

Care Quality Commission

Inspection Evidence Table

Leighton Road Surgery (1-582132545)

Inspection date: 30 September 2020

Date of data download: 21 September 2020

Overall rating: Requires Improvement

At the July 2019 inspection, the practice was rated inadequate overall and placed into special measures because:

- We saw evidence of a lack of clinical oversight and clinical systems to ensure patients were appropriately entered onto disease registers or received appropriate reviews.
- The system to manage pathology results was ineffective and abnormal blood results were not being appropriately actioned.
- Safety alerts were not appropriately managed and there was no oversight to ensure these had been actioned.
- Medicines that required additional monitoring were not appropriately managed and blood tests were not being completed at the necessary time.
- National GP patient survey results were below local and national averages and had declined since 2018 results.
- Patients told us there was difficulty accessing the practice via the telephone and staff told us there was not enough provision for appointments.
- The practice had not completed business planning, succession planning or action plans to improve the service.

At the September 2020 inspection, the practice was rated requires improvement overall because:

- Clinical systems had improved, and patients were receiving the appropriate care and reviews.
- Pathology results were managed effectively and records we looked at showed appropriate action was being taken.
- Medicines that required additional monitoring were appropriately managed and blood tests were being completed as necessary.
- The practice had not met the Public Health England target for completing cervical screening and levels of screening completed had declined since 2019.
- The number of mental health care plans completed by the practice was below local and national averages and declined since 2019.
- National GP Patient survey results remained below local and national averages and some indicators had further declined since the 2019 results.

- Patient feedback had improved regarding access to the practice however, some patients still told us that there was difficulty accessing the practice via the telephone. The practice had increased clinical capacity since the July 2019 inspection and had clear action plans to improve access.
- The practice had completed relevant business plans with associated action plans and had a clear vision of how to improve the service.

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

Safe

Rating: Good

At the July 2019 inspection, we rated the practice as inadequate for providing safe services because:

- There were ineffective systems to manage safety alerts and these had not been appropriately actioned.
- Medicines that required additional monitoring were not appropriately managed. We saw that some patients were not receiving blood tests at the necessary time.
- Fridges containing vaccinations were unlocked and emergency medicines were stored in patient accessible areas. Sharps bins were also not stored safely.
- Cleaning logs of rooms and multiple-use equipment were not maintained.
- Abnormal pathology results were not always actioned in a timely manner.

At the September 2020 inspection, we rated the practice as good for providing safe services because:

- The practice was inspected in November 2019 and was compliant with warning notices issued following the July 2019 inspection and legal requirements.
- Safety alerts were effectively managed and clinical records we checked showed appropriate actions had been taken.
- Medicines that required additional monitoring were managed effectively. Records we checked showed that all patients had received appropriate blood testing.
- All medicines including vaccinations and emergency medicines, were held safely in areas that could not be accessed by patients.
- Sharps bins were stored safely on wall mounted units.
- The system to review pathology results was effective. The practice had reviewed this process and told us that all results were fed back to patients by a clinician within 24 hours.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed safeguarding processes at the November 2019 inspection where we found effective processes in place.</p> <p>Each consultation room had information of local safeguarding contacts and how to escalate concerns.</p> <p>The practice held safeguarding meetings with community teams on a monthly basis where safeguarding registers were reviewed. Minutes of these meetings, with highlighted actions, were circulated to all staff, including locum staff. The practice also held twice weekly clinical liaison meetings with the multi-disciplinary team to raise any urgent safeguarding concerns.</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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had reviewed their induction processes and made appropriate changes in light of the COVID-19 pandemic. All staff immunisation records were collected at the point of recruitment and held by East London Foundation Trust (ELFT).</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 14/09/2020	Y
There was a record of equipment calibration. Date of last calibration: 25/03/2020	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: 01/04/2020	Y
There was a log of fire drills. Date of last drill: 22/09/2020	Y
There was a record of fire alarm checks. Date of last check: Weekly	Y
There was a record of fire training for staff. Date of last training: Ongoing	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 22/09/2020	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice conducted weekly checks of smoke detectors, emergency lighting and fire doors. A fire risk assessment had recently been completed with actions for improvement identified. High risk actions, such as removing keypad locks from corridors, had been completed within 48 hours and the practice had plans to complete the lower risk actions within three months.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 14/09/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had completed the urgent actions highlighted by the external audit, such as moving refrigerators to ensure access to a fire exit and had plans to complete the less urgent actions over the next three months.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:22/02/2020	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
<p>Explanation of any answers and additional evidence:</p> <p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"> Sharps bins that contained needles were accessible to patients which may increase the risk of needlestick injuries. The practice did not maintain up-to-date cleaning logs of rooms and non-single use items, such as blood pressure cuffs. <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice had reviewed the clinical waste policy and sharps bins had been mounted to walls away from the reach of patients. Cleaning logs of equipment and rooms were kept in each consultation room and reviewed daily. <p>At the September 2020 inspection we found:</p> <ul style="list-style-type: none"> The practice had reviewed Infection Prevention and Control (IPC) processes in light of the COVID-19 pandemic. They had increased cleaning, removed soft furnishings, put screens in place at reception desks and reduced patient interaction as appropriate. They had sought support from the clinical commissioning group and conducted training for IPC and the use of Personal Protective Equipment (PPE). They had also employed a housekeeper in order to ensure consistent cleanliness. The practice had completed regular IPC audits, including regular sharps bins audits to ensure compliance. The IPC audit had also identified that shelving in clinical rooms required removal and apron dispensers needed installing. We saw that both of these actions had been completed. IPC is a standing agenda item at all clinical governance meetings. A legionella risk assessment was completed in November 2019. This risk assessment recommended that water temperatures were checked on a monthly basis and we saw evidence that this was being completed. (Legionella is a term for a bacterium which can contaminate water systems in buildings.) 	

