

Care Quality Commission

Inspection Evidence Table

Naseby Medical Centre (1-537862501)

Inspection date: 24th to 30th September 2020 and the 14th December 2020

Date of data download: 16 September 2020

Overall rating: Good

At the last inspection in November 2019 we rated the practice as requires improvement for providing safe, effective and well-led services. At this inspection, we found that the provider had addressed areas in safe and well-led. The provider has moved to an overall rating of good; however, continues to be rated as requires improvement for providing effective services because data over time showed some areas where the practice remained below local and national averages.

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

Safe

Rating: Good

We inspected the practice in November 2019 and rated the practice as requires improvement for providing safe services. The practice is now rated good as the provider had made improvements to systems and processes to keep people safe. For example, there was oversight of staff training in areas such as safeguarding, and infection prevention and control and the recruitment process had been strengthened.

Safety systems and processes

The practice had clear systems, practices and processes which kept people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our November 2019 inspection, the provider had implemented a system to gain assurance that staff who were not directly employed by the provider completed safeguarding training at the appropriate level.</p> <p>Staff provided evidence of information sharing meetings held with health visitors' although there were no active or known safeguarding cases at the time of the inspection. Meeting minutes we viewed confirmed this. During our inspection, staff described systems to enable identification of vulnerable patients; however, this did not demonstrate how the practice checked whether vulnerable adults were looking after or had children. Following our first visit during this inspection, the provider submitted documents demonstrating an analysis carried out indicating how the practice cross referenced records to ensure ongoing monitoring where required.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Members of the management team explained processes introduced to gain assurance from locum agencies that recruitment checks had been carried out prior to commencing employment with the practice. Staff files viewed during our inspection, included relevant pre employment checks and where appropriate evidence of registration with a professional body as well as valid medical indemnity insurance.</p> <p>Members of the management team provided evidence demonstrating that clinical staff had received vaccinations in line with current Public Health England (PHE) guidance. However; during our inspection, we were not provided with evidence of the vaccination status for non-clinical staff. Management explained staff were offered appropriate vaccinations and risk assessments were carried out, however we were not provided documentation to confirm. Following our first visit during this inspection, the provider submitted evidence demonstrating the immunisation status of non-clinical staff.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 16/11/2020	Y
There was a record of equipment calibration. Date of last calibration: 16/11/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 21/12/2018	Y
There was a log of fire drills. Date of last drill: 18/09/2020	Y
There was a record of fire alarm checks. Date of last check: 25/09/2020	Y
There was a record of fire training for staff. Date of last training: 22/09/2020	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 20/08/2019	Y
Actions from fire risk assessment were identified and completed.	
<p>Explanation of any answers and additional evidence:</p> <p>During our discussions with members of the management team they explained that portable appliance testing (PAT) and equipment calibration annual checks were delayed due to the coronavirus (COVID-19) pandemic. The last check was carried out in September 2019. Following our first visit, the provider submitted documents demonstrating that PAT and equipment calibration had been carried out in November 2020.</p> <p>Members of the management team explained fire extinguisher checks were next due December 2020. In line with the practice fire risk assessment an annual training meeting had been held and minuted to remind all staff what to do in the event of fire. The management team explained during our interview that the last fire drill was carried out September 2020; however, logs to evidence this was not provided during our on-site visit. Following our first visit during this inspection, the provider submitted records evidencing the practice September 2020 fire drill.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 17/06/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17/06/2020	Y

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: April 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The management team carried out an internal infection prevention and control audit. Staff explained the practice rating status report was green which meant no issues identified; however, actions such as implementing additional personal protective equipment (PPE), increased hand washing, and the use of face masks was implemented as a result of the COVID-19 pandemic. COVID-19 risk assessment had been carried out for the premises.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: The management team explained they continued maintaining and updating staff rotas to manage any periods of staff absences and busy periods. There were also staff who worked part time who were able to work flexible hours when required.	

Staff explained, in order to offer more patient choice locum female GPs worked one session per week with the flexibility of offering more sessions when required. However, for continuity the practice continued to actively seek to recruit a full-time female GP. Since our November 2019 inspection, the provider recruited additional locum nurses which enabled the practice to provide slightly more nursing provision.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, there were gaps in the system for documenting patient information and clinical data.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our interviews and initial on-site visit members of the clinical team explained the process for managing test results as well as following up patients where there were clinical concerns. The management team explained this involved making a manual log of patients who required a follow up. GPs would then work through the manual log and contact patients; we were also told the on-call GP would check blood results and take action in response to abnormal results. Management staff explained receptionists would be tasked to support with contacting patients and arranging appointments. However, during our on-site inspection, there was no audit trail documenting actions taken to ensure patients were being followed up appropriately. Supporting evidence provided following our inspection, provided assurance that all incoming documents and pathology results were being actioned in a timely manner. During our second on-site visit the provider explained further changes which included recording actions on clinical records which would generate an audit trail of actions carried out following receipt of pathology results.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization however, were areas where the construction of the clinical searches and clinical record keeping resulted in irregularities in data quality.

