

Care Quality Commission

Inspection Evidence Table

Dr R Khanchandani's Practice (1-541897052)

Inspection date: 23 to 25 November

Date of data download: 23 November 2020

Overall rating: Requires Improvement

At the March 2020 inspection, the practice was rated as inadequate as they did not always ensure that care and treatment was provided in a safe way to patients. Effective systems and processes to ensure good governance in accordance with the fundamental standards of care were not established.

At the November 2020 inspection, the practice was rated as requires improvement as they had made some progress to ensure care and treatment was provided in a safe way to patients. We found the systems, practices and processes put in place needed some adjustment to ensure they were effective, supported good governance and embedded fully into practice. The results of the National GP Patient Survey highlighted that patients were not always able to access care and treatment in a timely way. Actions had not been taken to address the lower than average patient satisfaction.

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

Safe

Rating: Requires Improvement

At the March 2020 inspection, we rated the practice as inadequate for providing safe services because:

- The practice did not have clear systems, practices and processes to keep people safe.
- Appropriate standards of cleanliness and hygiene were not met.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not have systems for the appropriate and safe use of medicines.
- The practice did not have a system to learn and make improvements when things went wrong.

At the November 2020 inspection, we rated the practice as requires improvement for providing safe services because:

- Some of the systems, practices and processes put in place to keep people safe had not been fully implemented and followed.
- Improvements had been made to ensure appropriate standards of cleanliness and hygiene were met and systems were in place to assess, monitor and manage risks to patient safety.
- A system had been put in place to learn and make improvements when things went wrong.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, some required a review to ensure they were effective.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, the practice had not undertaken DBS checks for reception staff who were carrying out chaperoning duties. There were no risk assessments in place to determine if a DBS check was needed dependent on their specific duties as a chaperone and the contact they had with patients, particularly children and vulnerable adults.</p> <p>At the November 2020 inspection, the practice had completed risk assessments to determine if a DBS check was required for their staff according to their job role and responsibilities. DBS checks had been obtained for all relevant staff including those members of staff who carried out the role of chaperone.</p>	

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.	Partial
Explanation of any answers and additional evidence:	

At the March 2020 inspection, we reviewed five staff files and found the practice had not obtained references to demonstrate satisfactory evidence of conduct in previous employment for two members of staff. The practice had not completed a risk assessment to determine if it was safe for these staff members to work with no checks on previous employment.

There was no system in place to check the ongoing professional registrations for clinicians. Professional registration was checked on employment. It was not checked annually when renewed by clinicians.

At the November 2020 inspection, the practice had strengthened their recruitment processes and pre-employment checks were in place.

The practice had implemented a policy to check the ongoing professional registration for clinicians. The policy stated that these would be checked on the same day each year for all clinicians rather than when the registration was due for renewal for each individual.

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: January 2020	Y
There was a record of equipment calibration. Date of last calibration: March 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check:	Y
There was a log of fire drills. Date of last drill: April 2019	Y
There was a record of fire alarm checks. Date of last check: November 2020	Y
There was a record of fire training for staff. Date of last training: Various dates for online training	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: July 2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: At the March 2020 inspection, there was no control of substances hazardous to health (COSHH) risk assessments for cleaning equipment kept in the practice or for practice consumables. We were informed until recently the independent cleaning company used by the practice did not leave cleaning products	

on the premises. However, there had been a change to the process to reduce the risk of spreading infections. Copies of the COSHH had not been obtained by the practice.

There was a record to show the fire alarms had been checked when serviced in August 2019. The practice informed us that the fire alarms were checked once a week. There was no documented log or record of this.

The fire risk assessment had not been completed by a person that had the necessary experience for the role. No mitigating actions had been identified from the fire risk assessment. We noted areas of risk relating to fire safety in the practice. For example,

- Fire doors were propped open.
- There were no fire alarm or emergency lighting checks completed.

Staff had not received fire safety training.

At the November 2020 inspection, COSHH risk assessments were in place for practice consumables. There was no cleaning equipment kept on site. COSHH risk assessments for cleaning equipment were held by the independent cleaning company.

