

Care Quality Commission

Inspection Evidence Table

Oldfield Surgery (1-569083319)

Inspection date: 27 July to 11 August 2021

Date of data download: 16 July 2021

Overall rating: Requires Improvement

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

Safe Rating Requires Improvement

At the previous inspection on the 1 May, published 19 June 2019, we rated Safe as Requires Improvement. At this inspection we found the practice's systems and processes in regard to the management of medicines and recruitment require further embedding.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The safeguarding leads had reviewed the safeguarding adults and children's policies during July 2021. To help ensure continuity regarding safeguarding, one staff member had oversight of all safeguarding administration tasks, such as ensuring patients could be easily identified by staff on the patient records system and returning multi-agency risk assessment reports. A review of patient records found the practice had a system to highlight vulnerable adults and children to staff. Monthly searches were run to ensure children were correctly coded and these were used as the basis for discussions with health visitors. Over 95% of clinical staff had completed level three adult and child safeguarding training. All non-clinical staff had completed training to level one training. The human resource manager agreed to review the guidance to ensure any non-clinical staff who, within their role, had contact with children and young people, parents/carers or adults who may pose a risk to children, were trained to level two. The practice followed up children of concern if they did not attend their appointment. Additionally, the practice received a report twice a year (December and June) from Child Health advising them of any patients on the child safeguarding list that had not had an immunisation appointment. 	

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.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The provider, Heart of Bath, was a stand-alone Primary Care Network (PCN), that had fully supported the COVID 19 vaccination program for over 28,000 patients. As a result, staff members, including the human resource manager, had been working in the vaccination centre until 30 June 2021. This had impacted on systems and processes which had been introduced but had not had time to embed. For example: - The Human Resource manager, who joined the practice in May 2020, told us they were transferring information onto a computer management software system, but due to the pandemic this had been interrupted. This meant information was kept on two systems and the management team did not have assurances and oversight of staff recruitment. Clinical staff had medical indemnity cover in place when they carried out work outside of the NHS indemnity scheme. The practice provided evidence of staff disclosure and barring, professional registrations and fitness to work checks. The practice had information about the staff team's hepatitis status and staff were asked on induction about their vaccination history which was kept in their individual staff files. This meant the management team were not assured staff immunisation history adhered to the Green Book – government guidelines regarding the immunisation against infectious diseases. At the time of 	

the inspection, the HR manager was in the process of collating and checking the full immunisation history.

- The practice used locum staff occasionally, at the time of the inspection they used approximately eight hours at both Oldfield Surgery and at St James's Surgery a week.

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: <ul style="list-style-type: none"> • St James Surgery – 11 June 2021 • Junction Road – 11 June 2021 • Oldfield Surgery – 19 June 2021 	Y
There was a record of equipment calibration. Date of last calibration: <ul style="list-style-type: none"> • Oldfield Surgery – 21 December 2020 • St James Surgery – 21 December 2020 	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: <ul style="list-style-type: none"> • St James surgery – 24 November 2020 • Oldfield Surgery - 24 November 2020 	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had completed independent fire risk assessments in November 2019 and had responded to the recommendations. In addition, the practice submitted annual fire risk assessments for Oldfield and St James Surgeries, which were completed by the practice manager, who had experience of fire prevention. • The practice had 23 fire wardens who had completed appropriate training. • Staff had completed fire drills at Oldfield Surgery on 30 June 2021 and St James's Surgery on 30 June 2021. • The last electrical hardwiring certificates for St James's Surgery was in January 2018 and Oldfield Surgery in January 2019. • At the previous inspection the practice did not have a system for fire alarm checks, at this inspection we found staff had carried out fire alarm checks in June 2021. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: See health and safety risk assessments	N/A
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: <ul style="list-style-type: none"> • St James's Surgery - 30 June 2021. 	Y

<ul style="list-style-type: none"> Oldfield surgery - 30 June 2021. 	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice submitted certificates to demonstrate they had independent contractors check the hot water systems for legionella in January 2021. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were mostly met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: St James Surgery January 2021 Oldfield Surgery January 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> 100% of staff had completed level one infection prevention and control training, and 77% had completed level two. The lead nurse was responsible for infection control, who had completed an annual statement on 26 April 2021. This included the changes the practice had made in response to COVID 19. On the day of the inspection, we found some sharps bins required updating. The staff immediately changed the bins. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff confirmed febrile patients were offered face to face appointments and the clinicians confirmed they used the National Early Warning Score (NEWS) to assess illness. 	