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)	1.09	0.84	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)	5.0%	7.7%	8.6%	Tending towards variation (positive)
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)	3.52	5.14	5.35	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)	2.47	1.54	1.92	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our initial on-site visit clinical searches carried out by us did not identify all patients who were treated for a long-term condition this suggested either patients were not receiving appropriate care and treatment or there were issues with the practice disease register and the use of read codes. Following evidence submitted by the provider and our second on-site visit which included a further review of the clinical system we found the manner in which read codes and clinical searches were set up had impacted on the data viewed during our initial on-site visit. For example, there were a number of patients diagnosed with a long-term condition but not included on the practice disease register because some patients records had not been coded at the time of diagnoses.</p> <p>A further review of patient records during our second on-site visit showed patients care and treatment were being managed appropriately and had not been compromised despite issues identified with the data such as the configuration of read codes. Clinical leads explained the process they had implemented since our first site visit for validating disease registers which was used to search for missed patients as a result of the irregularities with data quality. Clinical leads demonstrated awareness of historical read codes which had been previously used in patients records. However, the practice did not demonstrate a process for ensuring where diagnosis had changed over time in the course of managing patients care that patients clinical records were always reflective of such changes.</p>	

Medicines management	Y/N/Partial
<p>Data obtained from the practice clinical system at the time of our first visit regarding the management of patients prescribed medicine to treat respiratory conditions indicated patients were not routinely receiving a medicine review to check whether treatment remained safe and effective. Clinical leads explained patients were being offered appointments but had not attended. However, patient records did not evidence this. From the patients who had attended appointments, records indicated that reviews were carried out in line with national recognised guidance. Following our first visit during this inspection, the provider took action and reviewed clinical records. Additional evidence provided indicated inconsistent record keeping; however, provided assurance that patients had not been receiving unsafe care.</p> <p>During our second on-site visit we viewed a further random sample of patients diagnosed with respiratory conditions and found reviews were being carried out. We saw a mixture of information being recorded on clinical templates as well as free text in patients' clinical records. Clinical leads explained this was due to national changes in the Quality and Outcomes Framework (QoF is a voluntary scheme within the General Medical Services (GMS) contract, aimed at supporting the delivery of good quality care).</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:	Three
Number of events that required action:	Three

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

Event	Specific action taken
Blocked driveway restricting ambulance access	Management team reported this to the local authority who made arrangements to remove the obstruction. No parking signs located around the building and patients reminded of the no parking zones.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The management team described the system for receiving and sharing safety alerts within the practice and explained examples of actions taken to ensure patient safety. For example, the nursing team explained receiving an update regarding changes to routine immunisations. The clinical team explained action taken following receipt of an alert recommending that treatment should be interrupted in patients who were hospitalised for major surgical procedures or acute serious medical illnesses. Members of the management team explained alerts were discussed during clinical meetings as a standing agenda item and were then added as a batch report carried out monthly.</p>	

Effective

Rating: Requires improvement

We inspected the practice in November 2019 and rated the practice as requires improvement for providing effective services. The provider had made improvements in relation to managing non-clinical risks and staff training. Searches carried out on the practice clinical system during our first on-site visit indicated a number of patients who were not included on the practice disease registers. However, a further review of clinical records during our second on-site visit showed despite the irregularities of data quality searches the effectiveness and appropriateness of care provided had not been compromised. However, the rating remained unchanged. This was because data over time indicated that actions taken to increase the uptake of national screening and childhood immunisation had impacted some indicators; however there were indicators where uptake remained below local and national averages.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our second on-site visit a random sample of records checked showed reviews had been carried out; indicating irregularities with data quality due to the construction and use of clinical read codes.</p> <p>Actions carried out such as informing patients of medicines which were prescribed for short term therapy as well as informing patients of plans to withdraw long term therapy resulted in a reduction in the quantity of hypnotics prescribed.</p>	

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) (NHSBSA)	1.14	0.70	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.
- A weekly phlebotomy service was available at the practice for the convenience of patients requiring blood tests.
- 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.
- GP consultation rooms were all located on the ground floor. Although the nurse consultation room was located on the second floor, staff explained nurses would use one of the ground floor consultation rooms if and when required.