A fire risk assessment had been completed and logs of fire alarm and emergency lighting checks were completed. There was an action log put in place following the fire risk assessment to complete the recommendations. For example,

- Clear and concise signage was in place to direct staff and patients what to do in the event of a fire.
- Storage was removed from the staff staircase so there was a clear exit.
- No smoking signs were displayed at the entrances to the building.

All staff had completed fire safety training.

The practice informed us that they had not completed the planned fire drill when it was due in April 2020 due to the restrictions in place with the COVID-19 pandemic. There had been no alternatives considered to ensure staff knew what actions to take if they needed to evacuate the practice in the event of a fire.

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: June 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.	Y
Date of last infection prevention and control audit: April 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
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, an infection prevention and control (IPC) audit had been completed for the main surgery. There was no audit completed for the branch surgery.</p> <p>There were some IPC concerns found. For example,</p> <ul style="list-style-type: none"> • There were cluttered surfaces in the treatment room that did not allow for the removal of dust. • There was no readily available information for sharps injuries to direct staff to the correct procedure to follow in the event of an injury. • Soap and hand gels were not wall mounted to allow for non-touch usage. <p>A legionella risk assessment had been completed for the main surgery in January 2019. There was no risk assessment completed for the branch surgery. It was not evident that the person who had completed the risk assessment was suitably experienced for the role. Some actions had been identified to mitigate the risk of legionella in the practice that included water temperature checks and running water outlets each week. There was no log kept to demonstrate these actions had been completed.</p> <p>At the November 2020 inspection, IPC audits had been completed for the main site and the branch surgery and actions completed. Additional measures were put in place due to the COVID-19 pandemic to minimise the risk of the spread of the infection. For example,</p> <ul style="list-style-type: none"> • A one-way system was in place for patients moving through the practice with separate entrance and exit points. • Hand-gel was available for staff and patients throughout the building including at the entrance and exit. • All visitors to the practice had their temperature checked on entry and confirmation that they were not experiencing recognised symptoms of COVID-19. • All staff were responsible for cleaning the surfaces of their work area including clinicians after seeing a patient. <p>A legionella risk assessment had been completed for the branch surgery by an external company. The practice had completed their own legionella risk assessment for the main site. No mitigating actions had been identified although the practice were recording and logging water temperature checks. It was not clear from the risk assessment that this action was necessary. It was still not evident that the person who had completed the risk assessment was suitably experienced for the role.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y

Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, we found non-clinical staff had not received sepsis training and no guidance readily available for them to recognise red-flag symptoms.</p> <p>At the November 2020 inspection, non-clinical staff had completed online sepsis training and guidance was available in the reception office to help them recognise red-flag symptoms.</p>	

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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, there was no failsafe system in place for the monitoring of two-week wait referral requests to secondary care for an urgent appointment. No checks were made to ensure patients with a potential cancer diagnosis had received an appointment within the recommended timeframe.</p> <p>Following the inspection, the practice informed us they had implemented a system to ensure patients received an appointment within the recommended timeframe.</p>	

At the November 2020 inspection, we found the practice had put a formal process in place to manage all two-week wait referral requests to secondary care for an urgent appointment. A log was kept of referrals and they were processed within 24 hours of when the patient had their GP consultation. There was an identified staff member who was responsible for managing the process and they contacted all patients to ensure they had received their appointment with a secondary care doctor.

The practice had carried out an audit of the process in November 2020 and found all referrals had been appropriately managed within the recommended timeframe.

A review of the patient computer records showed that some test results received by the practice had been assigned to one of the clinicians but had not been reviewed for two weeks. The practice took immediate action to rectify this and reviewed all of the test results at the time of the inspection. There were no abnormal results found that would have required action.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization. However, they had not always been followed.

