

Care Quality Commission

Inspection Evidence Table

Dr Roman Sumira (1-494786249)

Inspection date: 4 December 2020

Date of data download: 30 November 2020

Overall rating: Good

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

At our previous inspections in September 2019 and October 2019, we rated the practice as Inadequate due to a significant number of areas of non-compliance with the Health & Social Care Act 2008 Regulations. The practice was placed in special measures and a notice of decision was issued.

At this inspection, we found the practice had made significant improvements in all areas of previous non-compliance to such an extent that we have rated the practice as Good overall.

Safe

Rating: Good

At our previous inspection in October 2019, we rated the practice as Inadequate for providing safe services because of the lack of effective systems & processes relating to safeguarding, a lack of clinical oversight and governance arrangements, the lack of delivery of high-quality person centred care including the monitoring of medicines and reviews. There were no safe storage arrangements for medicines, and dispensary staff had not completed up to date training. There was also a lack of effective systems and processes to ensure good governance, and at the branch surgery, the premises and equipment were not fit for use.

At this inspection, we have rated the practice Good for providing safe services because significant improvements had been made in all areas of previous non-compliance.

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	Y/N/Partial
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
Explanation of any answers and additional evidence:	
At our previous inspection on 10 October 2019, we found:	
<ul style="list-style-type: none"> • The process the practice had in place with regard to safeguarding was still not effective. • The practice did not have a safeguarding register. • We were unable to establish what circumstances made the patients vulnerable. For example, it did not identify which children were subject to a child protection plan and which children were a looked after child. • We found that one of the long-term locum GPs did not have the appropriate level of safeguarding training. • A safeguarding meeting had been scheduled for 17 October 2019. We reviewed information sent to the Care Quality Commission by the Northamptonshire Clinical Commissioning Group (CCG) where issues were identified and offers of support to put systems in place had been offered. The practice had certified themselves as meeting various criteria on the Assurance Framework but were unable to provide the relevant evidence. • At the time of this inspection, we were not assured that the offers of support had been accepted. 	
At this inspection, we found:	
<ul style="list-style-type: none"> • All staff had completed appropriate levels of safeguarding training and we saw evidence to verify this. • There were safeguarding registers in place. For example, the practice had introduced an intranet folder for staff to access with subsections for children who may be at risk and vulnerable adults. This folder had restricted access only to those with the appropriate safeguarding clearance. Relevant external agencies had access to records via the clinical system. Notifications had been placed on patients' records, identifying those who were considered at risk. • There were now regular discussions in place 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. 	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The practice used a safeguarding tab in its clinical system which demonstrated a timeline of safeguarding incidents. Due to the COVID 19 pandemic, the quarterly regional safeguarding meetings were held virtually, which enabled the GP and nurses to meet with health visitors and midwives responsible every six weeks. The practice had allocated a member of the administration team to have responsibility for safeguarding who worked alongside the safeguarding lead. Meetings were held regularly to discuss any updates and information sharing and to keep the registers and patient records updated. At the last inspection it was identified that partners and staff had not received training appropriate to their role however at this inspection all training had been completed and was up to date. Significant events were discussed at practice meetings and we were shown minutes of meetings which provided evidence to corroborate this. 	

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> <ul style="list-style-type: none"> At this inspection, we checked staff records to ensure that all registrations were correct and up to date. We were shown evidence that all staff vaccination records had been completed. 	

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: 3 August 2020 for both sites	Y
There was a record of equipment calibration. Date of last calibration: 3 August 2020 for both sites	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: Studfall Medical Centre 3 December 2020 Weldon Surgery 23 November 2020	Y

There was a log of fire drills. Date of last drill: August 2020 for both sites	Y
There was a record of fire alarm checks. Date of last check: Studfall Medical Centre 3 December 2020 Weldon Surgery 23 November 2020	Y
There was a record of fire training for staff. Date of last training: 25 November 2020 for both sites	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Studfall Medical Centre September 2020 Weldon Surgery October 2020	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection on 10 October 2019, we were told that fire warden training had been difficult to source but the Health and Safety Manager at the Northamptonshire Clinical Commissioning Group had offered to carry out this training to the staff identified as fire wardens. No date had been identified for this training to take place. Since the last inspection, a fire risk assessment had been undertaken, along with fire training for staff including identifying and training fire wardens. Actions from the fire risk assessment for the Weldon site were completed by 20 October 2020. No actions were required for the Studfall site. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Studfall Medical Centre 4 November 2020 Weldon Surgery 16 January 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Studfall Medical Centre September 2020 Weldon Surgery September 2020	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection on 10 October 2019, we were told by the practice manager that they had arranged for a building contractor to assess the Weldon surgery building and were currently waiting for the official quote which would be considered with a date to start. The Care Quality Commission</p>	

requested evidence of this and for further risk assessments, but these were not available on the day of the inspection.

