

Care Quality Commission

Inspection Evidence Table

Castlefields Surgery (1-2897162123)

Inspection date: 16 November 2020

Date of data download: 21 October 2020

Overall rating: Requires Improvement

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

The practice was rated inadequate in January 2020 and put in special measures. We found the practice had made improvements across several areas of non-compliance identified at our previous inspection. We have rated the practice Requires Improvement overall because some patients had not received their blood monitoring and blood pressure monitoring for the last 18 months. The medicines they were on required more frequent monitoring. Following the inspection, the practice took action to mitigate this risk.

The number of patients who had received their cervical screening was below the local and national average. Although the practice had taken some action to act on this we have not yet seen the impact of this.

Safe

Rating: Requires Improvement

At the last inspection the practice was rated Inadequate for providing safe services because the practice did not have all the systems, practices and processes to keep people safe and safeguarded from abuse. The practice did not have an effective system for ensuring that Medicines and Healthcare Regulatory Agency (MHRA) and patient safety alerts were received and actioned. Staff did not always have the information they needed to deliver safe care and treatment. The system for the summarisation of patient records were not effective. Risks were assessed but not all were well managed.

Following this inspection, the practice is rated Requires Improvement for providing safe services because they had fallen behind with monitoring blood pressure and blood tests for patients on medicines for long term conditions. This was raised with the practice during the inspection and the practice has already started to action this.

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. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| 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. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, the following concerns were identified:</p> <ul style="list-style-type: none"> • In the patient records we reviewed, we found icons were not in place to identify if patients had child protection plans in place. There were no icons for a parent or sibling to ensure that staff were aware of safeguarding concerns for the child/adult or family. • Safeguarding policies had been reviewed and updated but did not contain guidance on female genital mutilation (FGM), trafficking or sexual exploitation. Since the inspection the practice had updated the safeguarding policy accordingly. • We reviewed detailed minutes of safeguarding meetings, however there was no documentation on patient records to indicate that a discussion had taken place. <p>During this inspection we found:</p> <ul style="list-style-type: none"> • Patient records now contained the relevant icons to identify if child protection plans were in place. We also saw a child protection action log which was regularly updated, and we saw minutes of meetings where child protection issues were discussed. All the patient's relatives had also been added to the plan. • The practice's safeguarding policy included guidance on female genital mutilation (FGM), trafficking and sexual exploitation. • Patient records also contained details of discussion points raised at the practice's safeguarding meetings as well as on the meeting minutes. | |

| Recruitment systems | Y/N/Partial |
|---------------------|-------------|
|---------------------|-------------|

| | |
|---|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Yes |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Explanation of any answers and additional evidence: | |
| During this inspection we saw a copy of the recruitment policy which was updated annually. The practice also followed a recruitment qualification policy which was updated on an annual basis. Staff files we looked at during the inspection confirmed that recruitment checks were followed in accordance with our regulations. | |
| During this inspection we saw evidence of Nursing and Midwifery Council and General Medical Council checks carried out of clinical professionals. | |

| 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: 12 November 2020. | Yes |
| There was a record of equipment calibration. Date of last calibration: 24 June 2020 | Yes |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks. Date of last check: September 2020 | Yes |
| There was a log of fire drills. Date of last drill: 12 November 2020 (this was carried out on a weekly basis) | Yes |
| There was a record of fire alarm checks. Date of last check: This is done every Thursday morning. | Yes |
| There was a record of fire training for staff. Date of last training: The practice staff had carried out this training on different dates online. | Yes |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed. Date of completion: September 2020 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: | |

At our previous inspection in January 2020, the following concerns were identified:

- We saw a comprehensive fire risk assessment had been completed in February 2019 and this was accompanied with an action plan. The action plan contained some updates which had been completed by a contracted third party. However, it was unclear which components of the action plan related specifically to the practice and we did not see any evidence to support that the practice had taken ownership of the plan. For example, by following up on action points which in some cases had passed their target completion date. We spoke with the management team and advised that the practice should request a copy of the completed fire risk assessment for their own records and notes of any actions needed to be taken by the practice.
- Fire drills were completed every six months, but minimal records of the drill were recorded. Following the inspection, the practice provided us with a copy of a completed fire drill log for 21 January 2020.
- The Legionella risk assessment action plan had not been fully completed since being produced in July 2019. The practice informed us that some actions had been taken but the plan was overseen by a contracted third party. However, the practice was not able to demonstrate that they were following up areas identified for action which were relevant to the practice which posed a potential risk to patients and staff.