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>Staff told us that there was enough staff to cover absences and the teams worked together to ensure that the workload was managed.</p> <p>Clinical records we looked at showed treatment was in line with guidance and risk assessments were completed where necessary.</p> <p>The practice had analysed the local population and was aware that in the absence of a local hospital, patients would attend the practice when they may be acutely unwell. The practice had developed a policy that included 'red flag' symptoms that ensured reception staff escalated these patients to the duty doctor urgently. Patients who had safeguarding concerns or who were on the palliative care register were also escalated for urgent appointments. When appropriate, reception staff were also aware to signpost patients with symptoms of COVID-19 to the 'red hub' at the Leighton Road site. (A 'red hub' is a modified unit used for all patients showing signs of COVID-19 in a particular area needing to be seen by a health care professional throughout the pandemic.)</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.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us there had been a backlog of referrals and summarising of new patient notes in the past, however, an increase in staffing had ensured this was completed. Staff understood the importance of not letting this build up again.</p> <p>The system for managing pathology results was effective and there were cover arrangements to review abnormal results if certain clinicians are unavailable. We were informed that each day an identified GP reviewed all blood results and ensured actions were taken within 24 hours.</p> <p>The practice maintained monthly clinical multi-disciplinary meetings with community teams and had introduced twice weekly clinical liaison meetings to share information regarding vulnerable patients. The practice also used the same clinical record system as many community services to enable safe information sharing.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.80	0.86	0.85	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). (01/07/2019 to 30/06/2020) (NHSBSA)	6.3%	8.8%	8.6%	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 (01/01/2020 to 30/06/2020) (NHSBSA)	4.91	5.23	5.35	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	1.59	1.95	1.92	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

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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 July 2019 inspection we found:</p> <ul style="list-style-type: none"> • Fridges containing vaccinations and emergency medicines were unlocked and in a patient accessible area. We saw evidence that any breaches of the cold-chain were managed as a significant event and remedial actions, such as labelling plug sockets, were completed. We also saw that emergency medicines were held at a low level in a patient accessible area. • We checked records of patients who were prescribed medicines that needed additional monitoring and saw that appropriate blood monitoring was not always completed. <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> • Fridges containing medicines had been moved into treatment rooms and secured when not in use • The emergency medicines and equipment had been removed from an accessible area and was held securely behind reception. The practice had considered the safety of this location and was installing black-out blinds to ensure the medicines could not be seen from outside the practice. • We looked at patients who were prescribed medicines for mental health conditions and cancer that required additional monitoring and saw that patients had received appropriate blood testing prior to prescribing. 	

At the September 2020 inspection we found:

- Clinical records we checked showed all patients had received appropriate blood testing and review prior to prescribing.
- We saw that the practice had conducted several audits to identify where prescribing could be improved. For example, a two-cycle audit was completed regarding the prescribing of epi-pens following a recent safety alert. (Epi-pens are auto-injectable devices used for the treatment of severe allergic reaction). We saw that in March 2020, 33% of these prescriptions needed amendment and in September 2020 only 3% needed amending. There were plans to repeat this audit on a three-monthly basis.
- The practice told us that most prescriptions were generated via an electronic prescribing service, and they kept a very low level of paper prescriptions. Paper prescriptions were held in a locked office and logged to ensure they were not misused.
- Staff told us that the system for managing correspondence from other health care professionals was effective. Clinical records we looked at confirmed this.
- The practice had completed a risk assessment that identified which emergency medicines were needed onsite, this included consideration of how far they were from the nearest hospital. We saw that they held a range of emergency medicines and equipment which was checked daily.
- We saw evidence that the nurse manager conducted regular consultation and prescribing reviews for advanced practitioners, including locum staff. General feedback from these audits was delivered to the whole clinical team at clinical governance meetings, for example, improvements were needed in documentation of patient understanding. Individual feedback was given to clinicians as needed.

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:	14
Number of events that required action:	14
<p>Explanation of any answers and additional evidence:</p> <p>There were no concerns regarding the process of managing significant events at the July 2019 inspection.</p> <p>The practice had implemented a new system of recording incidents that were shared trust wide. This allowed identification of themes and learning to be shared across the various ELFT sites.</p> <p>We saw that significant events were discussed at clinical governance meetings and actions were taken to prevent recurrence of incidents. Each incident was reviewed after three months to ensure all actions had been completed. Staff we spoke to, including locum staff, were aware of the process to raise significant events and were involved in discussion regarding the management of incidents.</p>	

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

Event	Specific action taken
Trip and fall by a patient at the practice.	Medical attention given as necessary. A repeat health and safety assessment was completed in the area of the accident.
Vaccine delivery was not refrigerated on arrival.	The event was discussed with staff at a practice meeting. A revised protocol was put in place to ensure reception staff alerted nurses to an arrival of vaccinations. Reception staff were provided with training regarding the cold chain. All vaccinations that were not stored appropriately were destroyed in line with Public Health England guidelines.
A care home resident was not given appropriate antibiotics.	The practice determined that this incident was due to the inconsistency of GP's attending to care home residents. Since March 2020, the practice had ensured that the same GP visits the home to maintain consistency and get to know the residents.

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 July 2019 inspection we found:</p> <ul style="list-style-type: none"> • Recommendations made at the February 2019 inspection had not been acted on. • We looked at two recent safety alerts for thyroid medicine and diabetic medicine that were published in February 2019. We found that appropriate action had not been taken. We saw examples where patients had not received appropriate information regarding their medicines in line with these alerts. Staff we spoke with were not aware of recent medicine and safety alerts. <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> • The practice had reviewed the management of patient safety alerts and records we looked at confirmed the appropriate action had been taken. <p>At the September 2020 inspection we found:</p> <ul style="list-style-type: none"> • Patient safety alerts were also circulated by ELFT with actions to complete. • We saw evidence that the practice maintained a log of alerts that required action. The practice pharmacy technician then completed the relevant patient searches and ensured actions were taken. Clinical records we looked at confirmed this system was effective. • Patient safety alerts were a standing agenda item at all clinical governance meetings, and we saw evidence that relevant actions were discussed with clinical staff. 	