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) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.75	1.17	0.82	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). (01/10/2019 to 30/09/2020) (NHSBSA)	7.6%	9.9%	8.8%	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 (01/04/2020 to 30/09/2020) (NHSBSA)	5.55	6.29	5.34	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	59.1‰	80.5‰	124.1‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	0.72	1.02	0.68	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, there was no formal clinical overview for non-medical prescribers. The practice had not completed their own prescribing audits to ensure that appropriate prescribing that followed current best practice guidelines was taking place.</p> <p>There was no system in place for monitoring patients' health in relation to the use of medicines including high risk medicines. Some patients were overdue a review.</p> <p>There were no contact details available for the Controlled Drug accountable officer for the practice to report incidents of significant concern. For example, patients or healthcare professionals fraudulently obtaining Controlled Drugs.</p>	

Medicines management	Y/N/Partial
<p>At the November 2020 inspection, the practice had a policy for the clinical overview for non-medical prescribers. Audits had been completed on a sample of consultation records that showed current best practice guidelines were followed.</p> <p>Prior to the inspection we completed a search of the patient computer record system to check if there was monitoring in place of patients' health in relation to the use of medicines including high risk medicines. We found that some patients were overdue a review. It was not evident that the system the practice had put in place following the March 2020 inspection was being followed. When we reviewed the computer record system again as part of the November 2020 inspection we found that the practice had made some progress in completing the required reviews.</p> <p>However, there were still some reviews that required attention. For example,</p> <ul style="list-style-type: none"> • There were 72 patients out of 76 who were prescribed a novel oral anticoagulant (NOAC), a drug used in the prevention of stroke for people diagnosed with a heart condition, who had not received appropriate monitoring. • There were two patients out of three who were prescribed lithium who had not had their weight monitored, which is a recommended requirement when prescribing this medicine. <p>Following the inspection, the practice provided evidence that these patients had been contacted and reviews were undertaken.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	21
Number of events that required action:	21
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, the practice had logged three significant events that had occurred in the preceding 15 months. We noted that one of these did not directly relate to the practice. Staff we spoke with knew how to report significant events. However, it was not evident that they were doing so. For example, the practice had to close for 24 hours in February 2020 for a deep clean following a potential contamination. This had not been recorded by the practice as a significant event and no learning had been identified by the practice.</p> <p>At the November 2020 inspection, staff we spoke with were aware of the process for the reporting and recording significant events. A log was kept of all significant events identified and it was evident that staff were recognising when they occurred and reported them. Significant events were a standing agenda item of the practice clinical meetings and were also discussed at staff meetings. Staff informed</p>	

us they were able to take part in discussions regarding significant events and learning was shared with all staff.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Errors were identified on a repeat prescription for a patient. There were multiple entries for the same medicine and another that should not have been on repeat had been prescribed.	The patient and their family were contacted and the error explained. They were advised of the correct medicines the patient needed. The dispensing pharmacy was contacted and advised to remove the duplicate items from the prescription. The clinician had a meeting with their supervisor to discuss the event. When discussed at the clinical meeting it was identified that extra care is needed when issuing repeat prescriptions especially for those patients who are new to the practice.
Mandatory training had not been completed by all staff members.	An online training package was put in place for all practice staff to use. Mandatory training was identified and assigned according to the role each staff member undertook. Protected time was allowed for training. Staff members were responsible for completing their own training and acting on reminders they were sent when the training was due. The positive outcome of the measures put in place were discussed at a staff meeting and staff were acknowledged for completing the training that had been identified for them.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, the practice was not receiving or acting on Medicines and Healthcare products Regulatory Agency (MHRA) patient safety updates. On the day of the inspection the practice registered to ensure they received the alerts. They informed us that they had followed the local clinical commissioning group guidance regarding prescribing that covered patient safety updates.</p> <p>There was no log kept of the actions they had taken.</p> <p>At the November 2020 inspection, the practice had registered to receive the Medicines and Healthcare products Regulatory Agency (MHRA) patient safety updates. A log of the alerts was kept that detailed the actions taken. When we reviewed the patient record system, we found that one female patient of child bearing age did not have a recommended annual risk acknowledgement to show that the risks in pregnancy when prescribed valproate had been discussed. Valproate is a medicine used in the treatment of epilepsy and has a risk of congenital malformations in infants if taken by the mother during pregnancy.</p>	

Effective

Rating: Requires Improvement

At the March 2020 inspection, we rated the practice as requires improvement for providing effective services because:

- Care was not delivered and reviewed in a coordinated way. There were no formal care plans in place for patients.
- The uptake for cervical screening and baby immunisations was below the national targets.
- There was no overview of training completed. Some essential training had not been completed.
- There was no formal clinical overview for non-medical prescribers.