During this inspection:

- We saw that a fire risk assessment took place in September 2020. The fire risk assessment demonstrated that appropriate action had been taken; for example, the rubber seal on the carpet in the staff room was loose and had been fixed appropriately. One of the fire extinguishers had a broken pin. The practice contacted the external company, and this was replaced this following the risk assessment.
- The practice was now recording fire drills. We saw that a fire drill took place on a weekly basis.
- A legionella risk assessment took place on 14 April 2020. The practice shared a working document where actions had been taken following on from the assessment. For example, infrequent water outlets were being flushed more frequently.
- The onsite engineer checked the water tanks and the mixer taps and this was being done monthly. The practice checked these monthly as well. The practice had been getting the same room temperatures that were documented by the onsite engineer. If this wasn't the case, they had a plan in place for the onsite engineer to review.

| Health and safety | Y/N/Partial |
|---|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 12 November 2020 | Yes |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 12 November 2020 | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Health and safety management, including premises, was undertaken and held by the building owner and was the responsibility of a contracted third party. The practice did also keep their own record and evidence of updates in relation to any assessment and actions. | |

- Monthly walk rounds of the practice area were carried out and documented by the practice health and safety officer and covered areas such as premises, security and general health and safety. If any actions were required, they were carried out immediately. Records we viewed confirmed this. For example, they noticed that the burns and scalding kit had gone missing, so the health and safety officer ensured that this was replaced.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|-------------|
| There was an infection risk assessment and policy. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 28 May 2020 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| There was a system to notify Public Health England of suspected notifiable diseases. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>During this inspection, we looked at the practice's latest infection control audit from 28 May 2020. It showed that some of the walls had scuffs and marks. It identified that posters in the room needed laminating. Both issues had been recorded as actioned by the practice. The audit identified that it would be better for the gloves and apron holders to be mounted to the walls instead of being on the trolley. The practice was in the process of actioning this during the time of our inspection.</p> <p>As well as carrying out regular audits the practice had an infection control log and if any issues were raised, staff were encouraged to document them in the log. The log was stored on the practice's shared drive with all the relevant information of who the action belonged to. This was reviewed on a monthly basis. The practice had measures in place in response to COVID-19.</p> | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans for patients were developed in line with national guidance. | Yes |

| | |
|---|-----|
| The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | Yes |
| 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. | Yes |
| There was a process in the practice for urgent clinical review of such patients. | Yes |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>During this inspection, the practice was able to demonstrate how they had dealt with an emergency recently during the COVID-19 pandemic and taken appropriate steps to ensure everyone was safe during this time.</p> | |

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| 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. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> There was no policy in place for the summarisation of new patient records. We were told that since a member of staff had left there was a backlog of approximately 204 unsummarised patient records which dated back six months. There was no oversight of records that needed to be prioritised for summarisation. The practice had not reviewed the backlog of records for the likelihood of risk and was unable to demonstrate a documented action plan to identify how the backlog would be managed. | |

During this inspection we found:

- The practice was up to date with its patient records summarising. The practice manager had helped to get the backlog down. Every Friday the practice manager checked the status and if there were any outstanding notes, it was marked on the nurses' rota so that they had time to do this. They had trained more staff to ensure that notes were summarised in a timely manner since the last inspection.

Appropriate and safe use of medicines

The practice did not always have systems for the appropriate and safe use of medicines, including medicines optimisation in relation to the annual monitoring processes for certain medicines.