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. However, searches carried out on the practice clinical system picked up patients who were not included on QoF disease registers. During our second on-site visit a random sample of records showed patients care was managed appropriately; however, read codes which enabled patients to be identified were not routinely added to clinical records at the time of initial diagnoses.
- 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice was not routinely identifying patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with a recorded asthma diagnosis were offered an asthma management plan.

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)	73.6%	75.2%	76.6%	No statistical variation
Exception rate (number of exceptions).	1.6% (2)	9.1%	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)	100.0%	89.6%	89.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.0% (0)	11.8%	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) (QOF)	100.0%	88.8%	91.8%	Tending towards variation (positive)
Exception rate (number of exceptions).	27.3% (3)	5.8%	4.9%	N/A

Families, children and young people

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> At the time of our inspection, data available showed the practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators. However, the practice submitted data following our inspection, which demonstrated an increase in the uptake of childhood immunisation in two out of the four childhood immunisations. The provider demonstrated awareness of the childhood immunisation uptake data and had taken action to improve the uptake. Data regarding the uptake of childhood immunisation had been updated since our September 2020 inspection, which showed the practice had met the WHO based national target of 95% for two out of four childhood immunisation uptake indicators and met the minimum target of 90% in one indicator. 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 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 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,	34	50	68.0%	Below 80% uptake

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)				
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)	70	81	86.4%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	67	81	82.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	72	81	88.9%	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 operated a system which enabled staff to receive a list from the childhood immunisation service of children who required their immunisations. Reminders were placed on clinical system and staff actively contacted parents and legal guardians to make arrangements for their child to attend the practice for their immunisation.

The management team explained the practice was based in a multicultural neighbourhood and they had multilingual staff who were able to speak up to three languages. Designated childhood immunisation clinics were run and GPs had been trained to cover immunisation clinics if nurses were not available. Staff explained proactive efforts to engage with parents and legal guardians continued even if three appointments had been missed or appointment invitations not responded to. Staff explained during the pandemic to ensure immunisation clinics continued to operate appointments were staggered. Since our November 2019 inspection, the provider recruited additional nurses to increase appointment capacity.

Following this inspection, the provider submitted data covering the period between April 2019 to March 2020 obtained from Child Health Information System (CHIS local active clinical care records of all the children in an area, ideally containing information about an individual child's public health interventions such as immunisations). The data showed an increase in the uptake of childhood immunisations in all four uptake indicators. For example:

- 80% of children aged one 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).
- 91% of percentage of children aged two received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster).
- 96% of children aged two have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster).

- 98% of children aged two have received immunisation for measles, mumps and rubella (one dose of MMR).

Since our inspection, data within our evidence table regarding the uptake of childhood immunisations had been refreshed and showed the following:

- 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) was 80%, this demonstrated an improvement from the previous year, however remained below the World Health Organisation (WHO) target of 95%.
- 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) was 91%, demonstrating an increase from the previous year and met the WHO minimum target.
- The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England) was 96%, demonstrating an increase from the previous year and met the WHO based target.
- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) was 98% demonstrating an increase from the previous year and met the WHO based target.
- The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) was 85%, demonstrating a slight decline from the previous year, and remained below the WHO minimum target.

In addition, the provider submitted evidence of an audit undertaken in September 2020 on the uptake of childhood immunisations; unverified data indicated that three out of four indicators had met the WHO based national targets.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The uptake of national screening programmes such as cervical, breast and bowel cancer screening were below local and national averages. Data indicating trends over time showed the practice uptake of cervical screening remained below local and national averages prior to the peak of COVID-19 and there has been minimal improvement between 2018 and 2020.
- The practice demonstrated ongoing awareness of issues regarding the uptake of screening and the temporary pause of screening during the COVID-19 pandemic. Staff demonstrated awareness of when the temporary pause was lifted in June 2020 and continued taking action to encourage uptake of screening. Public Health England (PHE) data provided by the practice showed a slight increase in the practice uptake of cervical screening.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice operated a system to follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. This involved

recording actions manually which clinicians were then required to check and follow up. 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 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)	46.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	54.5%	64.3%	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)	22.7%	44.7%	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. (01/04/2018 to 31/03/2019) (PHE)	100.0%	73.4%	68.1%	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)	42.9%	52.8%	53.8%	No statistical variation

Any additional evidence or comments

Staff explained there were religious and cultural factors which heavily influenced patients' decision to attend national screening programmes. Staff described engagement with the Primary Care Network (PCNs are a group of practices working together to focus on local patient care as part of NHS long term plan) and cancer screening coordinator to arrange a screening awareness day at a neighbouring practice. Staff also explained the pause in the cervical screening programme from March 2020 to June 2020 due to COVID-19 pandemic impacted on the uptake and actions taken to follow up identified patients who may have missed their screening appointments temporary pause.