- Non-clinical and clinical staff had completed in-house sepsis training in January 2020.
- 69% of clinical staff and 77% of non-clinical staff had completed basic life support training. The practice manager confirmed that training had been delayed due to the pandemic and was planned for the week following the inspection.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a lead secretary, who managed a team of six staff across both sites. They were responsible for ensuring urgent and routine patient referrals were actioned and followed up. For urgent referrals there was a system for the staff team to check the patient had attended their appointment. • A review of patient records on the 27 July 2021, found test results, were dealt with promptly by the clinicians. The site managers had oversight of the blood tests and ensured they were promptly actioned. 	

Appropriate and safe use of medicines

The systems for the appropriate and safe use of medicines, including medicines optimisation were not always effective.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.64	0.66	0.70	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected	12.1%	11.3%	10.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	5.02	4.86	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	125.6‰	123.1‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	1.08	0.71	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	8.3‰	5.8‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
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

Medicines management	Y/N/Partial
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection on 1 May 2019, we found new systems and processes had not been fully embedded throughout the organisation, in relation to the monitoring of patients on high-risk medicines. At this inspection we found:</p> <ul style="list-style-type: none"> The practice had employed two pharmacists and had plans to employ two more in 2021. However, as the provider, Heart of Bath, was a stand-alone Primary Care Network, they had been working in the vaccination center from 8 December 2020 to 30 June 2021 and this had prevented them from completing the full review of the prescription service and increasing the number amount of medicine audits to ensure correct prescribing. The practice operated a Prescription Ordering Direct (POD) service that enabled patients to order their repeat prescription over the phone by trained call handlers using a standard operating procedure. Once the patient had given their consent, the call handler could electronically access the patient's clinical record and process the prescription request in the usual way. Any issues that were identified by the call handler were tasked directly to the relevant member of staff for resolution. The pharmacists explained they had two systems. For patients with long-term conditions, they would carry out a patient medicine review annually based on the patient's birthday, where the patient would receive up to three letters or texts asking them to book an appointment. Should the patient not attend the prescription the team would reduce how often a patient received a repeat medicine. The booking of the appointment generated any required tests, so that all the information for the review was available on the day of the appointment. For patients receiving high-risk medicines, such as methotrexate or azathioprine, patients were put on repeat prescriptions, recalled for tests as required by guidance, and the GP was responsible for checking the necessary tests were carried out prior to prescribing. For patients prescribed warfarin, all blood tests were carried out by secondary care, patients were provided with details of their medicine needs which was shared with the practice, and prior to authorisation the GP could check the patient's blood test online. However, we found: - We reviewed a sample of five patients on azathioprine and found two where the GPs had prescribed in the absence of the correct blood tests. The provider explained following guidance from NHSE in March 2020, which advised that GP practices were not required to carry out patients' medicine reviews due to the pandemic, clinicians had used a code to document the reviews in the patient notes by doctors because 	

Medicines management	Y/N/Partial
<p>further information about the review was considered not necessary. However, we reviewed four patient medication reviews from 9 July 2020 when the guidance was rescinded and found clinical staff had continued to not write their reasoning for continuing the patient medicines or completed an attached template</p> <ul style="list-style-type: none"> Following the inspection, the provider has put a new system in place to ensure the prescription ordering direct team request the GPs to carry out the medicine reviews and then ensure that the patient records are updated. The practice had also recruited two additional pharmacists to assist with medicine reviews. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	23
Number of events that required action:	20
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a lead for significant events and the practice manager had oversight. All significant events were reported, logged onto a computer software system and discussed at quarterly significant event meetings. They were also rated for the level of risk and feedback was available on the system and provided verbally to staff. All staff were encouraged to report incidents. 	

