

Care Quality Commission

Inspection Evidence Table

The Manor Street Surgery (1-539567468)

Inspection date: 14 September 2021

Date of data download: 03 September 2021

Overall rating: Good

At our previous inspection in December 2020 we rated the practice as inadequate overall due to ineffective systems to manage medicines safely, low numbers of care plans for those in vulnerable groups and lack of oversight of non-medical prescribers.

At this inspection we found that the practice had made significant improvements in all these areas.

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

Safe

Rating: Good

At our previous inspection in December 2020 we rated the practice as inadequate for providing safe services because we identified concerns in relation to the management of high risk medicines and patients diagnosed with asthma with high use of short-acting inhalers, monitoring of referrals, signing of cleaning schedules and completeness of recruitment files.

At this inspection we found significant progress was made to ensure the safe management of medicines. Patients on high risk medicines and those with high use of short-acting inhalers were appropriately monitored and followed up, systems had been put in place to demonstrate cleaning had been completed and recruitment files seen showed appropriate checks were in place. We did however identify areas the practice should improve, including: overdue portable appliance testing and lack of sepsis awareness support for non-clinical staff.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y

Safeguarding	Y/N/Partial
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.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a nominated clinical lead and deputy in place at the practice for safeguarding children and adults. Staff we spoke with were clear about who the safeguarding lead was. • The practice had a safeguarding policy in place for children and adults which was kept up to date and staff we spoke with knew where to find the policy if needed. • Staff received safeguarding training at an appropriate level for their roles and responsibilities. We reviewed a sample of training records and saw that training was in place and up to date. • The practice maintained a safeguarding register of their most vulnerable patients. Patients on the register were discussed at monthly multidisciplinary team meetings. Monthly invites were sent to the community health teams to attend, however the practice advised that they struggled to get attendance from health visitors and district nursing teams but were able to share information on an informal basis. • Information sharing with health and social care professionals largely took place on an informal basis by email or telephone. Staff told us that there was a good relationship with them. • Alerts were placed on the clinical system to ensure staff were aware of any safeguarding concerns when seeing patients. • Chaperone duties were undertaken by clinical staff and some admin staff who had received chaperone training and had undergone Disclosure and Barring Service (DBS) checks. From the sample of records reviewed we saw that this was in place. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

Explanation of any answers and additional evidence:
<ul style="list-style-type: none"> We looked at recruitment records for two members of staff and found appropriate checks in place. We reviewed a sample of four clinical records and saw that staff vaccination records were in place.

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: 26/07/2019	Partial
There was a record of equipment calibration. Date of last calibration: 20/08/2021	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: 09/07/2021	Y
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Portable appliance testing (PAT) was outside the recommended one year. The practice manager advised that the practice policy was to undertake PAT testing every three years. There was no risk assessment in place to demonstrate the rationale for this decision. Following the inspection, the practice advised that they were amending their policy to test annually. We saw that there was a control of substances hazardous to health (COSHH) risk assessment in place and safety sheets available for substances used on the premises. The Fire risk assessment reported low risk and no actions were required. We saw evidence that fire equipment had been serviced and maintained. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 22/01/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 09/07/2021	Y
Explanation of any answers and additional evidence:	