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA) | 0.89 | 0.92 | 0.85 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA) | 7.1% | 7.9% | 8.6% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2020 to 30/06/2020) (NHSBSA) | 4.30 | 5.09 | 5.35 | Tending towards variation (positive) |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA) | 1.60 | 2.01 | 1.92 | No statistical variation |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |

| Medicines management | Y/N/Partial |
|--|-------------|
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | Yes |
| 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). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| 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. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> Medicine reviews took place but there was no formalised system in place and no policy to provide guidance to staff. <p>During this inspection we saw:</p> <ul style="list-style-type: none"> There had been an improvement to the practice's process regarding medicines reviews, but the practice was behind with some medicine reviews in relation to national guidance. We saw that some patients on ACE inhibitors and ARBs (heart medications) had not had their bloods tested in the last 18 months nor had those patients received a blood pressure check within the same time period. There were 125 patients without blood monitoring in the last 12 months and 63 patients without the required monitoring in the last 18 months. Following the inspection, the practice has provided us with information to demonstrate it had started to address this issue. The practice confirmed that part of the delay was due to the COVID-19 pandemic. Certain anticoagulants, known as DOACS, did not have an important parameter in place to determine the correct dosage. There were 46 patients on a DOAC who had not had their creatinine clearance checked for 12 months in line with national guidance. This was a coding issue which the practice addressed straight after the inspection. | |

| Medicines management | Y/N/Partial |
|---|-------------|
| <ul style="list-style-type: none"> • The practice now has a Primary Care Network (PCN) pharmacist who carries out medicine reviews for them on a weekly basis. However, work was still needed to ensure that the process for recording medication reviews was consistent. • The practice did Medicines & Healthcare products Regulatory Agency (MHRA) alert reviews if medicines needed to be changed. When issuing prescriptions, the PCN pharmacist checked when they were last seen. • The administration manager for the practice had a lead role in chasing up medicine reviews with patients by text, phone or letter. | |

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. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 6 |
| Number of events that required action: | 3 |
| Explanation of any answers and additional evidence: | |
| At our previous inspection in January 2020, we found: | |
| <ul style="list-style-type: none"> • Improvements had been made to the process to the practice's significant events process that had been identified as an issue at an inspection in November 2018. However, clinical oversight by the lead GP was absent and therefore it was difficult to ascertain if they had ensured that actions and learning were appropriate. • Meeting minutes required more detail on learning and actions taken. Not all staff we spoke with were aware of significant events that had taken place in the practice. | |
| During this inspection we found: | |
| <ul style="list-style-type: none"> • Significant events were discussed at team meetings. All staff we spoke with during the inspection were able to give us examples of where the practice had taken actions and learned from events. We have seen meeting minutes where significant events were discussed. | |

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

| Event | Specific action taken |
|--|--|
| Telephone lines went down | The practice telephone lines went down so the calls were diverted to mobile phones. The practice manager advised Nene Clinical Commissioning Group (CCG) and Primary Care Network (PCN). The administration manager sent out text messages to patients to advise and the practice manager updated the practice website to advise patients to get in contact with the surgery by email through the practice website. The practice manager monitored this throughout the day and responded accordingly to the messages and queries from patients. Nene CCG sent out communications to other practices and patients as well. Reception staff followed up the patient contacts and the practice manager replied to the email messages straight away. |
| COVID-19 positive | A member of staff tested positive for COVID-19 after displaying symptoms of a cold. The staff member self-isolated for 10 days and all staff were informed. The practice carried out infection control procedures and quarantined all the staff member's things. Another member of staff's family member tested positive for COVID-19 so they self-isolated. The practice had a deep clean following this and followed COVID-19 protocols. |
| Patient came to phlebotomy area at hospital next door. He collapsed and came to the GP practice. | <p>The receptionist took a wheelchair out to him and staff activated the panic button.</p> <p>The lead GP came out to see the patient. He carried out his observations and called for an ambulance. The patient later tested negative to COVID-19, but this was not known at the time of the incident. The practice still de-contaminated on site and the practice manager went home to have a change of clothes.</p> <p>The practice discussed with the hospital following this significant event that they could have called an ambulance instead of bringing the patient to the practice.</p> |

| Safety alerts | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, we saw:</p> <ul style="list-style-type: none"> Patients were at risk of harm as the practice did not have an effective system in place to ensure that Medicines & Healthcare products Regulatory Agency (MHRA) patient safety alerts were | |

received and actioned appropriately. The practice had a safety alert protocol in place however this was not adhered to. There was no evidence of how the alerts had been shared and actioned. The practice was unable to evidence that all staff, including locum GPs and nurses, were aware of any relevant alerts or where they needed to take action.