During this inspection we found:

- Considerable refurbishments had been carried out at the branch surgery and concerns raised previously had been addressed. For example, the dispensary area had been separated and shutters fitted to secure the area and complete redecoration to the building had been carried out.
- Health and safety risk assessments was carried out in October 2020 and all actions identified had been completed by the time of this inspection.
- The practice had identified a continued issue for patients with limited mobility being able to access the branch site, however all patients with mobility issues were being advised they can have appointments at the main site but their medicines can be collected from the branch site if required.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

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

Explanation of any answers and additional evidence:

At the previous inspection in October 2019, we inspected the branch surgery at Weldon and found:

- There was evidence that the oversight of infection prevention and control had been considered since the last inspection.
- The practice manager told us they had looked into infection control lead training for the practice nurse but at the time of this inspection had not been able to source a suitable resource.
- There was an infection control policy in place.
- We found all the areas were carpeted with the exception of the treatment room on the first floor. The room used by the lead GP and the upstairs storage rooms had been cleared and decluttered.
- During our inspection, we found an unlocked cupboard containing cleaning products that fall under the Control of Substances Hazardous to Health (COSHH) standards. We were told and saw evidence that a locked cabinet had been purchased for the COSHH substances to be stored. This would be situated in the locked room upstairs. The practice manager told us she had

met with the cleaning company and they would meet again to discuss arrangements once the building reopened. Discussions would also take place in relation to changing the day of the cleaner attending the building, storage of mops, data sheets and risk assessments.

- We reviewed the infection control audit carried out for both sites and actions identified and completed had been carried out.

During this inspection we found:

- An online infection prevention control (IPC) training module had been completed by all staff in February 2020. Face to face training had been put on hold due to the COVID-19 pandemic.
- An infection control audit was completed on 27 November 2020. We found actions for the main site had been completed and for the branch site there were no actions as these had all been completed as part of the refurbishment.
- The practice's COSHH substances were now stored in an appropriate locked cupboard. We saw evidence of data sheets and risk assessments for all products held on site to show actions to be carried out in the event of a spillage or ingestion of a chemical solution.
- The dispensary area at the branch site was now secure and all areas were now compliant with regard to infection prevention and control.

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
Explanation of any answers and additional evidence:	

At the previous inspection on 10 October 2019, we found:

- Sepsis training was reported to have taken place at the practice learning team (PLT) meeting held on 9 October 2019, but no minutes of the meeting were available.
- Posters giving sepsis advice were in the rooms and there was a policy and additional information on the practice computer system.
- We did not see any policy which made reference to what to do in an emergency at the branch surgery in Weldon.

During this inspection we found:

- Evidence to confirm that all staff had completed mandatory training.
- A new induction pack had been devised to give all relevant information to locums.
- Staff cover for absences had been arranged with the primary care network on a sub-contract basis. This had put in been put in place due to the current COVID-19 situation. Under normal circumstances, staff would cover for each other and there was a reciprocal arrangement in place with another practice located within the building.
- The business continuity plan had been updated and all staff were now aware of what to do in an emergency. Staff we spoke to verified this.

COVID-19 - Access to site

Access to the building was restricted during the COVID-19 pandemic. An intercom system was in place and reception staff asked questions when patients arrived relating to COVID 19 symptoms and contact, before allowing access. All staff had access to appropriate personal protective equipment (PPE).

Appointments were available on the day or could be booked in advance. These appointments were generally on the telephone, however, the practice had arrangements in place for patients to be seen face to face by a GP or practice nurse if deemed necessary and appropriate.

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>At the previous inspection on 10 October 2019, we looked at 13 patient records where alerts were not in place for patients on Disease Modifying Anti-Rheumatic Drugs (DMARDs). We found on 10 of these records there was a large number of high priority reminders. This meant it was difficult to ensure prescribers were aware of the medicines a patient was being given.</p> <p>During this inspection we carried out a number of searches on three DMARDs and all patients' records were up to date, there were no outstanding reminders, all monitoring had been completed in line with guidance and all medicine reviews had been completed.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.65	0.89	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2019 to 30/09/2020) (NHSBSA)	6.7%	8.1%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2020 to 30/09/2020) (NHSBSA)	5.63	5.15	5.34	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	98.4‰	126.8‰	124.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.41	0.70	0.68	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) <small>(NHSBSA)</small>				

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
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence:	
At the previous inspection on 10 October 2019:	
<ul style="list-style-type: none"> We reviewed the process the practice had in place for medicine reviews. We found that that the practice still did not have a recall system in place to ensure all patients who received medicines 	