The provider arranged for the practice website to be updated in order to provide more information about national screening programmes including updates during COVID-19 pandemic. The practice nursing team was increased to enable access to more appointments. The practice actively discussed actions during practice team meetings; minutes provided indicated that the practice had been in contact with the local breast screening coordinator to improve screening rates. Actions included allowing the screening team to use the practice letterhead when recalling patients.

Since our November 2019 inspection, PHE data provided by the practice indicated a 3% increase in the uptake of cervical screening for patients aged between 25 and 49; and a 2% increase in the uptake of patients aged between 50 and 64. PHE data showed uptake of cervical screening over time remained below local and national averages; for example, the practice uptake remained below 50% between March 2018 and March 2020.

PHE data extracted by the practice indicated an increase in the uptake of breast cancer screening since our last inspection, from 47% to 55%. PHS data extracted by the practice also indicated a slight increase in the uptake of bowel cancer screening from 22% to 23% since our November 2019 inspection.

Following our inspection, the provider sent additional information received from the screening service detailing that the breast cancer screening round for the practice will take place between July and August 2021.

Since our inspection, data within our evidence table regarding cancer indicators has been refreshed; which showed the following:

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/06/2020) (Public Health England) was 45%, this remained below the national uptake rate of 70%
- Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) was 53%, this remained below local CCG average of 63% and national average of 70%
- Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE) was 23%, this remained below local CCG average of 44% and national average of 58%
- 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) was 100%, this remained above the local CCG average of 95% and national average of 93%
- 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) was 20%, this remained below local CCG and national average of 54%

The refreshed data indicated a slight decline in uptake across three of the five cancer indicators. Following our inspection, the practice submitted unverified data taken from their own audit carried out internally, which showed different uptake rates from that of PHE verified data.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

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

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

**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.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- 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)	93.1%	88.2%	85.4%	No statistical variation
Exception rate (number of exceptions).	3.3% (1)	12.5%	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)	80.0%	82.8%	81.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.9%	8.0%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, there were areas such as long-term conditions where clinical record keeping created irregularities when running data quality searches but had not been addressed to ensure more accurate data.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543.0	547.2	539.2
Overall QOF score (as a percentage of maximum)	97.1%	97.9%	96.7%
Overall QOF exception reporting (all domains)	14.6%	6.4%	5.9%

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

The clinical team carried out an audit to evaluate clinician's assessment of children with feverish illness and record keeping to ensure national guidelines on assessment of children with fever were being applied. Out of 50 records analysed as part of the audit, 31 patients had a history of fever or documented high temperature at consultation. From the 31 patients three identified as amber flag (a set of criteria prompting clinicians to take a specific course of action) and one indicated red flag (a criteria which prompts clinician to commence Sepsis six pathway). Clinicians were reminded to use Pediatric Early Warning Score (PEWS identify pediatric patients at risk for clinical deterioration). PEWS early warning score card traffic light system was added onto computer desktops and notice boards. The practice repeated the audit which showed all patients had safety netting.

Audit to assess hypnotic prescribing carried out between September and December 2018 and repeat between May and August 2020. The practice provided data from open prescribing (England's prescribing data) which indicated that the number of items prescribed December 2018 from 100 items to 69 items in June 2020 as a result of actions carried out by the provider. For example, patients were provided with information advising them about withdrawing long term therapy.

Any additional evidence or comments

During our initial on-site inspection, we identified a number of audits within the clinical system which highlighted possible missed diagnoses and patients diagnosed with a long-term condition who were not routinely added to disease registers. As a result, some patients were not included in standard recalls to monitor the effectiveness and appropriateness of their care and treatment. Discussions with members of the clinical team indicated that the audits we viewed during our first on-site visit had not been accessed, viewed or actions taken to improve the quality of record keeping.