- Following the January 2020 inspection, the practice sent us a prescribing audit log as further evidence. It contained seven patient safety alerts and demonstrated where actions had been taken. However, it was not a comprehensive list and therefore did not demonstrate the practice had an effective system in place to ensure that they were receiving, disseminating and acting upon all alerts and information relevant to general practice.

During this inspection we found:

An electronic system had been set up for MHRA alerts. The administration manager kept an action log for this, and alerts were sent to the pharmacist. The PCN pharmacist emailed the relevant staff as and when an alert comes through. The log was updated with the medicine that had the issue and which GP it had been assigned to for actioning. MHRA alerts were on the shared drive for all to access and was discussed at the clinical meetings.

- Also, during this inspection, we found some historic MHRA alerts which needed to be actioned. We saw that there were 13 patients who were prescribed a medicine that is not to be used in conjunction with clopidogrel. (Clopidogrel is an antiplatelet medicine taken by patients who have had a heart attack or stroke). This was pointed out to the practice during the inspection and it was actioned straight away.

Effective

Rating: Requires Improvement

We previously rated the practice Requires Improvement for providing effective services. We have still rated the practice as Requires Improvement for providing an effective service because the population groups of people with long-term conditions and working age people (including those recently retired and students) are rated as Requires Improvement because:

- The percentage of women eligible for cervical screening was below the national average of 80%. Although the practice had taken some action, we have not yet seen the impact for patients.
- Some patients with long-term conditions had not had their blood monitoring and blood pressure monitoring completed in a timely manner.

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. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • Patients were at risk as the practice did not have an effective system in place to ensure Medicines & Healthcare products Regulatory Agency (MHRA) patient safety alerts were received and actioned appropriately. <p>During this inspection we found:</p> | |

- The practice now had a system in place for ensuring that MHRA alerts were processed and actioned. The PCN pharmacist emailed the relevant staff as and when an alert came through. A log was updated with the medicine that has the issue, alongside which GP it has been assigned to. MHRA alerts was on the shared drive for all to access.

| Prescribing | Practice performance | CCG average | England average | England comparison |
|---|----------------------|-------------|-----------------|--------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) <small>(NHSBSA)</small> | 0.82 | 0.72 | 0.70 | No statistical variation |

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. The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- However, we saw that some patients had not received a relevant blood test in the last 18 months and their blood pressure had not been monitored over the same period which meant that their care needs was not effectively being met as a result. Some of this delay was due to the COVID-19 pandemic. The practice sent us evidence to demonstrate it had started to action this straight after the inspection.
- The practice realised that it had fallen behind with its blood pressure monitoring of patients on ACE inhibitors during the pandemic. As an alternative arrangement, some patients with high blood pressure were sending in their blood pressure readings from their home monitors and these were logged in the patient's records.
- Patients with rheumatoid arthritis were being monitored by the local hospital.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The practice had a diabetes specialist nurse who offered telephone support to patients during the pandemic.
- The lead GP was working on all the reviews for COPD patients and we saw comprehensive asthma care plans in place.

| Other long-term conditions | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF) | 77.8% | 77.7% | 76.6% | No statistical variation |
| Exception rate (number of exceptions). | 3.0% (7) | 13.0% | 12.3% | N/A |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in | 93.3% | 88.8% | 89.4% | No statistical variation |

| | | | | |
|---|----------|-------|-------|-----|
| the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small> | | | | |
| Exception rate (number of exceptions). | 3.2% (2) | 14.7% | 12.7% | N/A |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 92.5% | 94.2% | 91.8% | No statistical variation |
| Exception rate (number of exceptions). | 7.0% (3) | 3.9% | 4.9% | N/A |