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

Event	Specific action taken
<ul style="list-style-type: none"> The practice was not provided with correct patient discharge information from secondary care. This resulted in the practice providing the incorrect medicine. 	<ul style="list-style-type: none"> The practice reviewed the issue and contacted secondary care, who were carrying out an investigation about the incident.
<ul style="list-style-type: none"> A relative called the practice for a telephone call to the doctor, as they were worried about a child, this was sent by the administration staff by instant 	<ul style="list-style-type: none"> Action was taken to remind administration staff to book an appointment if a patient wants to speak with a doctor.

messaging and not seen by the doctor promptly.	
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a system for the review and action of Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts. However, for sodium valproate, although the practice had responded satisfactorily to the safety alerts, out of five patients reviewed there was no evidence of the Pregnancy Prevention Program risk assessment template recorded in the patient notes. 	

Effective

Rating: Requires Improvement

- We have rated effective as requires improvement because the systems and processes for monitoring patients with long-term conditions and those experiencing poor mental health had not been fully embedded.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment delivered in line with current legislation, standards and evidence-based guidance.

	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.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> To ensure nursing staff only treated patients within their competency, the reception staff had a list of which appointments they could allocate to the specific nurses and their roles. We carried out a review of over 50 patient records and found patients immediate and ongoing needs were fully assessed and reviewed. Serious illness was followed up promptly and referral pathways were followed. 	

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice supported seven residential and nursing homes.
- The practice employed a clinician to carry out urgent appointments for older and shielding patients who were unable to attend the practice.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- At the previous inspection in May 2019, we found systems and processes for monitoring exception reporting of patients with long-term conditions were not always operating effectively between 2018 and 2019, as a review of clinical records found inconsistencies. (A practice can exclude patients from data collection for the quality outcomes framework, where the practice has been unable to deliver the recommendation. For example, they have offered three appointments and the patient has refused to attend, or who are newly diagnosed, or newly registered.)
- In response the practice had changed their recall system for patients. This meant, that all patients would receive three invitations via a variety of methods for their scheduled care. The Lead GP in each area was made responsible and accountable for the exception reporting at the end of the quality outcomes framework for the year.
- On 1 April 2019, exception reporting changed to Personalised Care Adjustments (PCA). These allow practices to differentiate between the reasons for adjusting care and removing a patient from the indicator denominator, enabling more robust insight to be gained from their analysis.
- At this inspection, the practice's achievement for the effective monitoring and review of patients with long-term conditions between April 2019 and March 2020 was lower than regional and national averages for some indicators. Personalised Care Adjustments (PCA) was significantly higher than regional and national averages. The practice has therefore been rated as requires improvement for this population group.
- The lead GP explained that they had allowed lead GPs to agree to exception reporting for their own areas, but following the receipt of this data, they had moved to only the lead partner GP approving PCA. GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes.
- The practice employed a clinician to carry out long-term condition reviews for patients who were unable to attend the practice.
- During the pandemic there were increased anxieties across population about managing their respiratory conditions and spirometry had stopped. In response, the practice purchased two for outside use.

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)	74.5%	75.2%	76.6%	No statistical variation
PCA* rate (number of PCAs).	29.1% (590)	10.9%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the	89.6%	86.1%	89.4%	No statistical variation

Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
PCA rate (number of PCAs).	27.6% (117)	13.0%	12.7%	N/A

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

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	72.9%	80.2%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	3.0% (15)	5.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	72.5%	66.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	20.9% (195)	17.1%	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) <small>(QOF)</small>	62.6%	71.3%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.7% (93)	7.4%	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) <small>(QOF)</small>	90.1%	92.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	5.4% (30)	4.5%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	63.9%	74.0%	75.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	22.7% (212)	11.5%	10.4%	N/A

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

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for all of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- Young people could access services for sexual health and contraception.
- The practice had a dedicated clinic for eight-week baby checks and post-natal checks, which ran alongside a vaccination clinic to enable a single visit to the practice.