The practice had an external company undertake monthly water testing of the premises to help minimise the risk of legionella. We saw records to demonstrate this and evidence of actions taken in response to the legionella risk assessment including the replacement of the water heater in July 2021.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 12/08/2021	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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was an infection control policy that had been recently reviewed and was accessible to staff. • There was a dedicated infection control lead for the practice. • Training records showed that staff were up to date with their infection control training. • We saw that there were appropriate arrangements in place for the management of clinical waste. • Cleaning was undertaken by an external company, and cleaning schedules were in place for the cleaning of the premises. • The practice had introduced a system for ensuring clinical equipment and rooms were cleaned between patients. A 'clean' code was recorded in the patient records to show the cleaning had been done. An audit was undertaken during August and September 2021 to check compliance with the system, the audit showed an improvement from 33% to 100% in recording. • The practice had completed an infection prevention and control audit in August 2021 and actions identified were in progress. Actions identified included the replacement of all carpeted areas, the practice manager advised that this action should have been completed by now, but the new floor had been delayed due to unforeseen circumstances, we saw evidence to confirm this. • Staff were aware of arrangements for reporting notifiable diseases but told us that they had not recently had cause to do so. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff advised that there had been a recent turnover of non-clinical staff. The practice had successfully recruited three new members to the team who were currently going through their induction training. • Locum staff were given a guidance pack to support them when they worked at the practice. • The practice operated a duty doctor system so that there was always a clinician available to take urgent requests when needed. • Staff we spoke with knew where to find the emergency equipment and medicines when needed and training records showed that staff were up to date with their basic life support training. • Reception staff were given guidance on potential urgent symptoms and when they should refer to 999. • Training records showed that sepsis training was only offered to and completed by clinical staff. 	

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">• Coding was undertaken by a member of the administrative team who had undertaken this role for several years. They told us that one of the doctors audited their work, and we saw evidence of this.• The practice told us that they had access to the clinical system used by the out of hours service and so were able to share relevant information directly with them.• We saw that test results were viewed by the doctors and that action was taken in a timely way.• We saw that patients referred using the two week wait suspected cancer urgent referral pathway and urgent referrals were routinely monitored. Patients referred for routine appointments to secondary care were given a letter to let them know where they were referred to and what to do if they were concerned during the wait.• We reviewed two recent referral letters and saw that appropriate information about the referral, past medical history, medicines and allergies were included.	

Appropriate and safe use of medicines

The practice had / did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.49	0.68	0.69	Tending towards variation (positive)
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). (01/07/2020 to 30/06/2021) (NHSBSA)	10.1%	11.3%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	4.97	5.85	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	58.1‰	67.4‰	126.0‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.34	0.53	0.65	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	3.0‰	5.0‰	6.8‰	Variation (positive)

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.	Partial
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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in December 2020 we found that not all patients on repeat medicines had received an appropriate medicines review and that there were ineffective systems of monitoring patients on high risk medicines. We also identified patients with asthma that had high usage of short acting inhalers but no action taken to address this.</p> <p>At this inspection we reviewed a sample of patients on disease modifying anti-rheumatic drugs and patients on high risk medicines that require regular blood tests and monitoring. We also reviewed four patients on multiple medicines, and patients with asthma that had high usage of short acting inhalers to check regular medicine reviews were in place. We found improvements had been made in the management of these medicines.</p>	

Medicines management

Y/N/Partial

We reviewed records of 10 patients out of 46 prescribed the disease modifying anti-rheumatic drugs Methotrexate or Azathioprine and found all patients reviewed had received and were up to date with appropriate monitoring.

We reviewed 10 patients prescribed high risk medicines that require regular monitoring and blood tests. With the first high risk medicine reviewed, Lithium, several blood tests were required, however one of the blood tests for calcium was overdue in two cases. The practice advised that they had not until recently been aware of this requirement and had raised this as a significant event in which an audit and recall of patients had commenced. Records showed that all these patients had been called back to have this test.

With the second high risk medicine, Spironolactone, our searches found two of the five patients were overdue monitoring, however both had been completed by the time of our site visit. Staff told us that when patients did not attend for routine monitoring, they reduced the prescription to one week which we saw evidence of during our clinical searches.

We reviewed the records of four care home patients prescribed multiple medicines and found one of the four patients had not been reviewed in the last 12 months. The practice advised that they had recently introduced a regular ward round at the home and were working to ensure all patients were reviewed and had care plans in place.

