

Care Quality Commission

Inspection Evidence Table

Carnarvon Medical Centre (1-5584372381)

Inspection date: 21 July 2021

Date of data download: 21 July 2021

Overall rating: Good

We inspected the practice in November 2018 and rated it as requires improvement overall and requires improvement for providing safe and effective services.

We inspected in October 2019 to follow this up and we found that not all the concerns had been addressed from the previous inspection and in addition, new breaches of regulations were found. When we inspected this practice in October 2019, we rated the practice as requires improvement overall. We rated the key questions as follows: safe as inadequate, effective as requires improvement, caring as good, responsive as good and well-led as requires improvement.

At the inspection in November 2020, we rated the provider as inadequate overall and issued them with a warning notice. We found that there were concerns related to the safe and effective care of patients and that there was a lack of awareness of this from leaders. We also found that some of the improvements required at the last inspection had not improved sufficiently.

At this inspection we followed up on all of these concerns and we saw evidence that all of the issues arising from the previous inspection, including the concerns in the warning notice, had been adequately addressed.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

At the previous inspection we found that:

- There were no regular multi-disciplinary meetings held with other health professionals. This had not changed since the previous inspection.
- Although we saw posters on display which described the signs and symptoms of sepsis, clinical staff and reception / administration staff we spoke to could not clearly describe the signs and symptoms.
- There was no evidence of patient care plans on the system.
- There was a process in place to monitor the health of patients in relation to their use of high-risk medicines, however this was not effective.
- On the day of inspection, we found that prescription stationery was not kept securely, and its use was not monitored in line with national guidance. Vaccines were not appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.
- There was not an effective system for recording and acting on safety alerts.

- Where reviews of high-risk medicines had been undertaken, they were not recorded consistently in the patient's record.
- Significant events were not being reviewed effectively to identify learning. This had not improved since the last inspection.

At this inspection we found that all of these concerns had been adequately addressed.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
At the last inspection we identified the following concerns:	
<ul style="list-style-type: none"> • There were no regular multi-disciplinary meetings held with other health professionals. This had not changed since the previous inspection. • Although we saw posters on display which described the signs and symptoms of sepsis, clinical staff and reception / administration staff we spoke to could not clearly describe the signs and symptoms. 	
At this inspection we saw:	
<ul style="list-style-type: none"> • Evidence that regular multi-disciplinary meetings had taken place and minutes had been circulated. • Evidence that staff had received training on how to identify the possible signs and symptoms of Sepsis; staff we spoke to were able to clearly describe the signs and symptoms. 	

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

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: March 2021	Y
There was a record of equipment calibration. Date of last calibration: February 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: December 2019. Review scheduled for August 2021	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: June 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2020	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: July 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<ul style="list-style-type: none">• We saw evidence that potential infection control risks related to the COVID-19 pandemic had been considered and mitigated.• Infection prevention and control updates relating to COVID-19 had been disseminated to staff as they were received by the practice and staff were aware of their responsibilities.• At the previous inspection we saw that this was an informal system. At this inspection we saw that the procedures had been formalised and written records were kept.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence:	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information 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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection:</p> <ul style="list-style-type: none"> We found no evidence of patient care plans. Staff we spoke to told us that the patient kept a hard copy of their individual care plan and the practice also kept a hard copy. We were not shown any evidence of the plans. <p>At this inspection:</p> <ul style="list-style-type: none"> We saw that care plans were on the practice computer system which could be accessed by other professionals involved in the patient's care. 	