Following our first visit during this inspection, the provider submitted additional evidence which showed actions taken to better understand the issues identified during this inspection. The evidence provided indicated issues with record keeping as well as dated read codes on patient records which were no longer in use and had not been updated in line with national good practice guidelines where appropriate during the course of managing patients care and treatment. The provider submitted evidence demonstrating an action plan since our initial on-site visit aimed at avoiding the use of certain codes, terminology and ensuring the correct codes were being added to clinical records.

Searches carried out on the practice clinical system during our second on-site visit showed historical data resulted in irregularities when conducting searches. A random sample of records viewed showed the issues identified did not hinder patient care and we saw examples where patients had been referred to appropriate services and monitored effectively.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: The management team explained actions taken to improve the monitoring of training. For example, the provider implemented staff competencies and mandatory training checklist which were both reviewed by the management team on a monthly basis. Records viewed during our September 2020 on-site visit showed all staff were up to date with training identified by the provider as mandatory training.	

Coordinating care and treatment

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

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

Explanation of any answers and additional evidence:

Discussions held with the local health visiting team demonstrated active engagement between health visitors and the practice. We spoke with health visitors who explained a yearly plan of quarterly meetings and clear communication pathways between the community health visitors and practice. Health visitors provided GPs with advice and guidance regarding families as well as children who may require additional support. The team explained to avoid cancellation of meetings the practice would contact health visitors ahead of the meeting to confirm attendance. There were also discussions being held regarding the possibility of holding virtual meetings to avoid disrupting multidisciplinary arrangements during COVID-19 pandemic.

Helping patients to live healthier lives

Staff were mainly consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: Following our inspection, the provider submitted a document which indicated that the practice had reflected and planned to commence using read codes specifically related to disease areas. During our second on-site visit clinical leads explained historical incorrect read codes had been replaced with the correct read code; however, recognised that clinical records needed to be clearer. A random sample of records viewed showed patients had been referred to appropriate services.	

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>	97.5%	95.1%	94.5%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.5% (3)	0.6%	0.8%	N/A

Consent to care and treatment

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

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

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:	

CQC comments cards	
Total comments cards received.	N/A
Number of CQC comments received which were positive about the service.	N/A
Number of comments cards received which were mixed about the service.	N/A
Number of CQC comments received which were negative about the service.	N/A
Explanation of any answers and additional evidence: Due to COVID-19 and National restrictions imposed to tackle the pandemic, practices reduced their footfall. As a result, CQC comment cards were not sent out to the practice as part of this inspection.	

Source	Feedback
NHS Choices	Comments placed on NHS choices website described staff as helpful, friendly; patients felt reassured and looked after. Comments also showed that patients felt staff were kind, caring, competent and committed

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)	78.6%	87.1%	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)	75.7%	85.4%	87.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	94.5%	94.6%	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)	61.6%	79.2%	81.8%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware of the areas where patient satisfaction was below local and national averages. Records demonstrated active discussions during practice meetings exploring ways to improve patient satisfaction. For example, to improve patients overall experience of the practice; members of the management team reminded staff of the importance of call handling skills.

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

Any additional evidence

The practice carried out their own patient survey during August and September 2020. Three clinicians carried out telephone and face to face surveys following appointments. The practice sent out feedback forms and received 50 completed forms. Unverified data from the practice internal survey showed patients found the reception staff helpful and patients had confidence at trust in the healthcare professional.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	During the national pandemic footfall within the practice had been reduced as well as social distancing rules implemented in line with national guidance. As a result, during our on-site inspection, patient interviews had not been carried out.
NHS Choices	Comments posted on NHS choices website during 2020 showed patients were positive about the care and treatment received. For example, patients commented that they felt reassured and looked after; staff were kind and honest.

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)	80.0%	91.3%	93.0%	Variation (negative)

Any additional evidence or comments

The practice action plan included reminding staff that for any non-urgent appointment request, patients should be offered a choice of GP.