Our review of patients with asthma on short-acting inhalers identified 150 patients that had received six or more short acting inhalers in the last 12 months. We reviewed five of these patients. Two of which had 12 or more short acting inhalers, in both cases the patient had received significant follow up and offer of referral to specialist services. The practice was able to show how they had improved the management of asthma patients since our previous inspection. An audit undertaken by the practice showed 430 asthma reviews had been undertaken in the last 12 months and that there had been a reduction in the number of patients on more than 12 short acting inhalers. Of the original 14 patients identified in our last inspection, eight of the patients came off the short-acting inhalers completely through management and education and five more patients had reduced their number of inhalers by between 33% and 56% and one had been placed on a different chronic disease pathway.

At the last inspection in December 2020, we found the practice could not demonstrate the prescribing competence of non-clinical prescribers. At this inspection we saw six monthly audits were in place, staff also told us that there were informal opportunities for all clinical staff to discuss the management of any difficult or complex cases on a weekly basis.

Prescribing rates for antibiotic and hypnotic medicines were in line with or below local and national averages.

We reviewed the monitoring of emergency medicines and equipment and saw monitoring was in place to ensure they were available and fit for use. Risk assessments were in place for recommended emergency medicines which were not routinely stocked with the exception of one. The practice updated their risk assessment and provided this to us following the inspection to mitigate the risk.

Medicines management	Y/N/Partial
<p>During our site visit we reviewed two patient group directions at random and patient specific directions for the administration of medicines. These were in date and appropriately authorised.</p> <p>Clinical staff advised that controlled drugs were prescribed on a monthly basis as a way of monitoring prescribing.</p> <p>There were two medicines fridges. Records showed the fridge temperatures were monitored appropriately to ensure correct temperatures were maintained for the safe storing of vaccines and other relevant medicines.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Seven
Number of events that required action:	Six
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice used an information governance system to record incidents and significant events. Most staff we spoke with were aware of the reporting arrangements. We saw from the minutes of clinical meetings that incidents were discussed and shared with the clinical team. The practice manager advised that they would advise the administrative team of any incidents relevant to them. 	

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

Event	Specific action taken
New clinical templates introduced by the practice identified that calcium monitoring had been missed from tests undertaken for patients on a specific medicine. Previous clinical searches had not identified this.	Calcium monitoring was added to the clinical searches so that patients would be recalled for the test. All patients identified whose calcium monitoring was overdue were contacted to arrange an appointment. The incident was discussed at the clinical meeting to raise awareness that this test was required.
A patient was given an injection that was two days out of date.	The patient was made aware of the error at the time of the incident and a letter of apology was also sent. All stock was checked and the incident discussed at a clinical meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw from the minutes of the clinical meetings that patient safety alerts were discussed.	

During our clinical searches we reviewed action taken in relation to patient safety alerts. The first related to a medicine which can place unborn children at risk if taken by mothers when pregnant and a combination of two medicines which increase health risks to a patient. From a sample of records reviewed we saw appropriate action had been taken by the practice with regards to these medicines.

Effective

Rating: Good

At our previous inspection in December 2020 we rated the practice as inadequate for providing effective services because of the lack of consistent monitoring of patients prescribed repeat medicines, low numbers of care plans in place for vulnerable patients and lack of oversight of non-medical prescribers.

At this inspection we found the practice had made improvements in monitoring repeat medicines. Patients on the learning disability register had been invited for a review and 83% had been completed in the last year. However, our clinical searches of patients with mental health care plans identified patients whose care plans had not been reviewed during the last 12 months. The practice also had a higher than average personalised care adjustment rate for patients who had a mental health care plan documented in the preceding 12 months. Not all staff were receiving regular appraisals.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. There were improvements noted in patient care and medicines however, we found mental health care plans were not being regularly reviewed.

	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">At our last inspection in December 2020 records seen showed that patients with long term conditions had not been consistently reviewed or had care plans in place which the practice explained was due to the pandemic. Patients prescribed repeat medicines were also not consistently reviewed.	