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.62	0.73	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	21.4%	14.3%	10.2%	Significant Variation (negative)
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 (01/10/2020 to 31/03/2021) (NHSBSA)	6.37	6.35	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	70.2‰	125.4‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	1.58	1.21	0.66	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	8.0‰	8.6‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	P
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found that:</p> <ul style="list-style-type: none"> • Prescription stationery was not kept securely, and its use was not monitored in line with national guidance, specifically, no records had been kept of blank prescriptions issued, meaning that a high number were unaccounted for. • Although the practice had a defibrillator on site, there were no paediatric pads available. • We saw that the daily log for recording the temperature of the fridge in which vaccines were stored, was not complete; some weeks saw two or three days on which the temperature had not been recorded. • 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), (01/07/2019 to 30/06/2020) was significantly higher than local and national averages and had risen from 14.2% at the previous inspection to 17.5% at this inspection. There was no clear action plan for improvement. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 31/03/2021) was comparable to local and national averages. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> Prescription stationery was kept securely, and its use was monitored in line with national guidance. Due to the COVID-19 pandemic most prescriptions were issued electronically. Paper prescriptions were requested by the clinician as and when they required one and this was reflected in the monitoring. There were paediatric pads available to use with the practice defibrillator. We saw that the temperature of the fridges was recorded twice daily, consistently over the period since the previous inspection. 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), (01/04/2020 to 31/03/2021) was significantly higher than local and national averages and had risen from 17.5% at the previous inspection to 21.4% at this inspection. Staff at the practice told us that they were prescribing more of these medicines in the early stages of the COVID-19 pandemic. However, we saw evidence that the practice had been working closely with the pharmacist from the primary care network (PCN), and the local clinical commissioning group (CCG) to reduce the amount of these medicines prescribed. We saw unverified data, that the level of prescribing had begun to reduce. The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 30/06/2020) was higher compared to local and national averages. The practice was aware of this and was working closely with the community pharmacist and the CCG to reduce the number of prescriptions issued. <p>We completed a series of high-level clinical searches and our findings included the following:</p> <ul style="list-style-type: none"> For patients who were prescribed some medicines that were subject to a shared care agreement, it was not clear on the record if the prescriber had checked monitoring tests were satisfactory or that appropriate action had been taken if the tests indicated an issue. There were 17 patients prescribed methotrexate, we reviewed five records in detail, and it appeared that all five patients had not had the correct monitoring carried out before a repeat prescription was issued. However, after the inspection the practice sent us evidence that the appropriate monitoring had been carried out by a local hospital for all five patients. The procedure at the practice was to check the hospital system before issuing the prescription. Following the inspection, the practice told us that they would add a note to the patient record to indicate that the monitoring tests had been carried out. The same situation was identified on five records of patients who were prescribed ACE AR2RB and spironolactone. We looked at the records of five patients identified by search as having a potential missed diagnosis of diabetes. The risk to patients of a missed diagnosis of diabetes could mean the high blood sugar can affect various cells and organs in the body. Following the inspection, we saw evidence from the practice that they had reviewed all of these patients and that they had received appropriate care and treatment but this had not been coded appropriately on the computer system. The practice had agreed to amend the coding system. There was no risk to patients. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Nine
Number of events that required action:	Nine
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with told us that they knew how to identify a significant event and how to report it. They told us that learning from significant events was discussed at practice meetings. Minutes of the practice meetings that we saw included discussions about significant events and improvements made as a result. 	

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

Event	Specific action taken
Incorrect medication Prescribed	Clinicians advised to follow the procedures in place and that they check the correct medication has been prescribed before issuing the medication. Discussed at clinical and staff meeting
Incorrect Blood Test Given to Patient	Staff reminded to double check that the correct patient record is retrieved, and to check date of birth to avoid future errors. Discussed at staff meeting.

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"> We saw examples of actions taken on alerts, which satisfied us that there were was an effective system in place 	

Effective

Rating: Good

At the previous inspection we found that:

- Childhood immunisation uptake continued to be below the national minimum targets.
- Performance for some of the cancer performance indicators continued to be below local and national averages.
- There was no programme of quality improvement and information wasn't always used to make improvements about care and treatment.

