</li><li>Made online booking of same-day appointments available until 11am;</li></ul>	

- Made changes to the practice's website in order to encourage more patient use of the e-consultation process;
- Introduced an evidence-based flowchart for the triage nurse and receptionists to follow. For the receptionists, this gave clear instructions on who could be considered for a same-day appointment and who could be directed elsewhere. Patients were categorized depending on their concerns and symptoms and the flowchart listed a range of options receptionists could use, such as placing people on the triage list for the following day, booking a routine appointment, or signposting to another service;
- Carried out an initial audit of appointments to ensure patients were being triaged appropriately. Dates had been put in place for follow-up audits and plans had been made to carry out a survey to gauge patient satisfaction with the system.

While it is encouraging to see the practice had begun to make changes, we have not yet seen evidence that these will result in improvements for patients. The rating of requires improvement is based on what was seen on the day of inspection.

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)	69.8%	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)	66.7%	68.8%	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)	59.2%	66.0%	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)	76.5%	74.3%	73.6%	No statistical variation

#### Any additional evidence or comments

Patient satisfaction with the appointment system on the GP Patient Survey was below average. For example:

- 32% of respondents said they usually got to see or speak to their preferred GP when they would like to, compared to the clinical commissioning group (CCG) average of 51% and national average of 48%;
- 51% of respondents were offered a choice of appointment when they last tried to make a general practice appointment, compared to the CCG average of 63% and national average of 62%

- 59% of respondents were satisfied with the general practice appointment times available, compared to the CCG average of 66% and national average of 65%. This had reduced from 63% last year.
- 70% of respondents found it easy to get through to this GP practice by phone compared to a CCG average of 75% and a national average of 68%. This had reduced from 80% last year.

The practice told us they had also carried out their own survey, the results of which were in line with the GP Patient Survey. The results had been obtained shortly before the inspection and therefore, on the day of inspection, no plan was yet in place to address the concerns raised. A plan was sent to us following the inspection.

Source	Feedback
NHS Choices, patient comment cards.	There were two comments about the appointment system in reviews left on the NHS Choices website. One commented that it was difficult to get an appointment, while the other reported they were seen the same day as they had called before 9.30am. There were no comments about the appointment system left on the 11 patient comment cards we received.

## 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.	7
Number of complaints we examined.	7
Number of complaints we examined that were satisfactorily handled in a timely way.	Y
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Y

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• At the inspection in January 2019 we saw there was no information about how to complain on display in the reception areas. At this inspection in March 2020 we saw this was now in place.</li> <li>• Both verbal and written complaints were logged and investigated by the practice.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Test results not received by patient.	A face to face meeting was held with the patient and their result was retrieved and shown to be negative. Cytology were

	contacted, who confirmed a letter had been sent out to the patient and arranged for another copy to be sent.
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## Well-led

## Rating: Requires Improvement

The practice was rated as requires improvement for leadership at the last inspection in January 2019. While some improvements had been made we saw there were some areas which still needed to be addressed. We also found some additional areas for improvement. Therefore this domain continues to be rated as requires improvement.

### Leadership capacity and capability

**Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>At the inspection in January 2019, leaders we spoke with demonstrated they were knowledgeable about the challenges the practice faced delivering high-quality, sustainable care and treatment, but they confirmed there was no agreed plan in place to address these challenges. In March 2020, at the most recent inspection, we saw a plan had been written but no actions had been taken to address any of the challenges. The practice had taken action, however, to try and recruit staff when others had left.</li><li>Two requirement notices were issued following the previous inspection in January 2019. The practice had managed to address most of the concerns raised in the requirement notices, but not all of them in relation to governance. Further concerns regarding safety were identified at the most recent inspection in March 2020.</li></ul>	

### Vision and strategy

**The practice had a clear vision and credible strategy.**

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



- At the inspection in January 2019 the practice did not have a documented strategy in place to help them achieve their priorities. At this inspection in March 2020 we saw a vision and strategy for the practice had been documented in collaboration with all staff at the practice.

## Culture

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

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

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

Source	Feedback
Staff interviews	Staff told us they were well supported by managers, they were able to raise any concerns or make suggestions for improvement and felt valued by the practice. We were told by multiple members of staff that staffing levels were a concern but that managers at the practice were taking all necessary steps to try and recruit and some new staff were due to start in the near future.

## Governance arrangements

### The overall governance arrangements could be improved.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	

- At the last inspection the induction pack for locum GPs was out-of-date. In March 2020 we saw this had been updated but information regarding safeguarding and infection control was still missing. We were sent evidence following the inspection to show this had been added.
- There were established policies and procedures in place, which could be accessed by all staff. There was a system in place to review and update these, but we saw that old policies were not always removed from the shared drive once they had been updated. This resulted in duplicate policies being on the shared drive and it was not always immediately clear which one was the current version. Policies were filed in numerous folders, for example there were two folders for infection control information which could have led to staff accessing the wrong one.

## Managing risks, issues and performance

**There were processes for managing risks, issues and performance, but some of these required improvement.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the inspection in January 2019 there was no systematic programme of quality improvement. This had been improved when we inspected the practice in March 2020.</li> <li>• In January 2019 we saw that the health and safety risk assessment did not cover all the key risks to patient safety. In March 2020 this had been addressed.</li> <li>• In March 2020, we saw that actions had been identified on a fire risk assessment for the building's owners to carry out, but there was no system in place for the owners to report these to the practice once they had been completed.</li> <li>• Clinical staff had been trained to spot the signs of sepsis but reception staff had not. Training had been put in place for a date following the inspection.</li> <li>• The practice was not sharing learning from significant events externally using SIRMS. There also appeared to be a delay in the review of some significant events and learning from them could have been improved.</li> <li>• The system for recording and disseminating safety alerts to staff in the practice did not include a process to ensure all staff had seen and read relevant alerts. We saw evidence following the inspection to show that this process had been added.</li> </ul>	

## Appropriate and accurate information

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

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

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

**The practice involved the public, staff and external partners.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>In January 2019 there was no patient participation group (PPG) in place. Leaders told us they were committed to reforming their PPG group, and that a patient had recently expressed an interest in participating. In March 2020 there was still no group in place but we saw that the practice had made attempts to start one.</li></ul>	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Learning from significant events could be improved. For example, a patient who was not put on the triage list for a same-day appointment with a GP was given a nurse appointment for later that day instead, but when presented at the practice their condition was severe enough for staff to call 999 for an ambulance. Despite this, no changes to the appointment system were investigated or made, nor were reception staff given training in identifying deteriorating patients as a result of the significant event.</li></ul>	

- The practice was not sharing learning from significant events externally using SIRMS.

#### **Examples of continuous learning and improvement**

- Some improvements had been made since the last inspection.
- The practice did not have a systematic programme of quality improvement at the time of the last inspection in January 2019, but one was in place when we visited in March 2020.

## 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.