- At this inspection we saw that there had been improvement in the follow up patients prescribed repeat medicines. The practice had a prescribing lead and had introduced a clinical information team to support in the recall of patients.
- The practice had brought in templates for managing patient care, this had helped drive improvements and supported consistency in care.
- At this inspection the practice told us that all patients on the learning disability register had now been invited for a health review and 83% of those were seen in the last year.
- During our clinical searches we reviewed five patients on the mental health register and found one was now under a specialist service. Four of the five patients had a care plan but only one of the patients had been reviewed in the last 12 months and not in person. However, we did see evidence that the patients had been invited in for their review.
- The practice held weekly clinical meetings which staff used share learning and improvement. The meetings were used to discuss the care and treatment of patients.

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.
- 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 was working to ensure structured annual medicines reviews were in place for all their older patients. New arrangements with the local care home included regular ward rounds to improve the management of medicines and care planning.
- 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: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Healthchecks were being offered to patients.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	76.6%	75.0%	76.6%	No statistical variation
PCA* rate (number of PCAs).	34.4% (246)	10.5%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	90.6%	90.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	33.8% (27)	11.7%	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) (QOF)	72.2%	81.1%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	2.9% (5)	4.5%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	71.6%	66.1%	66.9%	No statistical variation
PCA rate (number of PCAs).	25.5% (65)	14.5%	15.3%	N/A

The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	66.7%	71.0%	72.4%	No statistical variation
PCA rate (number of PCAs).	3.6% (33)	5.7%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	91.5%	92.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.5% (8)	4.6%	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) (QOF)	80.4%	72.1%	75.9%	No statistical variation
PCA rate (number of PCAs).	16.1% (41)	10.6%	10.4%	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 practice had a higher than local and national average personalised care adjustment rate for patients with asthma, COPD and diabetes. Patients were invited on three occasions to attend their reviews before being excluded from the indicator. The practice advised that patients had been reluctant to attend during the pandemic.
- Since our last inspection in December 2020 the practice had worked hard to improve asthma reviews with their patients, the work had been audited and improvements in care noted. The audit showed that 430 reviews had been undertaken since the last inspection focusing on patients who appeared less well controlled and the work was still in progress to focus on a wider catchment of patients.
- A clinical information team had also been set up to assist with the regular recall of patients.

Findings

- The practice has met the minimum 90% for four of the five childhood immunisation uptake indicators. but not the WHO based national target of 95% (the recommended standard for achieving herd immunity).
- The practice was just below the minimum 90% for the percentage of children aged 5 who have received immunisation for measles, mumps and rubella (MMR).
- The practice secretary helped to monitor childhood immunisations and recall patients for their immunisations.
- We noticed that the percentage uptake of children had fallen since the previous year. The practice manager advised that they were working with the child health informatics team in reviewing the data.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Practice nurses told us that they would follow up any non-attendance and if they had safeguarding concerns would follow up with the safeguarding lead but did not have any formal meetings for sharing information with the health visitor.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	129	141	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) (01/04/2019 to 31/03/2020) (NHS England)	105	116	90.5%	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)	105	116	90.5%	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)	106	116	91.4%	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)	109	122	89.3%	Below 90% minimum

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

Any additional evidence or comments

The practice advised that they were currently trying to improve uptake of childhood immunisations and were actively monitoring uptake and following up any non-attenders.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The meningitis vaccine was available on request for eligible patients, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice advised that there had been 72 health checks undertaken in the last 12 months. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines 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 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: 31/03/2021) (Public Health England)	78.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	69.8%	69.1%	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)	68.5%	61.4%	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)	97.6%	94.9%	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)	48.3%	51.1%	54.2%	No statistical variation