At the November 2020 inspection, we rated the practice as requires improvement for providing effective services because:

- The uptake for cervical screening and baby immunisations was below the national targets. Actions taken to make improvements had not yielded the necessary improvements so far.
- Some improvements had been made. For example.
 - Care plans were in place as necessary for patients so care was delivered and reviewed in a coordinated way.
 - Staff had access to online training. Records of completed training were kept and staff had completed essential training.
 - A process was in place to ensure clinical overview for non-medical prescribers.

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

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. Care plans were in place for these patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks 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.
- The practice scored lower than others for one indicator where 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) was 140/90 mmHg or less.
- 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, 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
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	89.1%	97.1%	76.6%	Variation (positive)

RCP questions. (01/04/2019 to 31/03/2020) (QOF)				
PCA* rate (number of PCAs).	35.9% (345)	46.8%	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)	84.8%	100.0%	89.4%	No statistical variation
PCA rate (number of PCAs).	31.3% (42)	44.2%	12.7%	N/A

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)	69.4%	77.4%	82.0%	Variation (negative)
PCA rate (number of PCAs).	2.2% (6.0)	7.8%	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)	60.8%	62%	66.9%	No statistical variation
PCA rate (number of PCAs).	6.1% (60.0)	16.5%	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)	60.7%	66.7%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.2% (28.0)	No Data!	No Data	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)	94.5%	93.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	5.2% (4)	4.1%	4.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the childhood immunisation uptake indicators. The practice had not met the minimum 90% for all of the childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations and those who did not attend appointments. The practice informed us there had been a high number of non-attendees during the COVID-19 pandemic.
- 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.
- A register of children who had long-term conditions and complex diseases was kept and alerts were placed on the patient computer record. These patients were discussed at the monthly multi-disciplinary team meetings. All of these children had open access to the practice and the local hospital.
- 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)	217	258	84.1%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	183	237	77.2%	Below 80% uptake
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)	186	237	78.5%	Below 80% uptake
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)	178	237	75.1%	Below 80% uptake
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)	147	280	52.5%	Below 80% uptake

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

At the March 2020 inspection, the practice was aware they had achieved below the NHS England target of 90% minimum uptake for childhood immunisations. We were informed that a meeting had been arranged for the nursing staff to put an action plan in place to improve the uptake. This would include a review of practice nurse appointments available.

At the November inspection, we were informed by the practice that they had increased their contact with parents or guardians of children due to have childhood immunisations to establish why they had not attended. The amount of appointments available with the nursing staff had been reviewed and a new practice nurse had started who provided more availability of appointments. However, actions taken to make improvements had not yielded the necessary improvements so far.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had not met the 80% target set by Public Health England for the uptake of cervical screening.
- The uptake for bowel cancer screening was below local and national averages.
- 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.

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: 30/06/2020) (Public Health England)	58.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	62.7%	81.6%	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)	39.9%	63.9%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.00%	100.0%	100.0%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	52.4%	75.0%	53.8%	No statistical variation

Any additional evidence or comments

The uptake for cervical screening had decreased from the previous published result of 60.4%. The practice informed us that they had made efforts to increase the uptake of cervical screening. They recognised that due to their patient demographic there were some misconceptions regarding cervical screening so they provided eligible patients with links to online educational videos, in different languages, when they were invited for their appointments. One of the GP partners had been interviewed on a local radio station to discuss the benefits of cervical screening. They had also provided educational material to local community gyms and mosques.

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.
- All patients receiving end of life care were visited by a GP every two weeks.
- 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.
- Patients with caring responsibilities were referred to a carers organisation in Luton for support services.