Effective Improvement

Rating:

Requires

At the July 2019 inspection we rated the practice as inadequate for providing effective services because:

- We saw evidence of a lack of clinical oversight and clinical systems to ensure patients were appropriately entered onto disease registers.
- We saw evidence to show that not all patients with a long-term condition received appropriate reviews.
- We saw examples of abnormal blood results not being actioned or followed up. We also saw examples of patients who had not been followed up by the practice when they had not attended appointments.
- We saw evidence of patients being inappropriately exception reported who had not had the appropriate follow up. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)
- We found the system for checking the monitoring of medicines that required review was not effective.

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

- The population groups of working age patients and patients experiencing poor mental health have been rated requires improvement however, the other population groups have been rated good because patients were able to access effective services.
- The practice had not reached the Public Health England targets for cervical screening uptake. The level of screening offered had dropped since 2019.
- The practice were below local and national averages for the completion of mental health care plans. The percentage of patients with completed care plans had dropped since 2019.
- There was clear clinical oversight and systems to support patients receiving care for long-term conditions or on disease registers.
- We saw that systems to review blood results were effective and, following patient input, the process had been revised to ensure all blood results were fed back to patients by a clinician within 24 hours of receipt.
- Exception reporting was in line with local and national averages. Clinical records we looked at showed patients were excepted appropriately and had the necessary follow up.
- We found systems to monitor medicine prescribing was effective and the practice conducted regular audits to ensure patients had received the appropriate blood monitoring. Clinical records we checked showed all patients had received the necessary blood testing prior to prescribing.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: We saw evidence that up to date clinical guidance was shared and discussed at clinical governance meetings. Clinical guidelines were embedded into clinical systems and records we looked at were in line with national guidance. Throughout the COVID-19 pandemic, the practice has been aware of health inequalities that were within their practice population. They had utilised tools from the clinical commissioning group in order to further identify actions that could reduce these inequalities and ensure all patients could access health and wellbeing services. The practice had developed a 'walk-in' policy which included 'red-flag' symptoms and protocols to ensure these patients were immediately escalated to the duty doctor.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) <small>(NHSBSA)</small>	0.58	0.77	0.70	No statistical variation

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 medication reviews for older patients. The newly formed Prescription Clerk Team had a dedicated phone line for managing prescription concerns on an individual basis. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. • The practice was aware that a large proportion of the older population was shielding during the COVID-19 pandemic. Regular welfare calls were made to patients and, where appropriate patients were taught how to self-manage, for example, changing their own dressings with remote support.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. The lead GP had protected time to review disease registers and ensure patients were receiving the appropriate care.
- Patients with long-term conditions were referred to social prescribers to support with lifestyle changes and community resources where appropriate.
- 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. However, due to guidance published by NHS England, this service has been paused due to the COVID-19 pandemic.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma or other long-term conditions.
- Patients with COPD were offered rescue packs. All prescription requests for rescue packs were reviewed by the respiratory nurse and patients were invited in for a consultation if necessary.
- Patients with asthma were offered an asthma management plan. Patients who were difficult to engage in asthma planning were offered online questionnaires and remote reviews. Online questionnaires were also available for patients with stable epilepsy and hypertension.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	79.1%	77.2%	76.6%	No statistical variation
Exception rate (number of exceptions).	17.5% (238)	14.4%	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	92.3%	89.6%	89.4%	No statistical variation

Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
Exception rate (number of exceptions).	13.9% (42)	16.6%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
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) <small>(QOF)</small>	93.7%	94.4%	91.8%	No statistical variation
Exception rate (number of exceptions).	5.6% (15)	3.7%	4.9%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for all of four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of four childhood immunisation uptake indicators.
- The practice had identified that they had a higher than average number of young children in their practice population and hosted a regular midwife clinic. These clinics were available daily and at weekends and to all patients across the Primary Care Network.
- 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.
- The practice contacted the parents or guardians of children due to have childhood immunisations. Childhood immunisations continued safely during the COVID-19 pandemic. The practice told us examples of where they had adjusted provision to meet the needs of young children, including referring to Cognitive Behavioral Therapy services for needle-phobic patients.
- 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.
- Young people could access services for sexual health and contraception. The practice held weekly coil and implant clinics for both registered and unregistered patients.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	241	251	96.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	307	328	93.6%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	308	328	93.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	307	328	93.6%	Met 90% minimum

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

Any additional evidence or comments

The levels completed child immunisations has decreased since the July 2019 inspection. The practice was aware of the levels of child immunisations they have had achieved. They told us that the area had a high transient population that were often difficult to engage in vaccination programmes. Families of newborn children were contacted three times via telephone and letter to attend immunisations before being referred to health visitors for follow up.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice was below the National target for uptake of cervical screening.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. The practice has audited the percentage of patients that are registered with online service, including prescription services, and this is above local averages.