Any additional evidence or comments

- Uptake of cancer screening was just under the 80% target. The practice advised that they were looking to hold a Saturday clinic and undertake a cancer screening audit.
- Uptake of breast cancer and bowel cancer screening was in line with local and national averages.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- The practice advised us that all patients with a learning disability had been offered an annual health check. Of those patients 83% had taken up the offer in the last 12 months.
- The practice had achieved purple star status (a local accreditation scheme) in working to address health inequalities for people with learning disabilities.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Palliative care patients were discussed as part of the multi-disciplinary team meetings.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice did not provide services for patients who misused substances, these patients were signposted to other services.
- The practice was responsible for a local residential home for patients with a learning disability. There was regular engagement with the home.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- We reviewed five patients with a mental health care plan and found that reviews were overdue for three of the five patients. Although, there was evidence that these patients had been invited for their review.
- There was a high personalised care adjustment rate for patients with a comprehensive agreed care plan documented in the record in the preceding 12 months. The practice advised that patients were automatically excluded after three invites.
- Same day and longer appointments were available 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.
- 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.
- Clinical staff had access to online dementia training.
- Patients with poor mental health, 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) <small>(QOF)</small>	100.0%	88.7%	85.4%	Variation (positive)
PCA* rate (number of PCAs).	50.9% (27)	10.7%	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>	79.2%	83.2%	81.4%	No statistical variation
PCA rate (number of PCAs).	12.2% (10)	6.1%	8.0%	N/A

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

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	England average
Overall QOF score (out of maximum 559)	549.6	533.9
Overall QOF score (as a percentage of maximum)	98.3%	95.5%
Overall QOF PCA reporting (all domains)	8.1%	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 practice shared with us some of the audits they had recently undertaken, these included.</p> <ul style="list-style-type: none"> A two cycle asthma audit undertaken in January and August 2021. The audit resulted from our previous inspection in which 14 patients with high short-acting inhaler use were identified. The
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purpose of the audit was to improve asthma management in line with evidence-based guidance. Patients who were at highest risk were prioritised in the audit. Changes were made to the monthly searches so that these patients could be easily identified and reviewed. Results from the second audit showed patients with high short-acting inhaler use (12 or more per year) and who had taken steroids (twice or more per year) had been regularly reviewed. Eight of the patients had improved control through reduced use and were no longer on the high-risk list and five patients had a reduction in the number of short-acting inhaler prescriptions of between 33% and 56% and continue to receive regular follow-up. The threshold has now been reduced to include patients whose use of short-acting inhalers is over 6 inhalers per year.

- Other audits over the last 12 months have included infection control audits, medicine fridge audits to ensure Public Health England (PHE) criteria is being followed, safeguarding coding audits to improve completeness and accuracy of the registers and chronic kidney disease audit to ensure all patients are identified for appropriate follow up.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, not all staff were receiving regular appraisals.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our previous inspection in December 2020 we found the practice did not maintain formal oversight of clinical staff in advanced roles. At this inspection we saw evidence from two six monthly audits of consultations that have been put in place. All clinical staff had opportunities to discuss any cases they wished to within the clinical team. Weekly informal meetings were held so that staff could discuss any cases they had seen. Staff reported they have protected time for learning and development. The practice had identified their own mandatory staff training requirements. We reviewed a sample of training records and saw that staff were up to date with this. We saw evidence of role specific training in areas such as long-term conditions, cervical sample taking and immunisations. There was a system of internal appraisals in place which included the salaried GPs, nursing and administrative staff. We reviewed a sample of appraisals and saw that some of the appraisals had been completed in the last 12 months but not all. Those not in place related to non-clinical staff. 	

- There was no system in place for monitoring external appraisals and revalidation for clinical staff with their professional bodies was up to date. This is the process by which doctors and nurses retain their right to practise.
- The practice was able to give an example as to how they had approached poor staff performance.

Coordinating care and treatment

Staff worked with other organisations to deliver effective care and treatment, although struggled to get all members of the community teams to participate in regular meetings.

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice held regular multidisciplinary team in which they discussed the practices most vulnerable patients. There was regular attendance by the palliative care team however, the practice advised that they struggled to get all members of the community team to attend including the health visiting and district nursing teams.</p>	

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 was working with their high-risk asthma patients to improve management and control of their care and condition.• Patients had access to NHS health checks.• Patients were signposted to local smoking cessation, weight management and social prescribers, if needed.	