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.
- A social navigator was available in the practice to signpost patients for support services.
- A mental health link worker was available in the practice one day a week.
- 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 (01/04/2019 to 31/03/2020) (QOF)	90.9%	98.2%	85.4%	No statistical variation
PCA rate (number of PCAs).	43.4% (59)	54.3%	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)	88.5%	100.0%	81.4%	No statistical variation
PCA rate (number of PCAs).	1.6% (1)	15.9%	8.0%	N/A

Any additional evidence or comments

The practice was aware they had high personalised care adjustments in some areas. Personalised care adjustments allow practices to adjust care and remove a patient from a particular indicator denomination due to a number of business rules. There was a recall system in place that meant patients were contacted at least three times and invited into the practice for their review.

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)	517.59	Not Available	533.9
Overall QOF score (as a percentage of maximum)	92.6%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	7%	Not Available	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

Any additional evidence or comments

The practice had completed four two cycle audits in the past two years. In the first cycle of the audits, actions were identified to make quality improvements. The second cycle of the audit demonstrated that the improvements had been made. For example,

- An audit was completed to ensure that patients prescribed non-steroidal anti-inflammatory drugs (NSAIDs) received appropriate medicines to prevent gastro-intestinal bleeding. The second cycle of the audit showed an increase in the number of patients receiving the gastro-protection medicine and for those who weren't, a discussion regarding the risks of taking NSAIDs had taken place.

The practice had undertaken two one cycle audits that looked at recent changes that had been made in the practice. For example,

- An audit had been done of the new process put in place to ensure urgent referrals to secondary care were made and patients received an appointment within the recommended timeframe of two weeks.

The practice identified when an audit was required from a number of different areas including reported incidents, identified learning needs and patient safety alerts.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, the practice training policy did not identify what was considered mandatory training for the practice staff.</p> <p>There was no overview of training completed and no record that staff had completed essential training. For example, fire safety, infection prevention and control and basic life support.</p>	

We were informed that the practice had planned to start using online training and the system used would supply an overview of training that staff completed.

There was no formal clinical overview for non-medical prescribers. The practice was not doing their own prescribing audits to ensure that appropriate prescribing following current best practice guidelines was taking place.

At the November 2020 inspection, the practice had updated the training policy to identify what training was considered mandatory. Online training was provided for all staff and a log was kept to ensure the practice management had an overview of what training had been completed. Records showed that all staff had completed essential training.

A process had been put in place for the clinical overview for non-medical prescribers. Audits had been completed on a sample of consultation records that showed current best practice guidelines were followed.

Coordinating care and treatment

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

Indicator	Y/N/Partial
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.	N/A

Explanation of any answers and additional evidence:

At the March 2020 inspection, there were no formal care plans in place for patients. The patient computer record system indicated that care plans had been completed. However, when we looked at individual records, they did not contain any. This included patients with dementia who were covered by a Quality and Outcomes Framework (QOF) indicator for having care plans reviewed annually.

At the November 2020 inspection, the practice were using a computer software tool to help them manage the care of their patients and to ensure current guidelines were followed. A review of the patients' computer records showed that the practice were using care plans for patients when appropriate.

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
Explanation of any answers and additional evidence: Smoking cessation and healthy eating advice were offered in the practice. Patients were also referred to a local wellbeing service for health and lifestyle advice.	

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

The practice was rated as good for providing caring services when they were inspected in November 2014. This domain was not inspected as part of the March 2020 inspection.

At the November 2020 inspection, we rated the practice as good for providing caring services because:

- Staff dealt with patients with kindness and respect.
- Feedback from patients was positive regarding the care they received.
- The practice had measures in place to support carers. However, less than 1% of the practice population was identified as having caring responsibilities.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mostly 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: The practice were aware of their diverse population and had made links with the community via local mosques and radio stations to provide health education and support.	

CQC comments cards

Due to the COVID-19 pandemic, CQC comment cards were not able to be used. Prior to the inspection, patients were encouraged to complete 'Share your experience' forms through the CQC website.

Total comments received.	26
Number of comments received which were positive about the service.	23
Number of comments received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Share your experience forms	Positive comments were made regarding all staff groups within the practice. Staff were described as friendly, polite and helpful. Comments made about the clinical staff included that they were courteous and supportive to patients. Patients said they felt listened to and were happy with the service and treatment. There was one negative comment regarding the care received at the practice and the mixed reviews commented negatively on access to the practice via the telephone.