- The practice manager explained one practice nurse was responsible for the child immunisations and they would text on the day to remind parents/guardians if they had missed an appointment, and then recall them by letter, text or telephone.
- Child health reported to the practice every six months regarding children who did not attend appointments. Any safeguarding concerns were followed up by the health visiting team or child health

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)	204	222	91.9%	Met 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)	213	225	94.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	211	225	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	209	225	92.9%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	208	223	93.3%	Met 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- Although, the cervical screening data was below the NHS 80% target. The verified cervical screening data for April 2020 to March 2021 had improved by 1% to 69.2%. Unverified data

submitted by the practice demonstrated the uptake of cervical screening on 1 April 2021 to present time for aged 25 to 49 was 70.8% and aged 50 to 64 was 79.1%.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	68.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	69.1%	74.4%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	62.7%	67.0%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	88.2%	89.3%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	61.5%	56.7%	54.2%	No statistical variation

Any additional evidence or comments

- The lead practice nurse explained that any abnormal results for cervical screening was reliant on the individual nurses ensuring patients had an appointment at the hospital and they did not have oversight. This meant the practice did not have safety net in place should the individual nurse fail to follow up the abnormal result.
- Each practice nurse had oversight of their own cervical screening inadequate results, which were reviewed during their annual appraisal. During discussion the lead nurse agreed to the introduction of oversight and more frequent reviews of the results.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- During the pandemic when vulnerable patients were shielding, the nursing team visited patients in their homes to enable care to continue.
- The practice offered primary medical services at a homeless center, where the nursing team saw patients on site and would carry out outreach work to engage with patients who did not attend the center.
- The practice had a dedicated clinic with a named GP for patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- 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) 25.7%, which was lower than the CCG average of 78.7%. The provider explained the clinical commissioning group had employed an external company to carry out the care plan reviews commencing in March 2021. In addition, the provider submitted unverified data which stated the number of mental health patients with an agreed comprehensive care plan completed, from April 2021 to date, was 135 out of 257. However, the practice had not ensured that patients with schizophrenia, bipolar affective disorder or other psychosis had a comprehensive agreed care plan. Therefore, the practice was rated as requires improvement for this population group.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Most staff had received dementia training in the last 12 months of 2019.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice maintained a register of patients with dementia or who had a learning disability, to ensure they were reviewed and offered the appropriate care and treatment.

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>	25.7%	78.7%	85.4%	Significant Variation (negative)
PCA* rate (number of PCAs).	3.2% (9)	20.2%	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>	89.7%	81.5%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.6% (16)	8.9%	8.0%	N/A

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

Any additional evidence or comments

The provider explained the clinical commissioning group had employed an external company to carry out the care plan reviews commencing in March 2021. In addition, the provider submitted unverified data which stated the number of mental health patients with an agreed comprehensive care plan completed, from April 2021 to date, was 135 out of 257.

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	513.6	533.9
Overall QOF score (as a percentage of maximum)	91.9%	95.5%
Overall QOF PCA reporting (all domains)	7.1%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

<p>The clinical staff had carried out a range of audits, this included</p> <ul style="list-style-type: none">• An audit to check patients who had diagnosis of dementia were correctly coded and diagnosed.• The pharmacists had an audit schedule for 2021 to ensure safe prescribing.• An audit of patients on insulin without a diagnosis of diabetes showed three patients were identified who had had diabetes in pregnancy, which had now resolved.• An audit to ensure patients with chronic kidney disease were accurately identified in the patient records system.• All the audits were one cycle due to the pandemic when the pharmacist and nursing team had been seconded to help with the vaccination program.• The pharmacy team had a schedule in place for the auditing of medication in 2021.
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Any additional evidence or comments

The provider, Heart of Bath, had an active clinical research unit, run by a clinical research nurse and study coordinator and supported by a core research team which included two of the GP Partners. In addition, all staff were encouraged to take part in and promote research to patients. Heart of Bath was currently involved in over 20 research studies, working closely with the National Institute of Health Research (NIHR), universities and commercial sponsors. Since March 2020 they had focused on supporting Urgent Public Health Research, such as the Principal Trial, Virus Watch and surveys to understand the psychological response to the Covid-19 pandemic. Last year over 1,000 patients

participated in research studies delivered by Heart of Bath, potentially giving them access to innovative treatments.