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: 31/03/2020) (Public Health England)	72.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	68.9%	73.2%	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)	57.3%	56.8%	58.0%	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)	55.6%	54.9%	53.8%	No statistical variation

Any additional evidence or comments

The practice told us they pro-actively contacted patients who were due for cervical screening. They were offered various appointments with female practitioners.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required and for all annual reviews of dementia, learning disability and mental health conditions.
- 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 held monthly meetings with community palliative teams to share information and discuss patients. The minutes from these meetings and the palliative register was circulated to all practice staff. The practice followed up on any palliative patients who had attended A&E.
- 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.
- During the COVID-19 pandemic, the practice made regular welfare calls to all shielded, isolated and vulnerable patients, including carers. Appropriate actions were taken in individual cases, including safeguarding referrals where appropriate. Over 500 patients were offered advance care planning with a clinician at this time. Staff who undertook these calls were trained for the role and supported by management teams.
- Following the calls the practice made to housebound and isolated patients, they identified vulnerable patients with safeguarding and mental health concerns. This led to the practice employing a complex care matron who will establish systems to support this cohort of patients.
- The practice had developed twice weekly clinical liaison meetings to discuss vulnerable and palliative patients and develop relationships with community teams to enable information sharing.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

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 the administration of long-term medication. This was completed by the Prescription Clerk Team and escalated to a clinician. There was also a system in place to identify patients who were ordering excess amounts of medicines and this was managed appropriately.
- 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. Mental health training had also been provided for all non-clinical staff.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had identified that pathways for patients with mental health conditions were unclear and had begun an improvement project with external providers to increase access to community mental health services. They also held monthly multi-disciplinary meetings with community mental health teams to discuss patient needs and share information.

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) <small>(QoF)</small>	47.4%	79.8%	85.4%	Variation (negative)
Exception rate (number of exceptions).	10.0% (15)	27.1%	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) <small>(QoF)</small>	76.5%	81.2%	81.4%	No statistical variation
Exception rate (number of exceptions).	5.7% (9)	13.6%	8.0%	N/A

Any additional evidence or comments

The practice was aware of the low clinical indicators with the completion of mental health care plans. They had embarked on a quality improvement plan regarding increased integration of services with local mental health teams and one to one training for staff to increase knowledge and performance in mental health care.

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)	517.3	540.8	539.2
Overall QOF score (as a percentage of maximum)	92.5%	96.7%	96.7%
Overall QOF exception reporting (all domains)	6.8%	6.3%	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
Explanation of any answers and additional evidence: Any patients that had frequent admissions to hospital were discussed at multi-disciplinary meetings to ensure appropriate admission avoidance actions were in place.	

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

The practice had a clear audit schedule and participated in audits led by the clinical commissioning group.

The practice had completed a two-cycle audit regarding those with blood results that may indicate diabetes. The audit was initially completed in August 2019 where the practice identified 123 patients with abnormal blood results that had not had appropriate action taken. All of these patients were contacted and followed up as appropriate. The practice discussed these results with clinicians and strengthened the recall process. The audit was repeated in February 2020, where they found that no patients had abnormal blood results that had not been followed up appropriately. The practice now repeats this audit monthly in order to ensure all patients were followed up as necessary.

The practice had also completed a two-cycle audit regarding the referrals following the identification of a breast lump. This was discussed at clinical governance meetings. At the most recent audit cycle it was found that 42 of the 43 affected patients had been referred appropriately. We saw evidence that the results of this audit had been discussed with staff and actions taken.

Any additional evidence or comments

The practice had a strong focus on improving practice through audits and feedback. Quality improvement meetings were held every two weeks to discuss ongoing projects. Data was used to identify areas of concern and improvement activity was focused on this area, for example, improving mental health provision. ELFT had a clear audit plan that included training all staff to be involved in audit. We saw evidence of feedback of results of audit and projects to staff and their involvement in forums to discuss upcoming project ideas.

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>Staff told us that they had opportunities to discuss their learning needs and these were monitored by management teams. The practice had implemented monthly one to one sessions with all staff where data was used to monitor and improve staff performance. Staff told us they were encouraged to progress and develop new skills. Appraisal records we looked at showed discussion of objectives, career progression and support needed.</p> <p>We reviewed how the practice maintained oversight of advanced practitioners at the July 2019 inspection and found the process was effective. Since the July 2019 inspection, we saw that the practice had implemented a system of consultation audits of nursing staff completed by the nurse manager. We saw that feedback from these reviews was given to staff at supervision sessions.</p>	

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.	Y

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:	
<p>The practice held a health fair in January 2020 where 26 stalls were set up to provide information on local health, fitness, volunteer and support initiatives. Approximately 400 people from the local population attended. The practice received positive feedback from the community and planned to hold a further event in September 2020. However, due to the COVID-19 pandemic, this had to be postponed.</p> <p>The practice had also employed two social prescribers and have plans to set up a community hub for the local residents to access lifestyle advice and treatment.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	92.3%	94.2%	94.5%	No statistical variation
Exception rate (number of exceptions).	0.7% (31)	0.8%	0.8%	N/A

Consent to care and treatment

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

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

Caring Improvement

Rating:

Requires

At the July 2019 inspection, we rated the practice as requires improvement for providing caring services because:

- GP patient survey results were below local and national averages.
- The practice had not developed an action plan to improve patient satisfaction.

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

- GP patient survey results remain below local and national averages and had declined since the 2018 and 2019 surveys. However, the practice had developed an action plan to address these indicators.

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-judgmental 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: Patients told us, via CQC 'share your experience forms' that staff were friendly and helpful and showed care and compassion.	

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.

CQC comments cards	
Total comments cards received.	33
Number of CQC comments received which were positive about the service.	18
Number of comments cards received which were mixed about the service.	7
Number of CQC comments received which were negative about the service.	8

Source	Feedback
CQC 'Share Your experience' forms	Patients told us they had seen improvements over recent months with increased access and friendly and helpful reception staff. They also told us that the COVID-19 pandemic was well managed with clear messaging and increased support.
CQC 'Share Your experience' forms	Some patients told us there was some delays in obtaining prescriptions, medicines advice and test results. They also told us there was confusion with which site to attend for their appointment.