Medicines management	Y/N/Partial
<p>were reviewed in a timely manner and received regular monitoring in accordance with the National Institute for Health and Care Excellence (NICE) national guidance.</p> <ul style="list-style-type: none"> We found the Lead GP still carried out the reviews opportunistically for patients who attended an appointment at the practice. The patients who did not attend an appointment would not be identified or called for a review. This was also not in line with the practice's own repeat prescribing policy, which stated that repeat prescriptions would last for an agreed length of time before a medicine review is carried out. We found that the practice still did not have an effective system in place for the management of high-risk medicines. There was no recall system in place. Whilst we did not find any patients at risk of harm from records, we looked at there was still no register of patients on these high-risk medicines. There was no policy to provide guidance to staff. During this inspection, we carried out multiple remote searches on the clinical system to check how the practice monitored and managed those prescribed high-risk medicines and/or with long term health conditions. The practice demonstrated that there was an effective system in place now for monitoring and reviewing all patients. This had been carried out in a timely manner. <p>At the previous inspection we found:</p> <ul style="list-style-type: none"> A secondary thermometer was in place inside the fridge. We checked the monitoring of the cold chain log. The practice manager told us that the secondary thermometer was checked each day, but they only documented the temperature from the thermometer on the outside of the refrigerator. There was no secure area for storing medicines in the dispensary <p>During this inspection we found:</p> <ul style="list-style-type: none"> The practice had updated the policy for monitoring the fridge temperatures and we saw evidence that these were checked and recorded twice a day. Following the refurbishment medicines were now stored securely at the Weldon Surgery dispensary. Oxygen was available and a defibrillator. Staff told us they had received training in basic life support and knew how to operate the equipment. 	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y

Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y

Explanation of any answers and other comments on dispensary services:

At the previous inspection on 10 October 2019, we found:

- There had been no changes to the dispensary as it had been closed since 6 September 2019. We were told by the practice manager that enquiries had been made for training updates for the dispensary staff. However, the practice had not been able to find any update training relevant to the staff but had planned to contact the local primary care network to see if a clinical pharmacist would be able to be able to provide annual updates.
- A competency checks form had been sourced and the practice would now use them for staff in conjunction with the appraisal form.

During this inspection, we found:

- Appropriate Standard Operating Procedures (SOPs) were in place, were in date and were specific to the service.
- No access was permitted by patients into the dispensary unless accompanied by a member of staff. The dispensary area was secured with shutters when not in use. This also allowed the cleaners to carry out their duties without any access to the dispensary area.
- Staffing arrangements were in place in the dispensary so that there were three people available to cover the dispensary and reception area. This enabled a second check on all prescriptions to be carried out.
- The dispensary had in place a log where any errors or near misses were recorded. There were only a small number of errors noted and these were used as reminders for vigilance in future. These errors were monitored to identify trends. Any issues were raised and discussed at team meetings.
- The fridges in the dispensary area were well maintained, checks were carried out twice daily and maximum and minimum temperatures were logged. The internal logger was downloaded weekly and we saw evidence of this. Staff were able explain to us how they would handle a situation where the fridge temperature went out of range and explained the cold chain policy. We noted that the fridge was marked with a special plug to prevent accidental switching off.
- Dispensary staff had undertaken training appropriate for their roles. Online training had been carried out and pre-COVID 19 they had attended a pharmaceutical conference to gain further knowledge. Annual appraisals were carried out for dispensing staff.

- There were correct medicine disposal bins in place in the dispensary and staff that we spoke to knew how to dispose of medicines appropriately

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong and had a system to learn and make 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:	5
Number of events that required action:	5

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

Event	Specific action taken
Small electrical fire at branch site. Label printer caught light.	Contractor was on site during event. Investigated by practice and printer disposed of. Staff advised to use hand written labels until replacement printer arrived. Electrical testing was up to date. Practice purchased a fire blanket.
NHS 111 incorrect appointment booking.	NHS 111 booked a patient in directly to a GP list. This patient was registered at the other practice within the building. The practice manager contacted NHS 111 to discuss and NHS 111 team created separate folders dividing the two practices based at the same location. Patient was seen by a GP at the other practice

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
At the previous inspection on 10 October 2019, we found:	
<ul style="list-style-type: none"> • The practice still did not have an effective system in place for ensuring that alerts from the Medicines & Healthcare products Regulatory Agency (MHRA) were monitored and actioned. 	

- Since the last inspection a safety alert log had been put in place. However, we found only one safety alert on the log which demonstrated that the provider had not received all the patient safety alerts distributed by the various agencies.
- There was still no evidence of how they had been shared and actioned.
- We looked at 11 patient records in relation to patient safety alerts.
- We found in five of the records no evidence of action had been taken in relation to the alerts for injectable medicines in relation to diabetes, anti-thyroid medicine and a medicine used for epilepsy that could cause problems for women of child bearing age.