At this inspection we found that:

- The practice has not met the minimum 90% for four of five childhood immunisation uptake indicators. However, the practice had achieved 89.7% for three of the indicators and 86.6% for the remaining indicator. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators. Practice performance for all of the indicators had improved since the previous inspection.
- Performance for some of the cancer performance indicators continued to be below local and national averages. However, the practice had recently developed a clear action plan to improve the performance for all of the cancer indicators, which included monthly monitoring of progress.
- There was a clear programme of quality improvement in place to make improvements to care and treatment.

We rated the population group, Working Age People (including those recently retired and students) as Requires Improvement as the cancer performance indicators had not improved since the previous inspection and continued to be below local and national averages.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence:	

Older people

Population group rating: Good

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

Long-term conditions	Practice	CCG average	England average	England comparison
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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. (01/04/2019 to 31/03/2020) (QOF)	78.3%	73.2%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.3% (5)	8.4%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	94.0%	88.8%	89.4%	No statistical variation
PCA rate (number of PCAs).	7.4% (8)	10.7%	12.7%	N/A

*PCA:.. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	86.9%	80.3%	82.0%	No statistical variation
PCA* rate (number of PCAs).	5.3% (6)	6.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	54.9%	64.2%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.6% (12)	10.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	71.0%	71.9%	72.4%	No statistical variation
PCA rate (number of PCAs).	3.3% (24)	8.5%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	94.7%	93.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	5.0% (3)	3.0%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.0%	72.4%	75.9%	No statistical variation

PCA rate (number of PCAs).	1.8% (6)	10.2%	10.4%	N/A
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*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- The practice performance for the percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020), was lower than local and national averages.
- The practice had employed a full time GP who specialised in diabetes and she had taken the leadership role for improving outcomes for patients with diabetes and also for early diagnosis of pre-diabetes. We saw that the practice had carried out audits to identify patients with diabetes and possible diabetes and they had an action plan in place for these patients.

Findings

- The practice has not met the minimum 90% for four of five childhood immunisation uptake indicators. However, the practice had achieved 89.7% for three of the indicators and 86.6% for the remaining indicator. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators. Practice performance over all of the indicators had improved since the previous inspection.
- Where children did not attend for an immunisation, the practice nurse called the child's parent/carer and discussed with them the importance of immunisation, inviting them to participate with the programme and offering them an appointment at the surgery. Concerns regarding vaccinations and possible side effects were discussed and parents reassured. Following this call any refusal from the parent/carer would be recorded in the clinical system.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	69	71	97.2%	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) (01/04/2019 to 31/03/2020) (NHS England)	52	58	89.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	52	58	89.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	52	58	89.7%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	58	67	86.6%	Below 90% minimum

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

Any additional evidence or comments

- Since the last inspection, the practice had implemented an action plan to improve childhood immunisation uptake and we found that all data had improved.
- Staff at the practice told us that they were continuing with their action plan to increase uptake further.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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 medicines 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: 31/12/2020) (Public Health England)	64.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	59.4%	61.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	49.1%	56.0%	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	91.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	52.9%	54.0%	54.2%	No statistical variation

Any additional evidence or comments

- The practice was aware of their performance for cancer indicators over a period. They had discussed this at recent clinical meetings and had recently agreed a series of actions to improve uptake of screening.
- These included promotion in the waiting area, opportunistic conversations with patients during a consultation, writing to patients and following up responses, promotion on the practice website.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- 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 medicines.
- 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 (01/04/2019 to 31/03/2020) (QOF)	65.6%	76.9%	85.4%	No statistical variation
PCA* rate (number of PCAs).	1.5% (1)	20.4%	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	81.3%	84.2%	81.4%	No statistical variation
PCA rate (number of PCAs).	15.8% (3)	6.1%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

At the previous inspection:

- We saw that only three staff had received dementia training.

At this inspection:

- We saw evidence that all staff had attended dementia training.
- The exception reporting rate for the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) was higher than local and national averages, although the total number of patients this related to was low (three). The term exception reporting had been replaced with Personalised Care Adjustments (PCAs) and the practice assured us that those three patients had been removed in line with guidance.