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

Carers	Narrative
Percentage and number of carers identified.	The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 102 patients as carers (2% of the practice list).
How the practice supported carers (including young carers).	The practice had a carer lead who was responsible for signposting patients to local support services as well as local authority assessments. Carers are provided with tailored flu vaccination invitations.
How the practice supported recently bereaved patients.	If families had suffered bereavement, their usual GP contacted them, and carries out home visits for all patients or families suffering from bereavement & signposting patient to Community Mental health services if needed as well as providing advice on how to find a support service. The practice had bereavement packs which included information and details of support services available for 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:	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During the pandemic the practice encouraged more patients to register for online services such as request for prescriptions and appointments. The practices internal patient survey indicated that patients were satisfied with the increase in online services.</p>	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had text to speech facility on the practice website which enabled patients to listen to the text and information on the website, rather than reading it on the screen. This helped patients with visual impairments to access the practice website. The practice made use of digital platforms during the COVID-19 pandemic to respond to patient's needs. Patients comments taken from the internal patient survey showed patients were more satisfied and preferred telephone and video consultations. Unverified data from the practice own patient survey showed 100% was able to book a telephone consultation, 8% required a follow up as a result of their online consultation and 100% would use telephone consultations again.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	9.30 – 12.30 - 4pm 6.15pm (extended hours from 6.30 to 8pm)
Tuesday	9.30 – 12.30 - 4pm 6.15pm (extended hours from 6.30pm to 8pm) Practice Nurse available from 9.30am to 2.30pm
Wednesday	9.30 – 12.30 and 4pm - 6.15pm (extended hours from 6.30pm to 7.30pm) Practice Nurse available from 9.30am to 2.30pm
Thursday	9.30am – 12.30 and 4pm to 6.15pm Practice Nurse available 9.30pm to 2.30pm

Friday	9.30am – 12.30 and 4pm - 6.15pm Practice Nurse available 9.30pm to 2.30pm

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)	79.9%	93.5%	94.2%	Variation (negative)

Any additional evidence or comments

The provider increased capacity within the practice nursing team in response to survey results. Practice nurses as well as the management team we spoke with explained nurse appointments were available between 9.30am and 2pm Tuesday to Friday. However; the practice website states that nurse surgeries were held daily between 9.30am to 2pm and 3.30pm to 6.30pm. Following our inspection, the provider updated the practice website which showed nurse appointments were available between 9.30am and 2.30pm Tuesday to Friday.

To improve patient satisfaction the practice action plan included updating the practice website as well as advising patients on the range of support available within the local community. Unverified data from the practices own patient survey showed 94% of patients involved in the survey was satisfied with the service provided.

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.
- 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 to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice took appropriate action to ensure patients treated for a long-term conditions 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.
- 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

- Additional nurse appointments within the practice was not available outside normal school hours for school age children so that they did not need to miss school. However, extended hours appointments were available as part of Hub arrangements on Tuesday and Wednesday evenings.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could arrange to be seen by a clinician in line with local guidance and policies surrounding COVID-19.
- Staff explained clinicians continued working virtually with members of the Patient Participation Group (PPG) to increase vaccination uptake for children.

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 was open until 6.30pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available once a month on a Sunday from 9.30am to 10.30am.
- Patients were able to access pre-booked cervical screening appointments. For patients who requested screening appointments outside of practice nurses and female locum GPs working hours staff explained patients were signposted to umbrella (sexual health clinic) as well as the local secondary care service.
- The practice carried out healthy lifestyle checks for patients over the age of 45 years old and offered advice and support with lifestyle changes.
- The practice provided a range of appointments focused on lifestyle; for example, smoking cessation, weight management and alcohol counselling.
- Meningitis vaccines for 18-year old's and students going to university were available at the practice
- The practice had installed a text messaging system with free Wi-Fi on site which allowed patients to respond to practice text messages as well as cancel appointments by text.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Traveler's.
- 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.
- Vulnerable and patients with more complex needs were contacted during winter periods informing them of the flu vaccination and offered further support. The practice offered learning disability health checks at specific appointments but would also alter clinics to complete an opportunist health check if a patient with a learning disability presented at the practice outside of the offered appointment times.

**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.
- Patients diagnosed with autism were offered either the first or last appointment of the day. Patients were allowed to wait in a private area if they were suffering from social phobia.

Timely access to the service

People were mostly able to access care and treatment in a timely way; however, survey results and feedback showed low patient satisfaction with getting through to the practice by phone the practice was addressing this.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were GP Hub arrangements in place enabled the practice to offer extended access appointments at other practices within the Primary Care network (PCN).</p> <p>During the COVID-19 pandemic staff continued to contact patients inviting them in for national screening. The provider expanded the nursing team to increase capacity of screening and childhood immunization appointments. The practice updated their website to include information regarding national screening campaigns. Meeting minutes viewed showed staff were in discussion with the Primary Care Network (PCN) to arrange a cancer awareness open day as well as offering appointments at a neighboring practice.</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)	40.2%	N/A	65.2%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	49.9%	59.6%	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)	58.7%	60.2%	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)	71.1%	68.1%	72.7%	No statistical variation

Any additional evidence or comments

The practice was aware of the national survey and carried out their own survey to better understand patients concerns. The practice identified phone access as an area of improvement and developed an action plan aimed at improving phone access. For example, members of the management team explained that they were in discussions with telecommunication companies with a view of upgrading the phone system in order to better cope with the increasing number of phone calls. Staff also engaged with the PCN for recommendations regarding the best options moving forward.