During this inspection we found:

- The MHRA safety alerts came into the practice to a generic email address.
- These were checked twice a day by a member of the administration team. Searches were being carried out to establish if any patients were affected by the alert. Results were then sent to clinical staff and a record held on the shared drive. The record included actions that were rated in order of importance or risk.
- We carried out searches and found that all patients identified in searches had been contacted either by letter or by telephone call and appropriate action had been taken.
- The practice were about to have an addition to the clinical system which would highlight in future when a patient was prescribed a medicine that was subject to an alert. Until this was in place the practice were undertaking audits of the alerts to ensure that no patients were at risk.

Effective

Rating: Good

At the last inspection in October 2019 we rated the practice as Inadequate for providing effective services because:

- Patients' needs were not assessed and care and treatment was not delivered in line with current legislation standards and evidence-based guidance supported by clear pathways and tools
- There was a lack of clinical oversight and structured information sharing
- There was a lack of quality improvement activity

At this inspection we found

- Patients' needs were regularly assessed, and care plans were in place
- meetings were held regularly to share information, new guidance and policy changes
- there was a schedule of both clinical and non-clinical audits in place.

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:	

At the previous inspection on 10 October 2019, we found:

- No discussions had taken place in regard to National Institute for health and Care Excellence (NICE) who identify good practice using evidence-based information and provide recommendations and guidance for healthcare professionals on how they should care for people with specific conditions.
- No care plans had been added to patient records since the last inspection.

During this inspection:

- We saw minutes of meetings where NICE guidance was now discussed between clinical staff.
- We reviewed patient records and saw evidence that care plans were in place for patients who required them.

Older people

Population group rating: Good

Findings

At the previous comprehensive inspection in September 2019 and the focused inspection in October 2019 we found:

- The practice did not have an effective system in place to carry out structured annual medication reviews for older patients.
- The practice did not have care plans in place.
- We were told by the management team that health checks such as frailty assessments had not been offered to patients over 75 years of age.

During this inspection we found

- Structured medication reviews were now in place and care plans were recorded in patients' records.
- Frailty assessments were being offered to patients over 75 years of age.
- 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.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions

Population group rating: **Good**

Findings

At the previous inspection on 10 October 2019, we found:

- Patients in this group were not having their healthcare needs met in an appropriate manner that was relevant to their needs.
- The system in place for medication and long-term conditions reviews was not effective. We found the system in place for medicines reviews was not effective.
- Patients with long term conditions did not have care plans in place.

During this inspection we found:

- The lead GP carried out annual reviews for patients with long-term conditions. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Personalised Care Adjustments (PCA) were consistently low. Since the last inspection the clinicians had spent a lot of time carrying out patient reviews, ensuring care plans were in place and updated regularly.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, the health care assistant was undertaking asthma reviews.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Also, those patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	78.9%	77.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.0% (1)	13.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a	93.5%	88.8%	89.4%	No statistical variation

healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)				
PCA rate (number of PCAs).	0.0% (0)	14.7%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	95.9%	81.5%	82.0%	Variation (positive)
PCA rate (number of PCAs).	1.4% (1.0)	5.8%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	85.7%	69.8%	66.9%	Variation (positive)
PCA rate (number of PCAs).	4.3% (6.0)	20.0%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	93.2%	74.3%	72.4%	Significant Variation (positive)
PCA rate (number of PCAs).	1.6% (5.0)	8.4%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	94.0%	94.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.0% (1)	3.9%	4.9%	N/A

Families, children and young people

Population group rating: Good

Findings

At the previous inspection, we found:

- All childhood immunisation uptake rates were slightly below World Health Organisation (WHO) minimum target of 90% (the recommended standard for achieving herd immunity). The practice told us they contacted the parents or guardians of children who were due to have childhood immunisations.
- Young people could access services for sexual health and contraception. The practice took part in the C Card scheme which was aimed at advice for young people between the ages of 13-24 years. The practice nurse told us that she gave advice but had not had any contraception training.

- The practice did not have arrangements in place to identify and review the treatment of newly pregnant women on all long-term medicines, for example, medicines to treat overactive thyroid gland. These patients had not been provided with advice and post-natal support in accordance with best practice guidance

During this inspection, we found:

- The practice had now met the World Health Organisation (WHO) based national target for three of the five childhood immunisation uptake indicators. The remaining two targets were slightly below but only represented two children in each case and the practice was aware of the children concerned.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice now 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. Previously staff were unable to attend due to the excessive travel time travel time to attend these meetings however, due to the COVID 19 situation, these meetings were now held virtually and both the GP and practice nurse had been able to attend the regional meetings with midwives and health visitors to improve communication and information sharing.
- Young people could access advice about services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	17	19	89.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	19	19	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	19	19	100.0%	Met 95% WHO based target

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	19	19	100.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	15	17	88.2%	Below 90% minimum