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	England average
Overall QOF score (out of maximum 559)	519.5	533.9
Overall QOF score (as a percentage of maximum)	92.9%	95.5%
Overall QOF PCA reporting (all domains)	2.5%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	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

- We saw evidence that the practice had discussed a range of topics in clinical meetings. They reviewed current performance and what was required to maintain and/or improve performance.
- A number of audits had been completed, including prescribing of Co-Amoxiclav, Cephalosporins and Quinolones, patients with a history of anaphylaxis, consent, patients with a diagnosis of diabetes and others.

Any additional evidence or comments

At the previous inspection we found that:

- There was minimal quality improvement work carried out.
- There was no evidence of a planned programme of audit and there was limited other quality improvement activity. For example, themes and trends were not looked at within complaints and significant events analysis and there was limited evidence of action plans following identification of these.
- The practice provided evidence of audits which they had completed. However, there were no two-cycle audits indicating any evidence of improvement.

At this inspection we saw:

- Evidence that there was a leadership oversight of significant events and complaints and we saw completed actions and learning from these.
- Evidence of two cycle clinical audits which had driven improvement to patient care.

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.	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
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	

Coordinating care and treatment

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

Indicator	Y/N/Partial
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
Explanation of any answers and additional evidence: At the previous inspection: <ul style="list-style-type: none">Staff told us that they had not attended any multi-disciplinary team (MDT) meetings, but consideration was currently being given to attending online MDT meetings in the future. At this inspection: <ul style="list-style-type: none">We saw minutes of MDT meetings for the months of March, April, May and June 2021.	

Helping patients to live healthier lives

Staff were 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 and tackling obesity.	Y
Explanation of any answers and additional evidence:	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We looked at three DNACPR decisions and all three were appropriate and in line with current legislation.• The practice had begun to use built in templates for consent on their computer system.• The practice had introduced a consent form to be completed at the time of registration, asking for consent for a named person to speak on the patient's behalf. This form was shown on the patient home screen as 'high importance'.	

Caring

Rating: Good

Kindness, respect and compassion

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

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

Source	Feedback
The practice team	The practice team was diverse and was broadly representative of the practice patient list.

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 (01/01/2021 to 01/03/2021)	88.6%	88.2%	89.4%	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 (01/01/2021 to 01/03/2021)	85.7%	87.2%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 01/03/2021)	93.6%	95.3%	95.6%	No statistical variation
		-		-

Any additional evidence or comments
<ul style="list-style-type: none"> All indicators were in line with local and national averages. The practice had improved performance for all of the above four national GP patient survey indicators, compared to the previous data which was for the period 01/01/20 to 31/03/20. The data used for this inspection was for the period 01/01/21 to 31/03/2021.

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

Any additional evidence
<ul style="list-style-type: none"> At the previous inspection, we saw no evidence that the practice had carried out its own patient survey /patient feedback exercises. During this inspection that the practice had carried out two patient satisfaction surveys, one in January 2021 which had been analysed and shared with the team. Plans to address any concerns were shared with the team. The second patient survey had taken place in May 2021 and was in the process of being analysed.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	<p>There was a limited number of patients at the surgery on the day of inspection, due to restrictions which were in place due to the COVID-19 pandemic.</p> <p>We spoke with three patients who told us that they felt they were involved in the care they received as much as they wanted to be.</p>

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	94.9%	92.5%	92.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 01/03/2021)				

Any additional evidence or comments

- The practice had improved performance for this indicator from 91.1% at the previous inspection, using data from the period 01/01/2020 – 31/03/2020, to 94.9% at this inspection using data for the period, 01/01/2021 -31/03/2021.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Most leaflets had been removed from the patient waiting area in line with COVID-19 guidance. There were signs advising people to ask at reception for information and there was information available on the practice website. 	