Staff identified a sharp increase in the number of calls received during the pandemic as well as following the re-opening of schools. To ease the pressure staff were advised to promote online services as a way of easing the pressure on the phone line.

Source	Feedback
The August 2020 to September 2020 practice internal survey	Unverified data provided by the practice showed out of 50 patients who completed the practice survey 52% found it easy to get through to the practice by phone, and 24% found it fairly easy. Data showed 58% were satisfied with the ease in which they were able to book appointments. Data also showed 72% were satisfied with the practice opening hours; 12% were fairly satisfied.
Staff interviews	Non-clinical staff demonstrated clear understanding of the appointment system; as well as systems in place for triaging and prioritising home visits. Staff also explained processes they were required to follow for booking appointments during the pandemic.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Members of the management team explained the practice had not received any formal written complaints since our last inspection, in November 2019. However, received a total of six informal verbal complaints. The practice kept a record of all informal complaints which were discussed during practice meetings and learning shared. For example, the practice discussed issues relating to phone access and explained ongoing discussions with telecommunication services to address the issues. Staff were also reminded to encourage patients to make use of online services to ease the pressure off the phone lines.	

Well-led

Rating: Good

At the last inspection in November 2019 we rated the practice as requires improvement for providing well led services. The practice is now rated good due to the improvements made to systems and processes to keep people safe, as well as further evidence provided following our inspection, regarding governance arrangements for clinical care.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels. Leaders demonstrate that they had the capacity and skills to deliver care. However, not all areas for improvement identified at the last inspection had been addressed. Following our inspection, the provider submitted evidence demonstrating actions taken.

	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:	
The management team and clinical leads demonstrated awareness of challenges associated with providing a service in a deprived and diverse community. Prior to the national lockdown the practice utilised various channels to engage with the local community including community leads, religious leaders, social prescribers. Members of the Patient Participation Group (PPG) attended local Mosques; to help raise patients' awareness and knowledge of the benefits of engaging in national screening programmes and childhood immunisations.	
The management team did not demonstrate a formal action plan with clear timescales or evidence of further progress made since our November 2019 inspection, to upgrade the IT infrastructure. For example, we found the current clinical infrastructure had not been upgraded in line with plans which the provider had pointed out during our previous inspection. Following our first on-site visit during this inspection, the provider sent evidence which demonstrated engagement with external IT support service since our inspection. This included a structured plan of action to strengthen the IT infrastructure within the practice. In addition, the provider submitted further information which was not made available during our first visit demonstrating historical correspondence with local commissioners, including ongoing communication with technology services as well as scheduled dates for system migration.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: Staff we spoke with demonstrated awareness of the practice vision and strategy.	

Culture

The practice had a culture which aimed to drive 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> <p>The provider had a flexible working policy in place. This included flexible working hours to support staff with caring responsibilities. Priority was given to staff who needed to leave for appointments and arrangements were made to cover staff. There were systems and processes in place to facilitate staff if they needed to shield as a result of national pandemics.</p> <p>Staff received annual appraisals and training records showed staff had completed all training identified by the practice as mandatory. The practice had strengthened processes for gaining assurance that staff who were not directly employed by the practice had completed training identified by the practice as mandatory.</p> <p>The management team operated an open-door policy and staff were encouraging to share ideas as well as raise any concerns. The management team actively responded to staff feedback</p> <p>Although the practice had not received any formal complaints since our November 2019 inspection, there was a lead person responsible for managing and monitoring complaints and significant events. Staff were able to demonstrate systems in place to enable the practice to respond to complaints in a timely manner. We saw that incidents as well as informal verbal complaints received were investigated, and learning shared throughout the practice. Records showed, patients who were affected by an incident or were unsatisfied with the service provided received an apology.</p>	

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

Source	Feedback
Staff	Staff we spoke with explained staff at all levels within the team were supportive and were happy to try new ways of working as well as implement suggestions from the teams to help improve the working environment. Staff received information regarding changes made as a result of investigations and learning outcomes. Staff felt encouraged to share any ideas as well as discuss any areas of concern.
Policies	Practice policies were in place which supported leaders to act on behaviour and performance inconsistent with the vision and values of the practice.
Policies and management interviews	The practice had processes which enabled leaders to take action to promote equality and diversity.