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)	73.1%	86.1%	88.5%	Variation (negative)
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)	71.4%	84.2%	87.0%	Variation (negative)
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)	89.3%	94.1%	95.3%	Tending towards variation (negative)
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)	44.9%	76.7%	81.8%	Significant Variation (negative)

Any additional evidence or comments

The practice was aware of the below average indicators within the GP patient survey. They had reviewed this and discussed it as a team. They had reached out to the patient participation group (PPG) who told us the practice had been open to suggestions and ideas of improvement.

The practice had developed an action plan with targets and timescales to improve these indicators. They had increased the standard face to face appointment time from 10 minutes to 15 minutes to allow more time to listen to patients needs and explain treatment options. They had also reminded clinicians to record detailed notes to ensure patients didn't have to repeat their medical history to each clinician. The internal patient feedback had improved as a result of these actions.

Question

Y/N

The practice carried out its own patient survey/patient feedback exercises.

Y

Any additional evidence

The practice had conducted patient feedback exercises in April, March and June where they surveyed over 1,000 patients at each survey. These surveys largely focused on access. The practice had sought support from the PPG in conducting patient feedback activities. They had also used social media to gain patients views. We saw evidence that this feedback was used to shape the service provided, for example, how to advertise and run socially distanced and safe flu vaccination clinics. Each indicator within the GP Patient survey had an individual action plan with timescaled targets for improvement.

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: Easy read and pictorial materials were available.	

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)	81.1%	91.9%	93.0%	Variation (negative)

Any additional evidence

The practice had evaluated their performance against this indicator and created an action plan to improve patient satisfaction in this area. This had been shared with staff and staff had been reminded to use the extra appointment time to ensure patient understanding so they could make informed decisions. The action plan also detailed how the practice would involve patients in improvement activity in order for appointments to be meaningful for patients.

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 435 patients as carers, which equated to 2% of their practice population. The practice had recently contacted all carers to ensure they needed to remain on this register and had the appropriate support in place.
How the practice supported carers (including young carers).	The practice had used posters in the local area to encourage patients to identify themselves as carers. Two members of staff were 'carers champions' and led on appropriate signposting. An information pack had been produced that included local and national support groups. The practice had plans to implement further support and information for young carers.
How the practice supported recently bereaved patients.	Bereaved patients received a sympathy card and a bereavement phone call. Bereavement calls were made to families irrespective of if they were registered at the practice.

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/Partia I
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had protocols in place to ensure that patients could access their clinical records where appropriate. We saw examples of where access to clinical records was expediated to assist with personal situations.</p> <p>The practice ensured that most video consultations took place on-site. However, due to the COVID-19 pandemic some GPs were working from home. The practice developed a working from home agreement with each affected GP to ensure all consultations were held confidentially and not disturbed.</p>	

Responsive

Rating: Requires Improvement

At the July 2019 inspection, we rated the practice as inadequate for providing responsive services because:

- Results from the most recent national GP patient survey published in July 2019 highlighted a significant drop in patient satisfaction since the previous published results in 2018.
- The practice had not completed any patient surveys to ascertain the views of patients particularly in relation to access.
- Patients told us there was still difficulty in accessing the practice by telephone and getting a routine or urgent appointment when they needed. Patients also told us that phone lines would regularly cut out during phone calls and we saw examples of this happening on the day of inspection.
- Some staff told us they felt there was not enough provision for face to face appointments.
- Patients told us they often suffered delays in receiving repeat prescriptions for medicines due to delays in appointment availability with GPs and nurse prescribers.

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

- Results from the GP Patient survey remain lower than local and national averages. However, many of these indicators had improved since the 2018/19 survey results.
- The practice had completed patient surveys and had developed action plans to improve patient access. The practice had increased the level of clinical capacity and appointments available.
- We had mixed feedback from patients regarding access to the practice via the telephone. Some patients told us there had been improvements in telephone access and appointment availability and others told us they still found this difficult.
- Staff told us there was increased availability of appointments and they were able to meet patients' needs.
- Some patients told us there were still delays in repeat prescription requests. The practice had developed a prescription clerk team who could be contacted directly by patients in response to this patient feedback.

These findings affect all population groups and therefore they have all been rated as requires improvement.

Responding to and meeting people's needs

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

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

The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Explanation of any answers and additional evidence:

At the July 2019 inspection we found:

- The practice had not carried out patient feedback surveys in relation to areas of challenge, for example access.
- The practice had not identified patient demand in order to streamline services

At the November 2019 inspection we found:

- A patient survey had been completed to ascertain the views of patients in relation to access which showed low levels of patient satisfaction related to access.
- The practice had begun a capacity and demand study in order to identify where the highest patient demand was.

At the September 2020 inspection we found:

- The practice had increased the number of clinicians employed and created a regular bank of locum staff to improve consistency for patients. Locum staff were able to book their own follow up appointments for particularly vulnerable patients, such as those with mental health conditions.
- The practice was planning to recruit a further five GPs in the coming months, with start dates for these staff agreed. Several of the locum staff had applied for permanent positions. The practice had also employed further minor illness nurses, social prescribers and pharmacists to meet patient needs.
- The practice discussed appointment availability, capacity and demand on a weekly basis and provided double the appointments needed for the practice population. At the time of inspection, we saw that there were appointments available for the same day.
- Historically, the practice had a poor local perception regarding access. They had commenced an improvement project, led by reception staff and the PPG, to share appointment information, call waiting times and number of appointments missed with the practice population.