Carers	Narrative
Percentage and number of carers identified.	At the last inspection, the provider was asked to improve the number identified. There were now 88 identified, compared to 55 at the previous inspection and this equated to 1.5% of the practice population
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The practice had developed a GP checklist to help them identify carers. Carers were identified on the new patient form. The practice had access to a social prescriber to signpost patients to local voluntary and statutory support resources. A staff member was the designated carers' champion. Adhoc support is offered to carers when they attend the practice.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> Staff contacted recently bereaved patients to offer support and to signpost to local and national support services.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Due to the COVID-19 pandemic, patients and staff were observing social distancing measures and plastic screens had been installed across the reception desk, which meant that conversations were louder than usual. However, staff told us that if a patient wanted to discuss a sensitive issue, they would be offered a private room.	

Responsive

Rating: Good

At the previous inspection we found that:

- There was limited learning from complaints.

This issue affected all population groups and therefore all population groups were also rated as requires improvement.

At this inspection we saw evidence that:

- There was a system in place to enable leaders to monitor trends and themes in complaints received and. Learning from complaints was shared and appropriate actions taken.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y

The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Although during the COVID-19 pandemic restrictions were placed on people accompanying patients to their appointments, where there was a clinically assessed need for the patient to have support to enable them to access care, they could be accompanied. Staff told us that they assessed the communication needs of patients. If a patient had a communication requirement that needed them to be able to visually see the clinician to communicate, they would be offered either a video consultation or a face to face appointment, depending on need. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6.30pm
Tuesday	8am – 7.40pm
Wednesday	8am - 6.30pm
Thursday	8am – 7.40pm
Friday	8am - 6.30pm
Appointments available:	
Monday	9am to 6.30pm
Tuesday	9am to 7.40pm
Wednesday	8am to 6.30pm
Thursday	9am to 7.40pm
Friday	9am to 6.30pm

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice provided effective care coordination to enable older patients to access appropriate services. There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Good

Findings

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

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.
- Postnatal & six/eight week baby check took place on the same day as first immunisations, minimising need for repeat visits to the surgery.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7.40pm on a Tuesday and Thursday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, 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: 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.

Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • During this inspection we saw various information leaflets which had been translated into other languages, for example, a carers' information leaflet. • All patients were triaged by care navigators who directed them to the relevant clinician for treatment. 	

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 (01/01/2021 to 01/03/2021)	68.0%	N/A	67.6%	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 (01/01/2021 to 01/03/2021)	72.3%	64.3%	67.0%	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 (01/01/2021 to 01/03/2021)	78.1%	72.2%	75.2%	No statistical variation

Any additional evidence or comments

- The practice had improved its performance in three of the four above indicators, compared to the previous inspection. The other indicator had remained almost the same. The data period used for the previous inspection was 01/01/2020 – 31/03/2020 and the data used for this inspection was 01/01/2021 – 31/03/2021.

Source	Feedback
NHS Choices	No feedback in the previous twelve months.
Healthwatch	No feedback provided.
Google	No feedback in the previous twelve months.

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

	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"> At the previous inspection we found that there was little evidence of practice-wide learning for improvements and to prevent occurrences being repeated. At this inspection, we saw evidence that complaints were discussed at staff meetings and the learning shared. At the previous inspection there was no process in place to provide an overview of complaints to identify themes and trends. At this inspection we saw that this had been adequately addressed. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient medication not received on time.	Issues concerning communication between the patient and the pharmacy were identified and addressed. The patient received the medication the after the practice received the complaint.
Patient unable to make an appointment.	A written response was sent to the patient, apologising and addressing each point of the complaint. Refresher training was organised for care navigators regarding when to refer to a clinician for advice.

Well-led

Rating: Good

At the previous inspection we rated this practice inadequate for providing well-led care. Some of the issues identified at the previous inspection had not improved sufficiently.