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">• The practice had a consent policy in place which included information and guidance on the Mental Capacity Act.• The practice advised that clinical staff had undertaken Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Clinical staff were able to demonstrate an understanding and gave examples of where capacity had been considered in care and treatment.	

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">• Discussions with staff demonstrated an understanding and awareness of the importance of person-centered care.• Staff had received training in equality and diversity.	

Source	Feedback
NHS Website	There were four reviews on the NHS Website (posted between October 2019 and November 2020). All four reviews were positive and had given the practice five out of five stars about the staff and the care and treatment they received.
Online Reviews	There was one positive review made in the last 12 months.
Friends and family test	Between 7 August 2020 and 4 August 2021, the practice received 1028 responses to the Friends and Family test. Of those who responded 94% said they would recommend the practice to others.

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)	94.3%	91.1%	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)	92.6%	89.9%	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)	98.9%	97.0%	95.6%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	95.7%	85.8%	83.0%	Variation (positive)

Any additional evidence or comments

Results from the most recent National GP Patient survey published in July 2021 were higher than local and national averages and had improved in all the above indicators from the previous year. The practice was rated third in Hertfordshire in terms of high patient satisfaction scores following the national survey.

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

Any additional evidence

- The practice told us they had not completed an in-house patient survey due to the competing demands on the service as a result of the COVID-19 pandemic.
- Feedback from patients had been gathered through the NHS website, the NHS Friends and Family Test (FFT) and comments and complaints received.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Patients responded positively in the National GP Patient Survey to questions about their involvement in decisions about their care and treatment. • Patients could access social prescribing support. 	

Source	Feedback
Interviews with Patient Participation Group (PPG)	We received no concerns from the PPG about the involvement of patients in decisions about their care and treatment.

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)	97.9%	94.4%	92.9%	Tending towards variation (positive)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	N/A
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: <ul style="list-style-type: none"> The practice website provided a range of information and links to support patients. Information leaflets were not currently displayed in the practice due to the pandemic but could be made available, when needed. The practice website could be translated into different languages, and fonts and type face to support those with a visual impairment or with dyslexia. Staff could access translation services for patients when needed. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 284 patients as carers, this equated to 2.3% of their practice population.
How the practice supported carers (including young carers).	The practice had two carers champions and provided carer's packs for those who were newly identified with advice and information. Carers were also offered access to annual health checks.
How the practice supported recently bereaved patients.	Recent patient deaths were discussed at the weekly clinical meetings, the GP who had most or recent contact the family to offer condolences and support, and provided bereavement information to the family.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with were able to tell us how they supported patients' privacy and dignity. 	

- Staff signed confidentiality agreements as part of their employment contract.

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us how they had introduced weekly ward rounds at a nursing home to improve access to care and treatment to the residents. Feedback from the National GP Patient Survey and other reviews indicated that patients' needs were being met. Staff we spoke with were able to tell us about how they supported accessible information standards for their patients, any specific patient needs were recorded onto the patient's clinical records, so staff were aware. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7am - 8pm (includes extended opening)
Tuesday	8am - 6.30pm
Wednesday	8am - 6.30pm
Thursday	8am - 6.30pm
Friday	8am - 6.30pm
Saturday	Extended access every second Saturday each month.
Appointments available:	
Monday to Friday	Telephone and video consultations, same day and pre-bookable appointments.

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 and complex medical issues.
- GPs undertook weekly ward rounds at a large nursing home.
- 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, where possible, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment on request.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues, when needed. Although invited, the community teams did not usually attend the practice multi-disciplinary team meetings.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Nurse appointments were available until 5pm for school age children so that they did not need to miss school.
- 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.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held mother and baby clinics with a GP.

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.
- The practice offered extended hours on a Monday and once a month on a Saturday morning. There were also bookable appointments available to all patients at additional locations within the area through the extended access service. Appointments for the extended access service were available every Monday to Friday evening and on a Saturday and Sunday 10am until 2.30pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

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

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. This included access to social prescribing and walking for health groups.