Practice Opening Times

Day	Time
Opening times: Grovebury Road Surgery	
Monday	8am – 6.30pm
Tuesday	8am – 8.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Leighton Road site is open from 8am – 5.30pm Monday to Friday	
Appointments available:	
Monday – Friday	Telephone appointments, face to face appointments, video consultations, walk-in blood testing clinics. During the COVID-19 pandemic, home visits or bookable appointment for blood testing were available.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	85.1%	92.7%	94.2%	Variation (negative)

Any additional evidence or comments

The practice had conducted anonymised patient surveys in April and March 2020 to gain patient feedback regarding how they felt their needs were met in their last appointment. Positive responses increased from 16% to 50% over this time period. However, the focus of the patient survey then changed to reflect the COVID-19 pandemic. The June 2020 survey indicated that some patients were not contacting the practice with their health needs at this time. The practice used local messaging to ensure that patients were encouraged to contact the practice where needed.

The practice had developed an action plan in conjunction with the Patient Participation Group (PPG) to increase patient feedback. This plan had been shared with staff.

The GP patient survey indicated that some patients were dissatisfied with the clinics often running late. The practice had increased the time of face to face appointments from 10 minutes to 15 minutes in order to allow the patient more time and reduce the chance of late clinics. We saw that patients who may need extra time or double appointments were discussed at practice meetings to ensure these were appropriately booked.

Older people

Population group rating: Requires Improvement

Findings

- This population group has been rated as requires improvement because some of the concerns found within the responsiveness domain affect all population groups. However, we also found positive aspects of care within this population group.
- The practice had identified that many patients did not have a named GP because of previous gaps in the clinical workforce. The practice planned to have a full complement of clinical staff by February 2021 in order for patients to see their preferred GP more often. The patients preferred GP was recorded within their clinical records to allow reception staff to book the correct appointment.
- 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.
- We spoke with a care home who was aligned to the practice. They told us that the practice had been supporting them with daily phone calls, regular meetings and home visits where necessary.
- The practice provided longer appointments for older patients as necessary and supported them with using video consulting where appropriate.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- This population group has been rated as requires improvement because some of the concerns found within the responsiveness domain affect all population groups. However, we also found positive aspects of care within this population group.
- Patients with multiple conditions had their needs reviewed in one appointment. Reception staff told us they were always able to offer appointments for reviews of long-term conditions.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- This population group has been rated as requires improvement because some of the concerns found within the responsiveness domain affect all population groups. However, we also found positive aspects of care within this population group.
- The practice had employed minor illness nurses and a pediatric nurse to respond to the higher level of demand for children's appointments. Children were also offered extended appointments where necessary.
- 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 held appointments during the afternoon for children who had become unwell during the day.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- This population group has been rated as requires improvement because some of the concerns found within the responsiveness domain affect all population groups. However, we also found positive aspects of care within this population group.
- 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 used the website enquiries portal to enable patients to raise non-urgent queries. These were followed up with telephone calls as required.
- The practice hosted extended access services on a Saturday, Sunday and occasional weekday evenings. Patients were also able to attend other sites hosted by the extended access service during the week.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- This population group has been rated as requires improvement because some of the concerns found within the responsiveness domain affect all population groups. However, we also found positive aspects of care within this population group.
- The practice held a list of patients identified as vulnerable and these patients had appointments prioritised. Any vulnerable patient who attended A&E was offered a follow up telephone consultation.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- This population group has been rated as requires improvement because some of the concerns found within the responsiveness domain affect all population groups. However, we also found positive aspects of care within this population group.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Invites to mental health reviews were completed via the telephone rather than letters as the practice had identified that this increased engagement and reduced non-attendance.
- The practice had identified that patients living with mental health conditions had poor access to community services. They had begun an improvement project with community teams to increase access. They were also working with the Institute of Healthcare Improvement to integrate local services. The practice had involved a patient who cared for a relative with a mental health condition in this project.
- Practice staff had received mental health training from local mental health teams.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

The practice had worked to ensure people were able to access care and treatment in a timely way however, patient satisfaction remained low.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritized.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had developed a 'walk-in' policy to ensure that those with urgent needs were referred to the duty doctor.</p> <p>As the practice had increased clinical capacity, if there were unplanned absences patient appointments were able to be transferred to other clinicians rather than cancelled.</p>	

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)	23.1%	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)	30.2%	58.4%	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)	25.4%	56.8%	63.0%	Significant 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)	49.5%	67.5%	72.7%	Variation (negative)

Any additional evidence or comments

At the July 2019 inspection we found:

- Results of the GP Patient survey were significantly below national and local averages. The practice did not have a formal plan to address this.
- The practice had lower clinical capacity than was needed for the patient population. The practice relied on locum staff. Locum staff we spoke to were not always aware of practice protocol.
- Patients told us there was difficulty accessing the practice by telephone and that the phone system was unreliable, and calls would get disconnected. Patients told us they could wait over an hour until their call was answered.
- Patients and staff told us there was often a lack of appointments and staff often had to redirect patients to other services, including NHS 111. At the time of this inspection, pre-bookable appointments were not available for six weeks.

At the November 2019 inspection we found:

- The practice had increased the number of locum staff and minor illness nurses in order to offer more patient appointments. The practice was in discussion with these locum staff to take on permanent roles. Locum staff were invited to clinical governance meetings and were therefore aware of the practice policies and procedures and had the opportunity to share learning.
- We saw that there was a higher provision of face to face appointments and pre-bookable appointments were available three days following the inspection. Reception staff told us that they did not regularly have to redirect patients to alternative provision.