Families, children and young people

Population group rating: Good

Findings

- The practice had met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for two of four childhood immunisation uptake indicators. The practice had met the minimum 90% target for two of four childhood immunisation uptake indicators.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access 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) (01/04/2018 to 31/03/2019) (NHS England) | 43 | 47 | 91.5% | 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) (01/04/2018 to 31/03/2019) (NHS England) | 46 | 48 | 95.8% | 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) (01/04/2018 to 31/03/2019) (NHS England) | 46 | 48 | 95.8% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | 45 | 48 | 93.8% | 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: Requires Improvement

Findings

- The practice cervical cancer screening figures was below the 70% uptake rate. The practice told us it was chasing up patients who did not attend their appointments, but it could not demonstrate the impact of that at the time of the inspection.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who | 63.8% | N/A | 80% Target | Below 70% uptake |

| | | | | |
|--|---------|-------|-------|--------------------------|
| were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England) | | | | |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE) | 75.7% | 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) | 50.5% | 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 occurring within 6 months of the date of diagnosis. (01/04/2019 to 31/03/2020) (PHE) | 100.00% | 94.5% | | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE) | 32.0% | 54.2% | 53.8% | No statistical variation |

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required. During the COVID-19 pandemic, the practice was offering online and telephone consultations.
- All patients with a learning disability were offered an annual health check. The practice had carried out an annual audit for the past three years on annual health checks for patients with a learning disability. The practice provided staff with further training and opportunistically carried out a health check if a patient attended for a routine appointment.
- 34 patients were on the learning disabilities register and nine were being looked after in secondary care. 20 health check invites this year had been sent and pre-health questionnaires with all of them. Out of these, nine health checks have been completed; 11 were overdue, and we were told they were being recalled for a second time. If patients were anxious about coming in, the practice liaised with carers to choose a day for the health checks to be carried out.
- 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 and provided appropriate support.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. They were also referred to the Living Well with Dementia Group.
- All staff had received dementia awareness training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|--|-----------|-------------|-----------------|--------------------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | 88.9% | 87.5% | 85.4% | No statistical variation |
| Exception rate (number of exceptions). | 28.0% (7) | 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) (QOF) | 95.2% | 82.1% | 81.4% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 8.7% (2) | 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) | - | - | 539.2 |
| Overall QOF score (as a percentage of maximum) | - | - | - |
| Overall QOF exception reporting (all domains) | - | - | - |

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

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

The practice had carried out a number of audits over the last 12 months. They had carried out an audit for patients with atrial fibrillation to safely move them from warfarin to other blood thinning medicines. They had carried out an "inadequate cervical screening" audit to look at any anomalies in the system. Identification of individuals with unacceptably high inadequate rates allowed them to undergo further

training. Continuous monitoring of these inadequate rates were used to measure levels of performance amongst all smear takers, but was particularly useful for new cervical screening takers, or those who have required retraining.

A prescribing audit had also been taking place to prevent overlapping of certain medicines. The practice had managed to cut down the prescriptions to an extent about this.

The practice was in the process of carrying out a cancer audit at the time of our inspection to review two week waits (a referral made from the GP to secondary care when symptoms indicate potential cancer) and at what stage cancer was diagnosed during the last 12 months.

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. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| 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. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> The practice had a system in place to ensure staff were suitably trained. We found that the practice used an internet search engine to access training for staff. We asked for further information on how the practice assured themselves that the staff were suitably qualified, competent, skilled and experienced staff. The practice could not provide this at the time of our previous inspection. After the inspection the practice sent us detailed information on how they assessed the training needs of staff, how learning was identified, and how they assured themselves that the staff were competent and suitably qualified. A training matrix was in place which was colour coded and could easily identify when staff members needed to complete specific training. They had also put a new procedure in place for staff training to provide guidance to staff. <p>At this inspection we found:</p> <ul style="list-style-type: none"> The practice had developed its staff training matrix. We saw a copy of the staff training policy which contained a copy of the mandatory training links which all staff had access to. The practice did use Practice Learning Time (PLT) afternoons to complete training. This had been updated since the COVID-19 pandemic with individual time built in for members of staff. | |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|--|-------------|
| We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Yes |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Yes |