Access to the service

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

	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"> During the pandemic, most appointments were via telephone consultations, with face to face appointments if needed. There was information on the practice website advising patients how to make an appointment. Patients could call by telephone or book online. Longer appointments were available on request. The practice advised us that their list size had increased by approximately 400 patients because of their access. 	

National GP Survey results

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 (01/01/2021 to 31/03/2021)	94.2%	N/A	67.6%	Significant Variation (positive)
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)	92.9%	73.0%	70.6%	Variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	83.1%	69.2%	67.0%	Tending towards variation (positive)

Indicator	Practice	CCG average	England average	England comparison
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)	91.7%	82.6%	81.7%	Tending towards variation (positive)

Any additional evidence or comments

Patients responded positively in the National GP Patient Survey to questions about access. Results from the most recent National GP Patient survey published in July 2021 were higher than local and national averages and had improved significantly in all the above indicators from the previous year. The practice was rated third in Hertfordshire in terms of high patient satisfaction scores following the national survey.

Source	Feedback
NHS Choices	There were positive comments on the NHS website about access to services.
Online reviews	Other online reviews were also positive about patient access.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Information about the complaints process was available on the practice website and leaflets available from the practice. We saw that there was a complaints policy in place which set out the expectations in responding to complaints. There were systems in place for recording written formal complaints received and action taken. Complaints were discussed in clinical meetings and reviewed annually to support learning and improvement. We reviewed two complaints and saw that they were responded to in a timely way. Responses to complaints included details as to how the patient may escalate their concerns if they are unhappy with the response received. However, the practice did not have a system for recording verbal complaints and suggestions to support further learning and improvement from them. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient was unhappy with their GP consultation	The concerns were investigated by the lead GP and discussed at the clinical meeting. A response was sent to the patient.
Confidentiality breach	The incident was investigated and disciplinary proceedings were commenced. The patient was informed of the outcome. Confidentiality training was included in the practice's mandatory training programme.

Well-led

Rating: Good

At our previous inspection the practice was rated inadequate for providing well-led services due to a lack of systems for ensuring clinical governance, safe medicines management, care planning for vulnerable groups and oversight of non-medical prescribers.

At this inspection we found there had been significant improvements made in all these areas and the practice is now rated as good for providing well-led services. However, continued work was needed to further improve the uptake of reviews for patients with poor mental health and to provide non-clinical staff with regular appraisals and other opportunities to provide feedback.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Since our previous inspection we saw that the practice had taken action to address the concerns raised and improve services to patients. A clinical information team was in place to support the timely recall of patients in relation to their medicines and disease management. There had been significant work to address patients who were most risk of poor asthma control. Ward rounds had been set up with the local nursing home to ensure regular communication and management of the residents and achievement of purple star status for services to people with learning disabilities. Patient feedback was very positive about the service. While some of the work was still in progress, the practice was moving in the right direction.The practice had faced staffing issues within the non-clinical team which they had successfully recruited to.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y

Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff we spoke with articulated the vision and values of the service. • The practice told us that there had been a documented strategy prior to the pandemic but were currently working to address any outstanding long-term condition reviews and had plans to undertake some refurbishment of the premises to replace unsuitable flooring. • Priorities were discussed at the partners and clinical meetings. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff were able give examples of how they had addressed duty of candour in the practice. • Staff we spoke with found leaders were approachable however, we noted that some staff had not had access to regular annual appraisals with which to formally raise and discuss any issues relating to their work. • Staff were encouraged in their learning and development and were given protected time to undertake this. • Staff we spoke with were aware of the whistle blowing policy and where to access this. The practice's freedom to speak up guardian was included in the policy. • Staff also had access to equality and diversity policy and training. 	

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

Source	Feedback
Staff interviews	Staff we spoke with described a supportive culture within the practice.