At the September 2020 inspection we found:

- The practice had improved their telephone system and increased the number of staff available to answer calls. We saw that they monitored capacity and demand weekly and were exceeding the required number of clinical sessions needed for their practice population. The practice conducted regular audits regarding the length of time before a call was answered and the latest audit showed this was five minutes and eight seconds.
- The practice had also upgraded their internet connectivity which had reduced the number of disconnected calls. The telephone system was planned to be upgraded in 2021.
- The practice had identified that some patients did not answer their telephone for consultations as the practice telephone number was withheld. In recent weeks, the practice had opened their telephone number, so patients knew who was calling. They planned to audit if this had reduced the number of missed calls in the coming weeks. Any patient who did not answer a telephone call for a consultation was followed up as necessary.
- The practice had increased the number of clinical staff and clinical sessions available for patients. They had also trained reception staff in care navigation to ensure patients were directed to the appropriate clinician.
- The practice also monitored patient messaging through their website, where patients were able to raise queries. The reception manager then contacted patients via the telephone and booked appointments if needed.
- The practice had conducted surveys that showed an increase in ease in getting a GP appointment from April 2020 to March 2020. However, they were unable to continue monthly patient surveys due to pressures during the COVID-19 pandemic. Staff told us that telephone access had improved, and they had seen an increase in appointment availability and a decrease in patient complaints.

Source	Feedback
The NHS Website	We saw mixed feedback from patients through the NHS Website. Some patients told us that access and appointment provision was poor however, some patients told us that access had improved and they were pleased with the level of care they received.
CQC 'Share your experience' forms	We saw mixed feedback through CQC 'Share your experience' forms. Some patients told us that access had improved, and they were able to access the practice easily by telephone. Some patients told us they still experienced difficulty getting appointments and accessing the practice by telephone.

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.	42
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	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:	
<p>The complaints process was reviewed at the July 2019 inspection where we found the process was effective. This process remained in place. We saw that complaints were discussed at clinical governance meetings where actions were recorded and monitored. The practice had also introduced a 'You Said, We Did' board to share practice improvements. Compliments were also displayed within the practice and shared with staff and patients.</p> <p>The practice had analysed recent complaints for themes and had created a series of audits to monitor improvements. For example, several complaints had been received regarding the recall process for annual reviews. These were now being aligned with patient's birth months to make them easier to track. Progress towards this goal was monitored and discussed at monthly Quality Improvement meetings.</p> <p>The practice had also identified that there were several complaints regarding the management of prescriptions and had set up a specific prescription clerk Team that included a pharmacy technician, a dispenser, a health care assistant and a member of reception staff. This team dealt with prescription related queries and resolved individual concerns. They had an aligned GP and a consultation room if face to face discussion was needed.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Many complaints relate to poor access to care	Increase in clinical staff had led to an increase in appointments. This had been shared with patients.
The practice identified two complaints regarding referral management	The practice conducted a referral audit which showed that 100% of referrals were sent to the correct department however, 4% were coded incorrectly. This was discussed with the staff involved.

Well-led Improvement

Rating:

Requires

At the July 2019 inspection, we rated the practice as inadequate for providing well-led services because:

- Clinical capacity had reduced, and the practice had not formally assessed the risk of this to patients or put in place any remedial actions.
- The reduction in clinical capacity had resulted in a lack of clinical oversight. Leaders had identified that patients had difficulty with accessing the practice; however, they did not have a formal action plan in place to address these challenges.
- The practice was unable to provide evidence that processes were in place to ensure that the patients who required emergency appointments were able to be seen in a timely manner.
- The practice did not conduct any form of assessment or audit to monitor appointment capacity or demand, despite the significant decrease in clinical capacity and levels of patient dissatisfaction particularly in relation to access.
- The practice had not completed any patient surveys or feedback exercises to seek patient views.
- The practice had not completed any succession planning.
- Risks to patient safety were not appropriately managed including management of safety alerts, management of patients with long term conditions, patients prescribed high risk medicines, emergency medicines and sharps waste.
- Locum staff were not invited to practice meetings and did not have a clear understanding of practice processes.

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

- Although improvements have been made in several areas, clinical indicators for mental health care plans and cervical screening remain lower than local and national averages. GP Patient survey scores are also lower than local and national averages. Action plans that are in place for these areas have not been embedded into practice or impacted on patient outcomes.
- Clinical capacity had increased the numbers of appointments offered consistently exceeded the required number for the practice population. Capacity and demand for appointments was monitored and discussed regularly.
- The practice had improved clinical oversight and patients received the appropriate care and review.
- The practice had conducted practice surveys and reviewed the National GP Patient survey results. They had created a clear action plan to further improve access and patient satisfaction.
- The practice had completed short- and long-term succession planning and had improvement plans in place to address identified challenges.
- Risks to patient safety were effectively managed, including safety alerts and medicines.
- Locum staff were invited to practice meetings and involved in the improvement plans of the practice. They told us they felt proud to work at the practice.

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: At the July 2019 inspection we found: <ul style="list-style-type: none">• The practice had not completed any succession planning. At the November 2019 inspection we found: <ul style="list-style-type: none">• The practice had developed a business continuity plan.• The practice had created a staff succession planning document that included details of how to manage clinical and administration shortfall and unplanned absences. At the September 2020 inspection we found: <ul style="list-style-type: none">• The practice fully understood the challenges to providing high quality care and had created systematic action plans based on staff and patient feedback, such as increasing access and satisfaction within consultations. For example, the improvements in reducing the number of missed telephone appointments was suggested and led by the reception manager. The nursing team also led and implemented systems to provide a safe and socially distanced flu immunisation programme.• The practice business continuity plan had been further developed to include short- and long-term planning and detail strategies to cover unplanned absences of management staff.	