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. | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Patients had access to appropriate health assessments and checks. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Yes |

| Smoking Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 97.2% | 94.5% | 94.5% | No statistical variation |
| Exception rate (number of exceptions). | 0.2% (2) | 0.9% | 0.8% | N/A |

Consent to care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| The practice monitored the process for seeking consent appropriately. | Yes |
| Policies for any online services offered were in line with national guidance. | Yes |
| Explanation of any answers and additional evidence: At our previous inspection in January 2020, we found: <ul style="list-style-type: none">Evidence of signed consent forms for minor surgery procedures. However, the practice had not carried out a minor surgery audit in the last two years. During this inspection we saw: <ul style="list-style-type: none">An audit of minor surgery had taken place in order to improve outcomes for patients. | |

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. | Yes |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>Prior to the inspection we spoke to the care home which the practice looked after. They were positive about the care their residents received. They commented on how well the practice responded to residents and how they helped to answer queries that families had as well.</p> <p>During the inspection we saw the reception staff helping a patient in a wheelchair and helping them to the car park.</p> | |

| Source | Feedback |
|-----------------------|--|
| Patient | <p>During the inspection the practice shared letters and cards sent to the practice from patients. The letters and cards commented on the care delivered by the doctors and nurses.</p> <p>We spoke with a patient during the inspection from the Patient Participation Group (PPG) who felt the practice was responsive to their needs. .</p> |
| Interviews with staff | The staff we spoke with during the inspection commented on the caring nature of the GPs and management team at the practice. The practice had set up a WhatsApp group for staff during the pandemic in order to support each other. |

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) | 90.3% | 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) | 82.3% | 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) | 92.4% | 94.9% | 95.3% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020) | 81.2% | 80.4% | 81.8% | No statistical variation |

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

Any additional evidence

The practice had carried out a patient satisfaction survey in June 2019 which we had seen during the last inspection as well. 30 surveys had been completed and all had been positive about their experience. Comments included “staff always pleasant”, “put you at ease”, “receptionists always welcoming” and “can always get an appointment”.

The practice were starting another survey at the time of our inspection.

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. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

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) | 91.7% | 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. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Yes |
| Information about support groups was available on the practice website. | Yes |
| Explanation of any answers and additional evidence: The practice team were able to help translating if required as a number of staff spoke multiple languages such as Hindi and Urdu. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 62 carers (2%) Carers were reviewed annually by the practice. During the COVID-19 pandemic, patients who were also carers had been asked about levels of support and their blood pressure and weight is checked at home. |
| How the practice supported carers (including young carers). | The practice had some carers leaflets in the waiting room with information about being a carer and information about support organisations. Information about carers is included in registration packs. |
| How the practice supported recently bereaved patients. | The practice contacted bereaved families. This was sometimes by phone and sometimes in person depending on the circumstances. Condolence cards were also sent out to families following a bereavement. |

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. | Yes |
| Consultation and treatment room doors were closed during consultations. | Yes |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |
| Explanation of any answers and additional evidence: A private room was available for patients to use if they were distressed in the waiting room. | |

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. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |

| Practice Opening Times | |
|-------------------------|---|
| Day | Time |
| Opening times: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| Appointments available: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| | <ul style="list-style-type: none">• 8am to 12 midday Saturdays• 8am to 12 midday Bank Holidays via the hub |

National GP Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020) | 92.2% | 94.4% | 94.2% | No statistical variation |

Older people

Population group rating: Good

Findings

- 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. The practice continued to offer home visits to house bound patients during the pandemic. The GPs also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The GP provides a weekly visit to the patients in the local care home. During the Covid 19 pandemic this was done remotely.

People with long-term conditions

Population group rating: Good

Findings

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 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. For example, working age patients could book appointments to see a GP on Mondays to Fridays after 5pm to 6.30pm or on Thursdays appointments were available to 8.30pm.
- The practice had reviewed access and implemented telephone consultations which supported patients who were unable to attend the practice during normal working hours.

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.
- The practice could recognise and knew those patients that were frail or whose health was deteriorating; they signposted them to other agencies for support.
- Home visits were available for this group of patients when needed, including during the pandemic.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice held regular screening for patients with dementia and depression.