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
The practice's uptake for the cervical screening programme was 75%, which was above the CCG average of 70% but below the Public Health England target of 80%.
- 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.
- During the COVID 19 pandemic the practice had moved to more telephone-based consultations, however face to face appointments and home visits were still carried out if necessary.
- Cervical screening was slightly below the national target and we were told that the practice was trying to improve this result however, it would be difficult to improve in the next 12 months due to the current challenges of access during the current COVID-19 pandemic.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/06/2020) (Public Health England)	78.2%	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)	73.8%	74.7%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	60.0%	56.9%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	100.0%	94.5%	92.7%	N/A

occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)				
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)	50.0%	54.2%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

At the previous inspection, we found:

- The practice did not have an effective system in place to carry out structured annual medication reviews for patients with a learning disability.
- We saw that care planning templates, to help plan and deliver care for patients with more complex needs were not in place.
- The practice did not have a list of vulnerable adults or any alerts on the patient record system.

During this inspection, we found:

- Structured medication reviews had been completed for all patients with a learning disability and they were offered an annual health check.
- Care plans were completed and stored in patients' records.
- The practice had in place a register of vulnerable patients, this was flagged on the patient record and, within the clinical system, clinicians could access the timeline of actions and interventions for these patients.
- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

At the previous inspection, we found:

- The practice did not have an effective system in place to carry out structured annual medication reviews for patients with poor mental health including dementia.
- There was no system in place for following up patients who failed to attend for administration of long-term medication.
- We saw that care planning templates, to help plan and deliver care for patients with more complex needs were not in place.
- We reviewed the training log and could not see where any staff had received dementia training in

the last 12 months.

- The practice told us 67% of staff had completed online mental capacity training.

During this inspection, we found:

- The practice now had an effective system in place to carry out medication reviews for patients with poor mental health including dementia.
- Patients at risk of dementia had been identified and were offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Care plans for patients diagnosed with dementia had care plans in place.

All staff had completed online mental capacity training and dementia awareness training.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- The practice had access to a social prescriber and referred patients who may be in need of counselling or well-being support.

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>	100.0%	87.5%	85.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	0.0% (0)	24.1%	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>	85.7%	82.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	12.5% (1)	11.6%	8.0%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.84	Not Available	533.9

Overall QOF score (as a percentage of maximum)	98.9%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	2.2%	Not Available	5.9%

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

Explanation of any answers and additional evidence:

At the previous inspection we found:

- The practice did not have a programme of continuous audits to monitor quality or to make improvements. They had not completed any clinical audits and had no evidence to demonstrate continuous improvements to patient outcomes or any action plans put in place to monitor implementation of any recommendations. We looked at the practice Clinical Governance policy, which had been reviewed in June 2019, and found that, in section four, it stated that clinicians would undertake regular clinical audits carefully and accurately, recording results and would take the appropriate action so that they could plan and implement changes and improvements.
- We found the system in place for medicines reviews was not effective. We found there was not a clear system in place to ensure all patients who received medicines were reviewed in a timely manner and received regular monitoring in accordance with national guidance. We looked at the practice's recall protocol which did not have an approved date but stated that people on chronic disease management, smear tests, childhood immunisations and those who take certain medicines which require blood tests will be subject to call and recall.
- We found that the practice did not have an effective system in place for the review of patients with long term conditions to ensure all patients were reviewed in a timely manner. We looked at the practice repeat prescription and medication review protocol, updated in August 2019, which stated that a periodic review of a patient at which the continuing need for acceptability and safety of medication in the repeat prescription are considered. A patient recall system should also be in place to ensure patients who do not order their medication are also reviewed.

The practice had worked hard since the last inspection to rectify the issues found previously and during this inspection, we found:

- A programme of clinical audits was now in place. First cycles of these audits had been completed in November and December 2019, however due to the COVID-19 pandemic these have been put on hold, with plans to re-audit in 2021. These audits included medication reviews childhood immunisations and the treatment and monitoring of patients with chronic kidney disorder.

- The practice now ensured that all patients who had repeat prescriptions were reviewed. The GP looked at not only the frequency of repeats but also those repeat prescriptions that were not requested.
- We saw evidence on the day of inspection and through the remote searches carried out, that the practice had completed all of the monitoring and reviews required, which were all up to date.

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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found:</p> <ul style="list-style-type: none"> • The lead GP had completed safeguarding training, but no other training had taken place. We also found that one of the long-term GP locums had still not provided evidence that training had taken place, for example, in safeguarding, fire safety, infection control, information governance and health and safety. • We were told that the dispensers were observed in their work but this was not documented or evidenced. The GP had not carried out the appraisal for the nurses so was not aware that they did not have infection control lead nurse training. • In addition, staff were often asked to dispense medicines at the branch surgery but did not have the relevant training and the GP had signed the health care assistant as competent to do spirometry testing when they had not received the training themselves. • At the inspection on 10 October 2019 we found that no extra training had taken place since our September 2019 inspection and had identified an issue with staff training. 	