Patient experience surveys, taken following the research were positive, commenting that their experiences consistently exceeded expectations.

Effective staffing

The practice mostly 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.	Partial
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- The practice had a system to monitor mandatory training. This demonstrated that 69% of clinical staff and 77% of non-clinical staff had completed basic life support training, 100% of the non-clinical staff team had completed level one safeguarding training for children and adults and 97% of clinical staff had completed the level three training. The practice manager explained the basic life support training was planned for August and had been delayed due to the pandemic.
- However, the staff's role specific training certificates were held in the staff's personal files, and this did not provide oversight and assurance to the management team that staff were skilled for the roles. Following the inspection, the practice was working towards moving to using one system.
- Staff could request specific funding for training, which was then reviewed and signed off by the GP partner. In addition, there was a flexible approach, and practice nurses could choose to block out time to achieve training requirements or alternatively, they could do this in their own time and claim for reimbursement. For example, a health care assistant was supported to attend a nursing course at university.
- The practice had a lead GP responsible for the supervision of advanced nurse practitioners. We were told advanced nurse practitioners carried out appointments within their scope of practice and GP partners monitored and supported them at each clinical session. To demonstrate that this system was in place the GP partners agreed to keep record of some of the clinical reviews.

- Nursing staff received weekly supervision and a review of their competencies with the lead practice nurse, and then informal supervision and an annual appraisal. Where appropriate they would increase the level of supervision. To demonstrate that this system was in place the lead nurse agreed to record some of the informal supervision.
- The practice carried out a review of the consultations for GP trainees to check and agree their prescribing.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

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 and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice employed a social prescriber who signposted patients to other sources of help. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> 76% of clinical and non-clinical staff had completed Mental Capacity Act training. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The GP survey results for January to March 2021 did not show a major variation despite the effects of the pandemic. Staff told us they understood and respected patients personal and cultural needs. The practice employed a care navigator who provided patients with information about other agencies that provided support. 	

Source	Feedback
Friends and Family	For June 2021 the practice had one response which stated the patient would recommend it to their friends and family.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	87.9%	91.9%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	90.7%	90.9%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	95.1%	96.8%	95.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	85.2%	86.7%	83.0%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> The practice submitted two patient surveys which were taken following patients participating in a research project, which contained positive feedback. The practice manager explained due to the pandemic they had not had the opportunity to carry out a patient survey. The last one was carried out in 2019.

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

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 (01/01/2021 to 31/03/2021)	92.1%	95.0%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	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 recorded on the patient records their needs and used interpretation services and a text service for patients with English as a second language and those with hearing loss. In addition, the reception area had a hearing loop.
- Staff described how they would print letters in large font for patients whose sight was impaired.

Carers	Narrative
<ul style="list-style-type: none"> • Percentage and number of carers identified. 	<ul style="list-style-type: none"> • The practices had identified 566 carers. Which was over 1% of the practice population.
<ul style="list-style-type: none"> • How the practice supported carers (including young carers). 	<ul style="list-style-type: none"> • Carers had access to a care navigator. • Wheelchairs were available for patient use
<ul style="list-style-type: none"> • How the practice supported recently bereaved patients. 	<ul style="list-style-type: none"> • The practices supported families by explaining the bereavement process and sending a sympathy card.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Good

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had responded to the pandemic and changed the appointment system. This included: -</p> <ul style="list-style-type: none"> Increased telephone consultations with GP's. Secure transfer of documents was used as a form of patient communication for photos and video consultations. Online consultations were available to patients via the website. The referral for patients with COVID 19 symptoms to the Hot Hubs (Oldfield Surgery and Elm Hayes). The nursing team had responded and treated shielding patients in their homes. If GP's called patients in for a face-to-face appointment, they were given extra time to put on and remove personal protective equipment (PPE) and to complete infection control processes. Practice nurses continued their clinics, with immunisations, cervical screening and dressings, extra time was allocated for PPE and infection control processes. The practice had stopped the online service to book appointments, as they were only providing urgent same day appointments. <p>At present they had: -</p> <ul style="list-style-type: none"> The practice had continued with telephone triage consultations. Face-to-face appointments were available, but only booked in once the GP had triaged the patient by telephone. The online booking appointment service resumed for appointments on the day and in advance. Urgent same day appointments were available from 8:00 am and 2:00 pm. The practice continued to follow COVID restrictions including, social distancing, face coverings and PPE. Although, the hot hubs for patients with COVID 19 symptoms had now closed, Heart of Bath, had an isolation room at Oldfield Surgery. When the practice closed, an improving access service was available, for routine telephone and face-to-face appointments, from 6pm to 9pm Monday to Friday, and 8am to 12 noon at Saturday and Sunday Widcombe Surgery. 	