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. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| Appointments, care and treatment were only cancelled or delayed when absolutely necessary. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>Visits were triaged by the GP as required. Residential home visit requests were automatically added to the home visit list for the GPs to review. During the COVID-19 pandemic the GP was still carrying out home visits for housebound patients.</p> | |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020) | 65.1% | N/A | 65.2% | No statistical variation |
| 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) | 61.6% | 63.4% | 65.5% | 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 (01/01/2020 to 31/03/2020) | 64.3% | 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) | 69.0% | 72.2% | 72.7% | No statistical variation |

| Source | Feedback |
|-------------|--|
| NHS Choices | There were two anonymous complaints about access on the NHS Choices website since our last inspection. The practice had responded and asked the patients to contact the practice directly so that this could be addressed. |

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. | Yes |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|--|-------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| Explanation of any answers and additional evidence: We saw complaints were discussed at practice meetings and the minutes were shared with the practice team. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|--|--|
| Patient results | A patient phoned to ask for results, but it came to light that Kettering Hospital hadn't sent these to the GP. This was chased up with the hospital and the patient was satisfied with the outcome. |
| Complaint about telephone access/ telephone | This complaint came through as an anonymous complaint, so the practice has encouraged the patient to contact the practice directly. Another member of staff has been recruited and some more telephone lines have been put in the system. |

Well-led

Rating: Good

At our previous inspection on 7 January 2020, we rated the practice as inadequate for providing well-led services because:

We found that overall leadership was not always effective. We found a lack of accountable leadership and governance relating to the overall management of the service. Systems and processes in place were not always established or operated effectively to ensure compliance with good governance.

At this inspection we found the practice had improved its governance arrangements and overall management of the service. We saw that the practice had put systems in place to ensure effective governance.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |

Explanation of any answers and additional evidence:

At our previous inspection in January 2020, we found the provider was unable to demonstrate that effective leadership was in place. We found there was a strong lack of clinical and performance oversight and focus on governance systems which resulted in significant issues that threatened the delivery of safe and effective care.

- The practice was led by a lead GP with the support of three long term locums, two practice nurses, one health care assistant and administration staff. The management team told us they prioritised safe, high quality and compassionate care. The lead GP told us they spent all their time seeing, treating and caring for patients and had struggled to deal with the systems and governance which underpinned that care. We were told that the lead GP would like to expand the practice and wanted to begin discussions about the possibility of a merger with another practice to improve quality and sustainability of workload.
- We found a lack of accountable leadership and governance relating to the overall management of the service. Systems and processes in place were not always established or operated effectively to ensure compliance with good governance.

During this inspection we found:

- Plans were in place for the practice to merge with a neighbouring practice. Both practices had been working more closely together as a primary care network (PCN). At the time of our inspection the practice recruitment systems and files were being reviewed by an external Human Resources (HR) company in preparation for the merger in April 2021.

- We saw an improvement in governance systems during this inspection. The practice had tightened their governance around safeguarding, significant events analysis and complaint analysis.

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. | Yes |
| There was a realistic strategy to achieve their priorities. | Yes |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • The practice could not demonstrate that there was a strategy in place to achieve their priorities. The lead GP had told us they aimed to provide a high standard of medical care in a professional and friendly manner. However, we were not assured that they had the capacity in view of the current staffing levels (use of long-term locums and part time staff) and the workload of the lead GP due to a lack of clinical oversight in some areas. • Staff at the practice told us they sought to achieve the best for their patients but there was no business strategy in place to support the team in achieving quality and sustainability. There was no documented strategy including vision and values. <p>During this inspection we found:</p> <ul style="list-style-type: none"> • The practice had produced a business strategic plan which set out the plans for the next five years. • We were assured that the capacity issues had been addressed since the last inspection. The governance at the practice had been improved significantly. | |

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. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • In the complaints we reviewed the practice did not offer an apology. • The practice did not have a whistleblowing policy. • There was no Freedom to Speak up Guardian identified. <p>During this inspection we found:</p> <ul style="list-style-type: none"> • The practice apologised to patients when things had not gone according to plan in terms of significant events and complaints. • A whistleblowing policy had been put into place and the practice had identified a 'Speak up Guardian'. | |