Governance arrangements

There were 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had strengthened areas of the non-clinical governance arrangements since our November 2019 inspection. In particular, systems to aid effective oversight of recruitment and training. Records viewed showed staff had received all training identified by the provider as mandatory training. Recruitment files for staff who were not directly employed by the provider showed the practice had gained assurance that all pre employment checks had been carried out. For example, the management team provide assurance they had viewed training records, indemnity insurance and registration with a professional body for clinical staff who were not directly employed by the practice prior to them commencing employment.</p> <p>Members of the management team used a mandatory training record checklist to support effective monitoring of staff training as well as a staff competency checks list to enable early identification of any training needs. Staff had received update training in infection prevention and control; standing operating procedure (SOP) policy for COVID-19 introduced.</p> <p>The practice operated a process for ensuring policies and procedures were reviewed and updated in line with local and national guidance updates. The management team explained practice meetings were more regular and update meetings in addition to quarterly practice meetings had been introduced since the previous inspection.</p> <p>During our first on-site visit documents we viewed did not demonstrate an effective process to ensure clinical records clearly reflected where patients diagnosis had changed over time. As a result, we found that this impacted on the accuracy of data quality searches carried out during our first on-site visit.</p>	

Clinical leads did not demonstrate that they had responded to the data viewed during our inspection. Following our first on-site visit during this inspection, the provider explained that the practice carried out their own searches which were used to manage patients care and treatment. Evidence provided showed since our first on-site visit during this inspection, the provider had analysed clinical data in more detail and identified ineffective use of clinical read codes due to historical diagnosis which remained on clinical records. The practice provided evidence of actions taken; which provided assurance that the issues identified had been addressed.

Managing risks, issues and performance

There were processes for managing non-clinical risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The management team had strengthened systems and processes to gain assurance as well as demonstrate that non-clinical risks were being managed safe and effectively.</p> <p>The provider continued working towards set objectives. For example, since our November 2019 inspection, the practice increased practice nurse capacity and were at the final stages of employing a female GP. Meeting minutes showed negotiations with NHS property regarding extending the building had been placed on hold due to the national pandemic; however, there were plans to reinstate these discussions November 2020.</p> <p>The clinical team had undertaken first and second cycle audits; clinical team used data from these audits as well as information from significant events, complaints and patient feedback to identify how to improve the quality of care.</p>	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making. However, there were gaps and inconsistencies in the quality of the data.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
The management team used non-clinical data and information about performance to support staff and drive improvement.	
During our second on-site visit a further view of the clinical system showed read codes used to identify patients were not routinely added to patients records at the time of initial diagnoses; therefore, patients would not have been included in standard recalls to assess the safe and effectiveness of treatment plans. A further search of the clinical system showed that despite these issues, patients care had not been compromised.	

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

The practice involved the public and staff to sustain high quality and sustainable care. Following our on-site visit the provider submitted evidence demonstrating engagement with external partners; in particular stakeholders. However, there was limited evidence of engagement with external partners; in particular key stakeholders.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<p>There was limited evidence demonstrating engagement with key stakeholders or proactive actions taken in light of feedback following our November 2019 inspection. For example, during our inspection, the practice demonstrated initial discussions with stakeholders and system providers regarding upgrading the IT infrastructure. During this inspection, we found that discussions had not progressed or result into development of a formal timely action plan. This was despite identification of significant risks in which without changes made the provider would be unable to fulfil contractual requirements. During our on-site inspection, the management team provided evidence of early communication with Midlands and Lancashire Commissioning Support Unit (CSU provides end-to-end support to health systems) where a meeting had been arranged for October 2020 with subsequent weekly meetings planned to monitor progress. During our interviews and initial on-site inspection, the provider was unable to provide evidence of a structured and timely action plan specifically aimed at upgrading the IT infrastructure.</p> <p>Following our first on-site visit as part of the inspection, the provider submitted evidence which showed engagement with IT support services had further progressed and a timebound action plan to upgrade the IT infrastructure had been developed and shared with CSU. In addition, the provider submitted further evidence which demonstrated historical correspondence between the practice and local commissioners as well as ongoing communication with technology and services company.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

During the inspection process staff we spoke with as well as documents viewed, demonstrated discussions held and improvements made following significant events and informal complaints received since our previous inspection. However, the provider was unable to demonstrate improvements made to the IT system. Following our inspection, the provider submitted evidence outlining that a system migration had been carried out since our inspection.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for most 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 several 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.