During this inspection we found:

- Training for all staff had been undertaken. This was evidenced in a training log and we saw evidence of certificates in staff personal files. This included basic life support training, information governance, fire safety and health and safety.
- The practice nurse had received an appraisal with both the GP and the practice manager.
- Infection prevention and control training had been undertaken.
- The health care assistant had undertaken specific asthma training to enable her to undertake assessment reviews and spirometry.
- Dispensary staff had all completed training relative to their role.
- The practice now kept a log of training completed by GP locums.

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 organisation, 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 organisation were involved.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Explanation of any answers and additional evidence:

At the last inspection, we found:

- The practice held palliative care multi-disciplinary meetings every three to four months in which the Macmillan nurse attended. However, from meeting minutes we had looked at, actions such as the removal of a patient from the palliative care register had not taken place. In each set of meeting minutes over a period of eighteen months from March 2018 to July 2019 this action was still to be completed.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. However, the practice did not have a process to monitor if the patients had received and attended an appointment.

During this inspection, we found:

- We reviewed the minutes of multidisciplinary team meetings and all actions had been completed.
- The practice continued to share relevant information with other services. For example, if those patients had been seen by another service it was noted in the patient record.
- During COVID 19 the practice had changed the way it delivered its service. Most consultations were held by telephone calls. The practice had access to a video call system AccuRx, however we were told that patients normally would send in photographs if required rather than using the video call system. The practice had appropriate governance in place to cover this different way of providing appointments.

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

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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection, we found:</p> <ul style="list-style-type: none"> The practice had not completed any minor surgery audits to monitor the process for seeking consent appropriately. <p>During this inspection, we found:</p> <ul style="list-style-type: none"> Due to the COVID 19 pandemic, the practice had not been able to complete a consent audit. However, as seen at the previous inspection, consent was being recorded in patient records. 	

Caring

Rating: Good

Kindness, respect and compassion

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

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

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)	95.8%	87.4%	88.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	92.2%	85.7%	87.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	100.0%	94.9%	95.3%	Tending towards variation (positive)
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)	93.1%	80.4%	81.8%	No statistical variation

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

Any additional evidence

The practice had undertaken a feedback exercise with patients to determine what their preference when accessing appointments. However, the results were not available at the time of our inspection. In addition, the practice was looking at ways of putting a satisfaction survey on the practice website.

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 information was available.	

Source	Feedback
Interviews with patients.	No interviews were undertaken with patients due to the COVID 19 pandemic.

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)	96.6%	92.1%	93.0%	No statistical variation

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

The practice used a language support line if required. Administration staff we spoke to explained the process.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 69 patients who were also carers. This was the equivalent of approximately 3% of the practice population
How the practice supported carers (including young carers).	Information was available in the waiting areas.
How the practice supported recently bereaved patients.	The GP contacts the family, a card is sent from the practice and leaflets and information on support and advice were available if required.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: During the COVID-19 pandemic the practice had introduced an intercom system on the main doors to ensure that staff and patients were kept safe.	

If the practice offered online services:

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

Responsive

Rating: Good

The previous inspection in October 2019 we rated the practice as inadequate for providing responsive services because:

- the practice was unable to demonstrate they met the needs of the practice population.
- the premises were not fit for purpose.

At this inspection we have rated the practice as good for providing responsive services because

- The practise was able to demonstrate that they reviewed the needs of the practice population and adjusted their services accordingly.
- A refurbishment had been carried out at the branch site, Weldon Surgery.

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:	
<p>At the previous inspection, we found: The premises and facilities at Studfall Medical Centre were appropriate for the services being delivered. However, we found on the 2nd September 2019 that the premises used for the branch surgery at Weldon were not fit for purpose for the services being delivered. The Care Quality Commission therefore made the decision that from 4.30pm on 6th September 2019 Dr Roman Sumira could not carry out any regulated activities at those premises until further notice. This was due to a number of concerns which included fire safety and infection control.</p> <p>Since the last focused inspection in October 2019 the practice had undertaken a full refurbishment of the branch site at Weldon. The site was now fully compliant in relation to the dispensary, storage of cleaning equipment and general condition. There remained the challenges with disabled access due to the structure of the building and therefore the site remained unsuitable for wheelchair users. However, all patients could be seen at the main Studfall site, and prescriptions could be collected from Weldon where possible.</p>	

Practice Opening Times	
Day	Time
Opening times: Studfall main location	
Monday	8am- 6.30pm
Tuesday	8am- 6.30pm
Wednesday	8am- 6.30pm
Thursday	8am- 6.30pm
Friday	8am- 6.30pm
Appointments available:	
Monday	9am-11.30am and 3.30pm-5.45pm
Tuesday	9am-11.30am and 3.30pm-5.45pm
Wednesday	9am-11.30am and 3.30pm-5.45pm
Thursday	9am-11.30am and 3.30pm-5.45pm
Friday	9am-11.30am and 3.30pm-5.45pm

Day	Time
Opening times: Weldon branch site	
Monday	10.30am -12noon
Tuesday	3.30pm-7pm (6.30pm-7pm extended access appointments)
Wednesday	closed
Thursday	10.30am-12noon
Friday	10.30am-12noon
Appointments available: Open access prior to COVID-19	

Older people

Population group rating: Good

Findings

- 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. In the current COVID-19 pandemic situation most consultations were held over the telephone.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- The branch surgery at Weldon did not have disabled access, however all patients could access appointments at the main site and use the branch site to collect prescriptions.