Practice Opening Times	
Day	Time
Opening times: Oldfield Surgery	
Monday	08:00 – 18:00
Tuesday	07:30 – 18:00
Wednesday	08:00 – 18:00
Thursday	07:30 – 18:00
Friday	08:00 – 18:00
Urgent Surgery, Monday – Friday	08:30 – 11:20 & 14:00-17:50
Saturday and Sunday	CLOSED
Opening times: St James's Surgery	
Monday – Friday	08:00 – 18:00
Urgent Surgery, Monday to Friday	08:30 – 11:00 and 14:30 – 17:30
Saturday and Sunday	CLOSED
Number of sessions available Weekly	
Number of GP sessions available weekly	Oldfield Surgery = 53 St James's Surgery = 39
Number of nurse sessions available weekly	Oldfield Surgery = 51 St James's Surgery = 41
Number of sessions by other clinicians, health care assistants, practice nurses and nurse practitioners	50 Sessions across both sites
Advanced medical or nursing practitioners	18 sessions across both sites

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. For patients who were shielding, the nursing team had offered home visits during the pandemic. The practice provided effective care coordination to enable older patients to access appropriate services. In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. There was a medicines delivery service for housebound patients by local pharmacies. The practice explained the uptake of health checks had been affected by the pandemic and provided unverified data which stated the number of health checks carried out for patients over the age of 75 was 19 in 2020 to 2021. The practice supported approximately seven care homes where the GPs carried out weekly ward rounds, we contacted two homes who said the staff were responsive to needs.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care co-ordination 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. The practice held multi-disciplinary team meetings weekly.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- For patients who were shielding the nursing team had offered home visits during the pandemic.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available after 6pm clinic and on Saturday mornings with the access clinic.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, though online and telephone appointments.
- When the practice closed, an improving access service was in place, for routine telephone appointments and face-to-face appointments, from 6pm to 9pm Monday to Friday, and Saturday and Sunday 8am to 12 noon at Widcombe Surgery.

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, 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.
- 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.

- The provider had another registered location with CQC, which provided services to the homeless community.

**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.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice offered consultation space to mental health services for hard to engage patients. It also hosted Talking Therapies meaning that patients could access help in a familiar setting.

Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • CQC received two concerns from patients regarding access to the practice in 2020 and one in April 2021. However, prior to the inspection we received nine positive comments about the practice. • In response to all negative feedback. The practice manager explained when the practices merged the telephone systems were unable to manage the high volume of calls. The practice manager met regularly with the contractors but was unable to resolve the issues. Therefore, they were planning to install a new telephone system in August 2021 in order to resolve access issues via the telephony system. 	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to	65.5%	N/A	67.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	73.4%	75.1%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	56.1%	70.1%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	84.7%	85.0%	81.7%	No statistical variation
Additional evidence: - <ul style="list-style-type: none"> 293 patient surveys were sent out and 132 surveys were received. 				

Source	Feedback
NHS choices	From February 2020 the practices had five - one star, two- two star, one – four star and two – five-star reviews. Most of the one-star reviews were regarding telephone access to the practice.

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.	17
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	

- Complaints were listened and responded to and used to improve the quality of care. The lead GP partner responsible for governance told us the practice viewed all patient feedback positively and used this to inform improvements to service delivery.
- We reviewed three complaints and found they had been responded to promptly and where necessary an apology was offered. However, the letters to the complainant did not include where to go to next if they were unhappy with the response. The practice manager agreed to amend this going forward.

Example(s) of learning from complaints.