The NHS Website	Comments were generally positive regarding the care received and staff attitudes. There were two negative comments. However, these did not relate to visits to the practice in the previous 12 months.
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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 (01/01/2020 to 31/03/2020)	80.5%	97.8%	88.5%	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 (01/01/2020 to 31/03/2020)	85.3%	95.1%	87.0%	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 (01/01/2020 to 31/03/2020)	94.6%	100.0%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	60.3%	97.9%	81.8%	Variation (negative)

Any additional evidence or comments

The practice were aware of the National GP Survey results. However, no actions had been put in place to address the area where they scored below the local and national averages.

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

Any additional evidence

The practice used the NHS Friends and Family Test to gather feedback from their patients. Feedback could be left either in the practice or online via the practice website. However, this had feedback had not been gathered throughout the COVID-19 pandemic.

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: Translation services were used for patients who did not speak English. The clinical staff were able to print health information for patients from the computer record system.	

Source	Feedback
Share your experience forms	We received positive comments from patients regarding their care and treatment and how they are kept informed of their medical conditions and medicines.

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 (01/01/2020 to 31/03/2020)	92.7%	99.3%	93.0%	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
Explanation of any answers and additional evidence: There was a Wellbeing Centre section on the practice website that contained links to health education and support services.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 109 patients with caring responsibilities. This equated to 0.7% of the practice population.
How the practice supported carers (including young carers).	The practice had identified a staff member to be a carers lead. They were supported in this role by the operational manager. Annual flu vaccinations were offered to carers. Support information was available in the patient waiting area and on the practice website.
How the practice supported recently bereaved patients.	A telephone call was made to recently bereaved patients with advice given of 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

If the practice offered online services:

	Y/N/Partial
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: Telephone and video consultations had been developed and increased due to the COVID-19 pandemic.	

Responsive

Rating: Inadequate

The practice was rated as good for providing responsive services when they were inspected in November 2014. This domain was not inspected as part of the March 2020 inspection.

At the November 2020 inspection, we rated the practice as inadequate for providing responsive services because:

- The results of the National GP Patient Survey highlighted that patients were not always able to access care and treatment in a timely way. Actions had not been taken to address the lower than average patient satisfaction.
- Learning from complaints and actions taken to prevent reoccurrence were not documented.

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:	
The practice was in a purpose built building with treatment rooms and consultation rooms over two floors. A lift was available for patients with mobility issues. There was an intercom at the front door for patients who required assistance. Disabled parking spaces and access enabled toilet facilities were available.	

Practice Opening Times	
Day	Time
Blenheim Medical Centre	
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
The Link Surgery (branch)	
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm

Thursday	8am to 2.30pm with telephone cover available until 6.30pm
Friday	8am to 6pm
<p>Appointments were available throughout these times.</p> <p>The practice made use of the Luton Extended Hours Service to book routine appointments with a GP, practice nurse or health care assistant in the evenings and weekends. This service operated on Monday to Friday evenings from 6pm to 9pm and Saturdays and Sundays from 8.30am to 2.30pm at two local GP practices.</p> <p>Home visits were available for housebound patients.</p>	

Older people

Population group rating: Inadequate

Findings

The concerns identified with the responsiveness of the service affected all of the population groups. However, there were areas of good practice for older people.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- Housebound patients were signposted to a medicines delivery service.
- The practice funded exercise and socialise classes for older people one day a week. We were informed these were attended by approximately 30 patients.

People with long-term conditions

Population group rating: Inadequate

Findings

The concerns identified with the responsiveness of the service affected all of the population groups. However, there were areas of good practice for people with long-term conditions.

- 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: Inadequate

Findings

The concerns identified with the responsiveness of the service affected all of the population groups. However, there were areas of good practice for families, children and young people.

- Appointments were available outside of school hours.
- 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.
- The practice was working with the primary care network and had started a multi-disciplinary clinic for children with complex needs.
- Sexual health advice and contraception services were provided including the provision for long acting reversible contraception (LARC).