People with long-term conditions

Population group rating: Good

Findings

At the previous inspection we found:

- The practice could not demonstrate that they prioritised appointments for patients with long-term conditions.

During this inspection we found:

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- The branch surgery at Weldon did not have disabled access, however all patients could access appointments at the main site and used the branch site to collect prescriptions.

Families, children and young people

Population group rating: Good

Findings

- There were systems in place 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 followed up all those children who did not attend immunisation appointments.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

At the previous inspection we found:

- The practice could not demonstrate that 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.

During this inspection we found:

- 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.
- Pre-bookable appointments were available to all patients at additional locations within the area, through the Extended GP Access Service.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The GP carried out assessments for patients who may be at risk of dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The GP carried out assessments for patients who may be at risk of dementia.
- The branch surgery at Weldon did not have disabled access, however all patients could access appointments at the main site and use the branch site to collect prescriptions.

Timely access to the service

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

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at	93.8%	N/A	65.2%	Significant Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
their GP practice on the phone (01/01/2020 to 31/03/2020)				
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)	90.4%	63.4%	65.5%	Tending towards variation (positive)
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)	78.5%	60.5%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	86.5%	72.2%	72.7%	No statistical variation

Source	Feedback
NHS UK Website	There was no current feedback on NHS UK Website.

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.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	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: There was a process in place where patients' complaints were initially reviewed by reception and then passed to the practice manager. Complaints were discussed, reviewed and minuted at staff meetings.	

Examples of learning from complaints.

Complaint	Specific action taken
Patient's relative unhappy about an inappropriate reference during consultation.	A letter was sent offering a full and transparent apology and an explanation of events. The staff member considered that on reflection, in future caution was necessary before proceeding with similar lines of enquiry during future consultations.
Patient was wrongly charged for a prescription for replacement medicines.	The practice checked with the Business Services Authority and found that the patient had been wrongly charged. The practice contacted the patient and made a full apology and offered a refund to the patient.

Well-led

Rating: Good

At the previous inspection in October 2019 we rated the practice as Inadequate for providing Well - Led services because:

- There was a lack of leadership within the practice at all levels there were gaps in the practices governance systems and processes and the overall governance arrangements were ineffective
- The practice had not implemented a clear and effective process for managing risks issues and performance.
- We saw no systems and process is in place for learning and continuous improvement

During this inspection we rated the practice as good because:

- The practice had improved the governance systems and processes and arrangements were in place to evidence this.
- The practice had undertaken risk assessments underdressed actions accordingly.
- Performance was managed and reviews were undertaken.
- There was a training schedule in place all training had been completed and there was a programme of audits was in place.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found:</p> <ul style="list-style-type: none"> The practice was led by a lead GP with the support of two long term locums, one practice nurse, one health care assistant and administration staff. They told us they prioritised safe, high quality and compassionate care. However, we found a lack of focus on the clinical leadership and governance systems required, which resulted in significant issues that threatened the delivery of safe and effective care which had not been identified or adequately managed. This was particularly in relation to the branch surgery at Weldon near Corby. We found that there was poor clinical oversight of the provision of regulated activities to ensure compliance with the Health and Social Care Regulations, for example, in relation, to medicine reviews, high risk medicines and the recall of patients who had long term conditions. <p>During this inspection we found:</p> <ul style="list-style-type: none"> The practice had worked hard to address the issues around a lack of clinical leadership and governance. They had addressed all issues in relation to monitoring and reviewing patients. 	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found:</p> <ul style="list-style-type: none"> The lead GP had told us they aimed to provide a high standard of medical care in a professional and friendly manner. We had concerns whether they were capable of doing so in view of the staffing levels (most staff were part-time) and the workload of the lead GP due to a lack of clinical oversight in some areas. 	

During this inspection we found:

- The lead GP provided a very high standard of compassionate care to all his patients. Since the last inspection there had been some staff changes which had improved the ability to provide high quality care. The current COVID-19 situation had raised an issue of how staffing levels would be covered should staff be unable to attend for work. The practice had negotiated with the primary care network (PCN) to arrange for staff cover if necessary.
- We discussed the ongoing strategy for the practice with the lead GP and the practice manager and we're satisfied that they had succession planning in place.