- We found that leaders could not demonstrate that they had sufficient involvement in the governance or performance of the practice.
- There was limited evidence of systems to monitor the effectiveness of care and treatment. Systems to identify and manage risks to patients were lacking.
- There was limited evidence of involvement of patients and third parties to improve the standard of care provided. There was a lack of assurance that decisions were made based on accurate and clear information.

At this inspection we found that these concerns had been adequately addressed.

- We found that leaders had implemented a change in staffing structure to enable them to have adequate oversight of and involvement in the governance and performance of the practice.
- We saw evidence of a programme of quality improvement which included clinical audits to manage risks to patients.
- We found that the practice held multi-disciplinary meetings with other healthcare professionals to improve the standard of care.

Leadership capacity

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the previous inspection we found that there was a lack of action plans to address areas where improvement was required. At this inspection, we saw that this had been addressed.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: At the previous inspection: <ul style="list-style-type: none">We saw that the practice had identified four points in their future planning, but these were not specific or measurable and were not monitored.Staff we spoke to were unaware of the future plans for the service.The plans the practice had made for the future did not include areas where improvement was needed. At this inspection: <ul style="list-style-type: none">We saw that the practice had identified three areas to focus on which were measurable.Staff we spoke to knew what the priorities for practice were.The areas of focus related to those areas where improvements were needed.	

Culture

The practice had a culture which drove high quality sustainable.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: At the previous inspection we found that: <ul style="list-style-type: none"> Whilst patients received an apology and were informed of action taken, there was a lack of meaningful learning when things went wrong. At this inspection we saw evidence that when things went wrong, the cause was established and lessons were learnt, which were shared with the practice team. 	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> Staff we spoke to told us that they felt much better working at the practice following the staffing restructure. Staff told us that they felt listened to and felt they could share ideas for improvement.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection, we found that:</p> <ul style="list-style-type: none"> Although there were lines of governance and responsibility, these were not always implemented effectively. There was lack of clarity around the boundaries for responsibility between administrative and clinical leaders. <p>At this inspection we saw evidence that:</p> <ul style="list-style-type: none"> The practice had been pro-active towards improvement following the previous inspection There was a whole team approach to improvement with visible leadership The practice team was clear about their individual roles and responsibilities New staff had been employed, including a senior GP, a practice manager, and a practice nurse 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection:</p> <ul style="list-style-type: none"> There was no programme of clinical audits which demonstrated improvement. <p>At this inspection:</p> <ul style="list-style-type: none"> We saw evidence of completed audits showing improvements for patients and a programme of audits for the future. 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
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The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>At the previous inspection we saw that:</p> <ul style="list-style-type: none"> • The practice had access to accurate information but did not always act on this to improve performance. • There was very limited audit activity or planning in place and it was not directed at the areas which needed most improvement. <p>At this inspection we saw evidence that:</p> <ul style="list-style-type: none"> • The practice used the information available to improve performance and patient care. • The practice had developed a programme of clinical audit, which was directed at areas the practice had identified as needing improvement. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	P
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
<ul style="list-style-type: none">• Explanation of any answers and additional evidence:• The practice had carried out two patient surveys, one in January 2021 and one in May 2021. We saw evidence that the information received from the January 2021 survey had been used to make improvements.• Although the practice had a Patient Participation Group, it had not met during the period of the pandemic. However, a meeting was planned for August 2021.	

Feedback from Patient Participation Group.

Feedback
N/A. See comment above.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• We saw from the practice training log that there was an ongoing programme of learning and development. Most learning had taken place online due to the COVID-19 pandemic.• Learning from complaints and significant events was shared within the team.	

Examples of continuous learning and improvement

<ul style="list-style-type: none">• Throughout our inspection and through talking to staff, it was clear that the practice encouraged staff to develop themselves and areas of interest. Staff were enthusiastic and committed to continuous improvement. They told us that managers supported them to learn new skills

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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.