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The concerns identified with the responsiveness of the service affected all of the population groups. However, there were areas of good practice for working age people (including those recently retired and students).

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Telephone consultations were available for those who could not attend the practice during normal working hours.
- Evening and weekend appointments were available at the extended access service.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The concerns identified with the responsiveness of the service affected all of the population groups. However, there were areas of good practice for people whose circumstances make them vulnerable.

- 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.
- Patients with caring responsibilities were identified and offered support information.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

The concerns identified with the responsiveness of the service affected all of the population groups. However, there were areas of good practice people experiencing poor mental health (including people with dementia).

- 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.
- Annual health checks were offered.
- The practice had access to a mental health worker and a social prescriber to support patients.

Timely access to the service

People were not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	35.0%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	34.3%	48.6%	65.5%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	35.7%	52.6%	63.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	44.6%	60.3%	72.7%	Variation (negative)

Any additional evidence or comments

The practice were aware of the National GP Patient Survey results and that they had scored lower than others both locally and nationally in areas relating to patient satisfaction with access to care and treatment. However, the practice had not completed or planned any actions to take to make improvements to these areas of patient satisfaction.

Source	Feedback
Share your experience forms	Two patients who gave mixed reviews commented that there was a long wait to get through to the practice via the telephone.

Listening and learning from concerns and complaints

Complaints were listened and responded to. Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	9
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
Any additional evidence or comments	
Both of the complaints we examined were handled in a timely way. One of the responses to the complaints did not contain information for the complainant to contact the Parliamentary and Health Service Ombudsman if they were not satisfied with the outcome of the complaint or how it was dealt with.	

	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: Information on how to complain was available in the practice and on the website. Staff we spoke with were aware of appropriate actions to take if a patient wished to make a complaint.	

Examples of learning from complaints.

Complaint	Specific action taken
A complaint was made about the appointment system.	An explanation was given to the patient as to why specific processes were in place when booking an appointment. The patient was invited to join the patient participation group (PPG) so their views could be taken into consideration for improvements to be made.
A complaint about a GP's attitude during a consultation	An explanation and an apology was given to the patient. A review of the consultation made at the GPs appraisal.
Any additional evidence or comments	
The practice kept a log of formal complaints made and completed an annual review of complaints. Trends were identified in the review. However, there was no documentation of learning identified and actions taken to prevent reoccurrence. Actions were taken appropriately to resolve individual complaints.	

Well-led

Rating: Requires Improvement

At the March 2020 inspection, we rated the practice as inadequate for providing well-led services because:

- There were concerns related to good governance within the practice.
- The practice did not always have clear and effective processes for managing risks, issues and performance.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

At the November 2020 inspection, we rated the practice as requires improvement for providing well-led services because:

- There were still some concerns related to good governance within the practice.
- The systems, practices and processes put in place had not been established fully and operated effectively to ensure compliance with requirements to demonstrate good governance.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels. However, this was not always effective.

	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.	Partial
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: At the March 2020 inspection, we found the governance structures in place did not always support the actions to address challenges. At the November 2020 inspection, we found the practice had made some improvements to address the concerns identified at the previous inspection. However, some actions had not been completed and the practice did not always identify for themselves what actions were needed. For example, <ul style="list-style-type: none">• The practice informed us they were aware they had scored lower than others locally and nationally for some areas of the National GP Patient Survey. They had not put an action plan in place to make improvements.• Learning from complaints and actions taken to prevent reoccurrence were not documented.	

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: The practice had a policy in place that outlined their vision and values. The values were displayed on the wall in the reception office.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: At the March 2020 inspection, the practice had some measures in place to support the well-being of staff such as regular staff meetings, informal meetings to celebrate successes and appraisals. However, they were not supported with essential training and clinical oversight. At the November 2020 inspection, the practice had identified the training their staff required according to their roles and all staff had received essential training. Clinical oversight measures were in place for locum GPs and non-medical prescribers.	