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.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At our previous inspection in December 2020 we found the practice had not addressed concerns previously raised during earlier CQC inspections. At this inspection we found the practice was addressing issues identified at our previous inspections and was making positive progress towards them. This included the clinical supervision of non-medical prescribers, systems for monitoring referrals and the management of patients with asthma and on high risk medicines. The practice held regular weekly clinical meetings in which governance was discussed. However, there was little opportunity for non-clinical staff to meet. Information was largely shared through emails and lacked formal opportunities for any discussion. Staff spoken with told us that they were clear about their roles and responsibilities. 	

Managing risks, issues and performance

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

	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:	

- At our previous inspection in December 2020, we found issues relating to asthma inhaler usage and lack of medicines reviews. The practice had also identified backlogs with the monitoring of some high-risk medicines.
- At this inspection our clinical searches showed that the practice was making progress in addressing the completion of timely medicine reviews. The clinical information team were supporting with timely recalls, the practice had undertaken an audit of missed blood monitoring and had taken action to rectify this. There had also been significant work to monitor the higher risk patients with asthma and were now starting to focus on the monitoring other patients on the asthma register.
- We saw that the practice had made significant progress in supporting patients with a learning disability however, we saw improvement was needed to improve support for patients with mental health needs.
- Risk and performance were discussed at the weekly clinical meetings which we saw from a sample of minutes.
- The practice had a business continuity plan in place which included relevant service and staff contacts in the event of disruption to the running of the service. There were reciprocal arrangements with another practice if they were unable to use the premises.

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:	

- The practice offered telephone appointments and if a patient needed to be seen in person they would be booked in. Patient feedback found high levels of satisfaction with access during the pandemic.
- Patients who might be digitally excluded could still access appointments by telephone.
- The practice had introduced a system to ensure the cleaning of rooms and equipment took place between patients and had audited the process.
- Staff were able to work from home where they needed to shield or isolate and there were examples of this.
- The practice was working to address backlogs in asthma reviews identified during our last inspection and were actively monitoring two week wait and urgent referrals.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice provided us with a range of audits completed to identify and mitigate risks. For example, in relation to asthma reviews, infection prevention control and specific tests required for a high risk medicines. • We saw evidence that there were systems in place for the managing the safety of the premises. However, we did note that portable appliance testing was not carried out in line with recommendations, which following the inspection the provider advised they had changed their policy on this. 	

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 practice had a policy in place for remote consultations. • The practice used a safe system for the sending of photographs and no sensitive images were allowed. • We saw evidence that the practice was registered with the Information Commissioners Office. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Partial
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 scored highly in the most recent National GP patients survey in terms of patient satisfaction. The practice told us about some of the things they had put in place in response to patient feedback including, hand sanitizer placed outside the front door and an option to add additional information box on the website when requesting repeat prescriptions.• The practice had an active Patient Participation Group (PPG) of approximately 40 to 50 members. Some of the group met in person and through online meetings during the pandemic and others were virtual members they could consult with. The PPG had met virtually on three occasions during the pandemic.• The PPG gave examples of suggestions that had been acted on including the provision of a more gentle beginners walks as part of the Herefordshire Health Walks scheme for those that were less able to walk far through health reasons.• Staff were also able to give examples of their involvement in the planning and delivery of services for example, asthma reviews. However, there were fewer formal opportunities for administrative staff to become involved and offer their views.• The practice worked with their local Primary Care Network to develop services to support their patient population.	

Feedback from Patient Participation Group.

Feedback
The PPG told us that they found the practice open and honest about challenges they faced and were receptive to ideas.

Continuous improvement and innovation

There were 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:

- Following our previous inspection in December 2020 the practice had undertaken significant action to improve the services. There had been a focus on asthma, and implementation of regular ward rounds with the local nursing home.
- We saw examples of audits to check systems and processes were working as intended, including non-medical prescribing.
- There were regular opportunities for clinical staff to learn and share from one another.
- The practice was a training practice for qualified doctors training to become a GP.
- The practice were particularly proud of their recent National GP patient survey results which were recognised as the third highest in the county and had increased on the previous year.

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.
- *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.