Culture

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

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

Explanation of any answers and additional evidence:

At the previous inspection we found:

- The practice whistleblowing policy did not contain details of external organisations to contact if staff felt unable to speak to the management team.
- Not all staff had completed equality and diversity training.

During this inspection we found:

- Staff we spoke to told us they felt comfortable to speak out individually and did not want to nominate a speak up guardian. However, the practice had in place a reciprocal arrangement with the practice in which they shared a building. Both practice managers would act as a Speak up Guardian for the staff from the other surgery, therefore access was available to a Speak up Guardian if required, by any member of staff. This information was available to all staff in the updated whistleblowing policy which we reviewed.
- All staff had completed equality and diversity training.

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

Source	Feedback
Staff	Staff members we spoke with told us that working at the practice had a family friendly feel and pre Covid 19 there were many social events in place. All felt very happy to work at the practice and would recommend it to anybody else. Staff we spoke to told us that they were able to undertake any training and felt very supported.

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>At the previous inspection we found:</p> <ul style="list-style-type: none"> • Some refurbishment had taken place at the Weldon Surgery and following the inspection regulated activities were able to recommence. • The practice safeguarding systems were still ineffective. • MHRA patient safety alerts we're still not actioned appropriately. • There were ineffective systems for managing patients on high risk medicines. • Medicine reviews were not in place. • There was no evidence that staff we're up to date with current guidance regarding patient treatment. <p>During this inspection:</p> <ul style="list-style-type: none"> • We found that the practice had implemented new safeguarding registers for vulnerable adults and children. Clinical staff were now attending regional safeguarding meetings and sharing information. • MHRA patient safety alerts we're being actioned appropriately. • A considerable refurbishment programme had been taken at the branch site at Weldon. • All medicine reviews were up to date including blood test monitoring; there were no outstanding reminders on patient records. • There was a programme of audits in place. • Staff we spoke to were aware of how to access and we're up to date with current guidance. • Mandatory training had been completed by all staff and the practice This included locum GP's. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found:</p> <ul style="list-style-type: none"> • The processes for managing risks, issues and performance were not always clear. When risk assessments had taken place at both the main practice location and the branch location at Weldon. However, this process was not effective as the actions and risks to patient safety had not been completed. • We had concerns about clinical supervision and oversight of other clinicians in the practice by the lead GP. • The practice did not have a quality improvement programme in place. • The practice had a disaster continuity plan held at the main location for major incidents such as power failure or building. It was a joint plan with the second GP practice that was based in the building. The plan included emergency contact numbers for staff and contractors. The plan needed to be made clearer on what actions related to which practice and to include further information in regard to the Weldon branch surgery. This would have ensured all the relevant risks to the practice were documented and actions to mitigate the risks were in place. <p>During this inspection we found:</p> <ul style="list-style-type: none"> • Risk assessments had been undertaken for both sites and actions completed. Clinical supervision and oversight was now undertaken by the lead GP for both the nurse and locums. • The practice had in place a specific business continuity plan. Staff were aware of this and were able to explain to us what they would do in the case of an incident which may impact on the day to day running of the practice. This was in place for both the main site and the branch surgery. 	

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
Explanation of any answers and additional evidence:	
<p>At the previous inspection we found:</p> <ul style="list-style-type: none"> • There was still no effective system full managing patient prescribed high risk medicines. • Although the practice had put in place an alert system for MHRA safety alerts we saw evidence that some had not been actioned. <p>During this inspection we found:</p> <ul style="list-style-type: none"> • We saw evidence which confirmed that the practice had systems and processes in place which would easily identify any risks. • Staff were aware of the processes to report any incidents or concerns and were knowledgeable in the recording and retrieving of information regarding alerts. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an active patient participation group who we spoke to after the inspection. They were able to demonstrate good involvement with the practice even though face to face meetings had not been possible during the COVID-19 situation, the practice had kept the group fully informed of any changes within the practice.</p>	

Feedback from Patient Participation Group.

Feedback

We spoke with the patient participation group. Due to the COVID-19 situation they were unable to meet face to face, however they continued to have regular contact with the practice manager who kept them updated with latest COVID-19 information and any changes to the practice.

We were told that the group and the patients at the practice feel they are very well cared for by the GP and other practice staff.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
At the previous inspection we did not see any evidence of continuous learning and improvement within the practice.	
Since the previous inspection the practice had made significant improvements to the areas where regular regulatory breaches had been identified. The practice had worked as a team in order to make sure that systems and processes were in place and patients were safe.	
One example of an improvement was regarding the practice's flu vaccination clinics. Previously, the practice sent letters inviting patients, however this had been unsuccessful, and uptake had not increased and telephone calls had to be made to follow up. This year there has been a significant increase in uptake as a result of telephone calls being made first rather than letters.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5

Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- ‰ = per thousand.