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

Source	Feedback
Staff	Staff we spoke with reported they were supported by the practice management and GPs. They felt safe attending work during the COVID-19 pandemic as they had been supported by personal risk assessments, personal protective equipment (PPE) and social distancing measures.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. These were not always effective.

	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
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, the policies and procedures in place were not sufficient to govern activity in the practice. For example,</p> <ul style="list-style-type: none"> • The practice training policy had not identified what was considered mandatory training. This led to staff not receiving essential training for their roles. • There was no policy for monitoring patients' health in relation to the use of medicines including high risk medicines. • Recruitment procedures were not followed to ensure staff were safe to work in the practice. <p>At the November 2020 inspection, some improvements had been made to the governance structures. We found some of the systems, practices and processes put in place needed some adjustment to ensure they were effective and embedded fully into practice. For example,</p> <ul style="list-style-type: none"> • The policy in place to check the ongoing professional registration for clinicians did not recognise that these were renewed on individual dates and therefore required a check on that date rather than the same date annually for all clinicians. • The process for managing test results had not been effective as we found some results had not been reviewed by a clinician for two weeks. • A policy was in place to monitor patients' health in relation to the use of medicines that required a review. A search of the patient computer record system indicated that necessary reviews had not been completed for all patients that required one. 	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the March 2020 inspection, risk assessments were not completed by people who had the necessary experience to do them. The risk assessments completed for fire safety and legionella did not identify necessary mitigating actions to reduce risk. There was no control of substances hazardous to health (COSHH) risk assessments for cleaning equipment kept in the practice or for practice consumables. An infection prevention and control (IPC) audit had not been completed for the branch site, The Link Surgery. The completed IPC audit for the main site, Blenheim Medical Centre, did not identify mitigating actions needed to improve IPC.</p> <p>At the November 2020 inspection, a fire risk assessment had been completed by an external company and recommended actions completed. However, the practice had not completed the planned fire drill when it was due in April 2020 due to the restrictions in place with the COVID-19 pandemic. There had been no alternatives considered to ensure staff knew what actions to take if they needed to evacuate the practice in the event of a fire.</p> <p>The practice had completed their own legionella risk assessment for the main site. No mitigating actions had been identified although the practice were recording and logging water temperature checks. It was not clear from the risk assessment that this action was necessary. It was still not evident that the person who had completed the risk assessment was suitably experienced for the role.</p> <p>Improvements had been made to IPC measures. IPC audits had been completed for both sites and necessary actions taken. This included additional actions to keep patients and staff safe during the COVID-19 pandemic.</p>	

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 to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice had a patient participation group (PPG) that had developed in the preceding twelve months. Prior to the COVID-19 they held meetings approximately every three months that were attended by representatives from the practice. Whilst the group could not meet in person the practice communicated with them via email. The PPG members reflected the age range and ethnicity of the practice population. There was information on the practice website for patients who wished to join the PPG.	

Feedback from Patient Participation Group.

Feedback
Feedback from the PPG on the day of the inspection was positive regarding the practice. They informed us that they felt listened to by the practice staff.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: At the March 2020 inspection, we found the practice did not recognise that significant events should be logged, investigated and learnt from to improve patient safety. There were three events reported within the last 15 months, one of these was not directly related to the practice.	

At the November 2020 inspection, improvements had been made to the process for reporting and learning from significant events. Significant events were a standing agenda item of the practice clinical meetings and were also discussed at staff meetings. Staff informed us they were able to take part in discussions regarding significant events and learning was shared with all staff.

Examples of continuous learning and improvement

- All of the GP partners were trainers. The practice was a training practice and currently had four GP registrars (GP registrars are qualified doctors training in general practice).
- The practice were part of a primary care network (PCN) and worked closely with other GP practices within the network to improve the care of patients within the locality. For example, a multi-disciplinary open access service for children with complex needs, and their families, had recently started that provided a 'one stop' weekly clinic where these patients could be seen by a GP, pharmacist, social prescriber and a care coordinator to have their needs and care assessed.
- The PCN had supported the practice to make improvements following the February 2020 inspection.

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 practices 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. (see [GMS QOF Framework](#)).
- ‰ = per thousand.