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

| Source | Feedback |
|--|--|
| Conversations with staff at the practice | We spoke with members of staff during the inspection and they spoke about a supportive environment with an open-door policy. The staff felt supported and kept up to date throughout this. |

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. | Yes |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>At our previous inspection in January 2020, we found although some systems and processes were in place, we found that not all of these were always operated effectively. For example:</p> <ul style="list-style-type: none"> • The practice did not have all the systems, practices and processes to keep people safe and safeguarded from abuse. Patient records needed to be reviewed to ensure the relevant icons were in place to identify families and siblings on safeguarding registers. • The practice did not have an effective system for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were received and actioned appropriately. • The system the practice had in place for the summarisation of patients' notes was not effective. • Risks were assessed but not all the actions required had been completed. For example, legionella. • We reviewed two complaints and found the complaint responses did not offer information on the Parliamentary and Health Service Ombudsman. This was not in line with the practice complaints policy or recognised guidance. • We reviewed significant events and complaints and found that learning and actions from significant events and complaints were not always detailed in the records we looked at. • Exception reporting required further monitoring in line with the practice policy. • We looked at the practice's cervical smear uptake data and found that clinical oversight was required as the practice had only achieved 62.3% against a national average of 80%. The practice did not have a system in place to ensure results were received and referrals made where appropriate. • Whilst we saw evidence that meetings took place, but these did not include all areas of practice governance and allow opportunities for learning to be shared and discussed with all staff. <p>During this inspection we found:</p> <ul style="list-style-type: none"> • Safeguarding processes had improved significantly. We saw evidence of discussions at relevant meetings and patients' notes were recorded with appropriate icons in place. • The practice had developed a comprehensive system for MHRA alerts. The practice were going to look at more historic alerts following our inspection. | |

- Summarisation of notes was now up to date.
- Significant events and complaints were being regularly discussed at practice meetings. We saw examples of shared learning following a review of meeting minutes.
- Governance had been strengthened significantly within the practice.
- Exception reporting had improved.
- Cervical screening was below the national average and the practice was trying to improve this at the time of our inspection.

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. | Yes |
| There were processes to manage performance. | Yes |
| There was a systematic programme of clinical and internal audit. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: | |
| At our previous inspection in January 2020, we found: | |
| <ul style="list-style-type: none"> • The process for dealing with patient safety and medical alerts was not effective. • The system the practice had in place for the summarisation of patient’s notes was not effective. The practice had a backlog and were unable to demonstrate a plan to address this. The risk to patients had not fully been considered. • There were some arrangements for identifying, recording and managing risks, but risks were not always dealt with appropriately. For example, patient safety alerts and legionella. | |
| During this inspection, we found the practice had taken action to mitigate the risks identified above. | |

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. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Yes |
| Explanation of any answers and additional evidence: All meeting notes we reviewed were well documented and the computer system allowed all members of staff to view and action these. | |

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. | Yes |
| The practice had an active Patient Participation Group. | Yes |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| Explanation of any answers and additional evidence: | |
| At our previous inspection in January 2020, we found: | |
| <ul style="list-style-type: none"> The practice had carried out a survey in September 2019 on how they could improve the practice. 19 questionnaires had been completed. The comments included how happy patients were with the service. These were in line with the GP national survey data for July 2019. However, on the day of the inspection, we did not see any action plans in place to improve the service further in response to survey findings. The practice had a participation group (PPG) but currently only had two active members. The practice manager told us they continued to take steps to advise the PPG and recruit further members. | |
| During this inspection: | |
| <ul style="list-style-type: none"> The practice was in the process of sending out another internal survey to patients to capture feedback. The PPG had three active members and felt supported by the practice. The previous members had left during the pandemic and this was newly set up PPG. The practice was continuing to recruit more members. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| PPG meetings were on a quarterly basis and felt the practice listened to them and responded to their needs. |

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. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: | |
| The practice had carried out a number of audits to improve outcomes for patients. They were discussing significant events and complaints regularly to share learning accordingly. | |

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.