Complaint	Specific action taken
<ul style="list-style-type: none"> • Patient contacted the practice for a on the day appointment, however they had all been allocated. The patient complained about the receptionist attitude. 	<ul style="list-style-type: none"> • The practice manager reminded staff to provide more explanation to the patients regarding the impact of the vaccination program and the pandemic to staffing levels.
<ul style="list-style-type: none"> • Patient complained regarding difficulty in access to an appointment to see a GP for further treatment. 	<ul style="list-style-type: none"> • The appointments system was changed to make more GPs available during the day and commenced providing secretarial details so they could help action any urgent requests for patient care.

Well-led

Rating: Requires Improvement

At the previous inspection on 1 May, report published 19 June 2019 the practice was rated requires improvement in well-led. At this inspection we have found that some of the systems and processes continue to require further improvements to provide the leadership team with assurances and oversight of the quality of care.

Leadership capacity and capability

There was effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Two large practices merged 1 April 2018, with a smaller practice also joining in quick succession. In addition, patients from other practice lists were registered at the practice due to two patient list dispersals by the local Clinical Commissioning Group (CCG). These actions created the provider Heart of Bath. A new practice manager had commenced on 1 July 2020.The practice manager and lead GP described this as a difficult time where they had implemented new systems and processes and encouraged staff to work across sites, which may have challenged some staff. We received eight staff questionnaires and spoke with different members of the staff team both during online interviews and during the site visit to the practice. As part of the interview template, we asked about the culture of the practice and whether the leadership team were approachable and open. We did not receive any negative comments and many of the staff members told us they enjoyed their work and they spoke positively about the new practice manager.	

Vision and strategy

The practice had a 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.	Partial

Explanation of any answers and additional evidence:

- The practice had a business continuity plan for 2021.
- In June 2020 the practice implemented a new structure which provided improved accountability and clearer specific management roles for staff.
- The lead partner and the practice manager had a vision for the practice to have a strong leadership which promoted improvements for staff and patients.
- Since the commencement of the pandemic in March 2020, the practice had concentrated on responding to all of the challenges it presented. The time the staff team spent supporting the vaccination program and other aspects of the pandemic had impacted on the leadership team being able to demonstrate a formal approach to monitoring the improvements they had made since the last inspection.

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.	Partial
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

- Staff reported the culture had improved as staff had risen to the challenges of working during the pandemic and since the commencement of the practice manager.
- To improve the culture the practice manager explained they had restructured the practice so that staff worked in teams with a team lead, who was visible and always available for support. This included the practice manager who worked across both sites.
- The practice did not have a freedom to speak up guardian but planned to put one in place from October 2021. However, the practice manager explained they had an open-door policy and encouraged staff to speak freely and staff had been actively encouraged to follow the whistle blowing policy for any concerns.

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

Source	Feedback
<ul style="list-style-type: none"> • We received eight questionnaires, and spoke with different members of 	<ul style="list-style-type: none"> • Where we asked about the leadership team, all said they enjoyed their work and spoke positively about the new practice manager. They also stated they felt able to raise concerns.

the staff, during online interviews and during the site visit.	
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Governance arrangements

The practice had recently implemented new roles and responsibilities, however some of the systems required further improvement to provide the leadership team with assurances and oversight of the quality of care.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in May 2019, we found that due to the merger, new systems and processes had been implemented but these were not fully embedded to demonstrate a sustained approach</p> <p>Since the last inspection the practice had responded to the challenges of: -</p> <ul style="list-style-type: none"> Two large practices merged 1 April 2018 and were quickly joined by another smaller practice. In addition, other patients were added to their list due to two patient list dispersals by the local clinical commissioning group, thus creating the provider Heart of Bath. A new practice manager had commenced in January 2020 and had recently put into place a new leadership structure to support and manage staff, which provided clear lines of responsibility to the team leader, partners and senior partner. Due to the size of its registered patient list, the provider, The Heart of Bath, was the singular member of a Primary Care Network. This meant they were solely responsible for providing staff for the locality vaccination centre. The practice manager explained they had seconded up to three GPs, two pharmacists, approximately half of the nursing staff and regular administration and the practice manager from December 2020 to July 2021 for seven days a week from 8am to 8pm <p>The practice manager and lead GP described this as a difficult time where they had attempted to implement consistent systems across all sites</p> <p>At this inspection we found the practice manager had responded to the findings of the May 2019 inspection. For example, staff members had protocols to follow for booking appointments, the practice was using computer management software to review complaints, and incidents and staff communication had been improved.</p> <p>However, there were areas where the new systems required further embedding to provide the leadership team with assurance and oversight. For example: -</p> <ul style="list-style-type: none"> The practice held staff information regarding recruitment, immunisation and training in three places, in staff files, and on two computer systems. This meant the practice did not have oversight to identify risks and mitigate them. Such as not adhering to staff immunisation as required by the guidance outlined in the Green Book –government guidelines regarding the immunisation against infectious diseases. 	