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: Staff told us that they were aware of the practice vision and were involved in how this would be achieved. Action plans that detailed improvement plans included measurable targets that were monitored on both a practice and trust-wide level. The practice vision also included creating a better perception of the practice locally by becoming involved in community events, such as the health fair. The lead GP also wrote a monthly column in the local newspaper to inform the public of the improvements at the practice. This article was also used to inform patients of local initiatives during the COVID-19 pandemic. They were aware of the challenges involved in overcoming this perception. Staff told us that they felt public perception of the practice had improved over recent months.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice vision included creating an improved culture of caring. This vision had been shared with staff at whole practice meetings. Staff we spoke with felt well supported. The practice had developed staff newsletters, forums and awards which meant that staff felt valued in their work. They had also held listening events, staff surveys and regular meetings for staff to raise any concerns or suggestions.</p> <p>Staff told us they felt able to raise concerns and were confident they would be dealt with. We were told that reception staff had raised an issue with the lack of a duty doctor being on shift at 8am however, staff had been reassured by the other clinicians who were on shift and knew that management teams had plans to improve the situation in the coming months.</p> <p>Individual risk assessments and conversations were held regularly with all staff during the COVID-19 pandemic to ensure staff felt safe to come to work or were able to work from home.</p>	

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

Source	Feedback
Staff questionnaires	Staff told us they were supported by management and felt proud of their team. They told us that they had seen improvements and ideas were acted upon. Many staff referred to the support and communication they had received during the COVID-19 pandemic. Some staff told us they would like to be more involved in decisions that affected their work.
Staff interviews	Staff told us they were very well supported by management teams both personally and professionally. We were told they were involved in improvement projects and their suggestions were implemented. Staff told us they were proud to work at the practice and to be involved in the improvements.

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
Explanation of any answers and additional evidence:	
<p>Since the practice had merged with ELFT, all governance structures had been reviewed. The practice receive corporate support from ELFT and staff have been transferred to ELFT recruitment systems. The trust had leads for key areas such as Human Resources, training, safeguarding and risk however, the practice manager held responsibility for day to day running of the practice. The practice align to all ELFT policies and protocols.</p> <p>Staff told us they understood their roles within this structure.</p> <p>The practice was working within the Primary Care Network (PCN) to use the Leighton Road site for activity that would serve the whole of the Leighton Buzzard population.</p>	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance however, some changes were yet to be fully embedded into practice.

	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>The practice had clear audit schedules that were focused on the areas of challenge within the practice, such as access. These were discussed at regular clinical governance meetings.</p> <p>The practice monitored complaints, significant events, patient feedback, social media and The NHS Website reviews. We saw evidence that these were discussed in meetings and appropriate actions taken. Patients who contacted the practice via social media or The NHS Website were encouraged to contact the practice via the telephone to discuss their concerns.</p> <p>The practice had clear action plans to improve clinical indicators however, some changes, for example integrating mental health services were yet to be fully embedded into practice. Patient satisfaction regarding access was still low.</p> <p>The practice had a major incident plan in place however, this had been updated and improved since the COVID-19 pandemic. The plan included learning from the first wave of the virus, restoration of services, staff testing and second wave and winter planning.</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
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence that clinical and patient indicators were used to focus improvement planning, for example increasing access to mental health services.</p> <p>Risks regarding Infection Prevention and Control, Fire Safety and Health and Safety were regularly monitored with mitigating actions in place.</p> <p>Complaints and significant events were analysed with actions taken where necessary.</p>	

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

The practice involved 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:	
<p>The practice involved the PPG in gaining patient feedback, improvement projects and staff recruitment. The PPG met six weekly and learning from these meetings was shared with ELFT. Members from the PPG had also attended local schools to speak to young people about their views of the practice. From this, the practice determined a specific PPG for young people needed developing and were in the process of setting this up.</p> <p>The practice involved PPG members in the recruitment of all new staff and were on all interview panels. The PPG told us that they valued this input.</p> <p>The practice involved patients in process mapping of new protocols in the practice. The practice had reviewed many of the processes within the practice and invited patients who were involved in those processes to the relevant meetings. For example, patients who had complained about delays in receiving blood test results was invited to participate in the mapping of the revised process. The practice implemented the suggestions from these patients and all results are now given by a GP rather than administration staff.</p>	

Feedback from Patient Participation Group.

Feedback
<p>The PPG told us they had been involved in all practice improvements in the last year and felt a valued and welcomed part of the practice team. They had been involved in patient surveys, recruitment, process mapping and the health fair. They told us that management teams were responsive to suggestions and always gave a rationale if ideas were not able to be actioned.</p> <p>The PPG had been involved in social media messaging and videos regarding access and one-way systems in the practice, during the COVID-19 pandemic and had been able to share practice changes within the practice population through a quarterly newsletter.</p> <p>They had also been involved in maintaining the practice garden that had been used for staff breaks, 'Meet the PPG' sessions and practice meetings in recent months.</p> <p>The PPG told us that they felt public perception of the practice was improving and negative feedback was reduced.</p>

Any additional evidence

The practice, in conjunction with the PPG, held a community health fair in January 2020 which was well attended by the practice population. The PPG told us this was a successful event and the practice was supportive of their suggestions in hosting this.

Continuous improvement and innovation

There 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
Explanation of any answers and additional evidence: The practice had a strong focus on improvements and planning. These improvements and projects were shared with staff and discussed at clinical governance meetings.	

Examples of continuous learning and improvement

The practice hosted the COVID-19 'hot hub' for the Leighton Buzzard locality. This was safely set up within 48 hours with a full standard operating procedure in place that included access criteria, PPE and enhanced cleaning. The practice divided staff teams and was able to reduce the staff working on site. This contingency planning meant that if there was an outbreak of COVID-19 within the staff team, the service would be unaffected.

The practice offered extensive support to isolated patients within the COVID-19 pandemic where they telephoned all vulnerable or shielding patients each month. Support for these patients was personalised with staff organising medicines deliveries, food packages and befriending services. This process also enabled them to identify patients who needed further referrals, for example to safeguarding teams.

The practice were using the lessons learnt from the COVID-19 pandemic to influence the winter planning and flu vaccination programme where they are focusing on these vulnerable patients and ensuring they were vaccinated safely and efficiently.

The practice had commenced a series of process mapping activities where all internal processes were being reviewed, in line with patient expectations. All of these new processes were built with input from staff and patients. Once these were finalised, they were shared with staff and patients.

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.