- A review of patient's medicines found two patients on high-risk medicines where the GPs had prescribed in the absence of the correct blood tests; and four patient's medication reviews where clinical staff had not written their reasoning for continuing the patient medicines or completed an attached template. Which demonstrated that the systems were sometimes ineffective.
- The lead practice nurse did not have oversight of the nursing teams results for inadequate and abnormal cervical screening results and actions taken.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The provider had an organisation risk register which commenced in March 2020. • The practice had a vision for the service but due to the pandemic had not recorded this. • The leadership team did not have fully effective assurance systems in place for training, recruitment and medicines. • The lead partner and the practice manager met weekly to review performance and risks. In addition, all partners met on a monthly basis. • The system to monitor the quality outcome framework data to ensure the quality of patient care was not always effective. 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y

The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All staff were offered to work from home during the pandemic where possible, and the practice supplied laptops. • An employee assistance program was implemented to give staff and their immediate families access to a wide range of services to support their wellbeing. Such as giving birthday leave as a morale booster amongst staff. • Staff were supported to isolate as per government guidelines to help protect staff, patients and the wider general public. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y

The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practices had a data protection certificate which demonstrated compliance until September 21. The practices had notices to inform patients how they kept their data safe and was considering adding this to the website following the changes during the pandemic. The service used a system which provided consultation by video online and would make patients aware of the privacy settings. 	

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. (PPG)	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:	
<ul style="list-style-type: none"> The practice had an employer's handbook that provided information regarding human resources, whistleblowing, salary and entitlements. Staff told us that staff meetings had better attendance because they were online. The leadership team explained that communication was through the weekly bulletin which was sent to all staff. Staff provided examples of how the management team had responded to their suggestions. The practice had carried out a staff survey in March 2021, which had 27 responses. Overall staff felt well supported and found line managers and the practice manager very approachable. Staff felt able to discuss any issues with the knowledge that they were listened to and if appropriate their ideas were acted upon. Staff felt communication had improved but information was not always passed to the relevant people. Some staff commented that current hourly rates needed addressing and their annual appraisal was overdue and role progression in the practice was limited. The practice manager explained that all these issues had been responded to. The last PPG meeting was held in May 2021 and was attended by six PPG members and staff where they discussed the appointment system and online appointments. Practice nursing staff last met on the 20 May 2021. Clinical staff met each month and held weekly informal meetings, the management team met twice a week and the partners held a monthly meeting. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence	
<ul style="list-style-type: none">The provider also offered a CQC registered service at another location, which was a homeless centre, where the nursing team saw patients on site and would also carry out outreach work to engage with other patients who did not attend the center.Partners within the practice held key roles with external stakeholder groups. For example, one partner was the local Care commissioning Group chair and one partner led on safeguarding for the local area.The Heart of Bath was a sole member of a primary care network, this meant they were solely responsible for the management and staffing of a vaccination center.Oldfield Surgery carried out a quality improvement program to reduce the practice environmental footprint of inhalers by switching to Echo inhalers. This consisted of providing information for both patients and clinicians.The pharmacists had an audit scheduled for 2021 to help ensure safe prescribing.	

Examples of continuous learning and improvement

Heart of Bath has an active clinical research unit, run day to day by a clinical research nurse and study coordinator supported by a core research team that included two GP Partners. In addition, all staff were encouraged to take part in and promote research to patients.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.