

Care Quality Commission

Inspection Evidence Table

Wheatfield Surgery (1-542749654)

Inspection date: 28 September 2021

Date of data download: 13 September 2021

Overall rating: **Requires Improvement**

We inspected the practice in August 2019 and rated the practice as requires improvement overall. Following the inspection, we issued a warning notice to the provider in relation to breaches of Regulation 12 Safe care and treatment as not all risks were proactively assessed and managed and there was limited clinical and governance oversight. We carried out a focused inspection in February 2020 to confirm compliance with the warning notice we issued. We found the provider had taken action needed to comply with the legal requirements. At this comprehensive inspection the overall rating remained unchanged. There was evidence of progress made however, there were gaps and inconsistencies and areas which required further improvement.

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

Safe **Rating: Requires Improvement**

We inspected the practice in August 2019 and rated the practice requires improvement for safe services and issued a warning notice in relation to breaches of Regulation 12 Safe care and treatment. We carried out a focused inspection in February 2020 and confirmed compliance with the warning notice we issued. During this inspection the rating remained unchanged, there was evidence of improvements made however, systems for assessing and managing risks in relation to patients care and treatment required strengthening and improved oversight.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Chaperoning was mostly undertaken by clinical staff however; training was in progress for non-clinical staff to enable them to undertake the role.</p> <ul style="list-style-type: none"> Safeguarding was a standing agenda item in clinical governance meetings, and we saw evidence of referrals made in response to safeguarding concerns. There were no formal multi-disciplinary team meetings to discuss and share concerns relating to vulnerable adults and children. Staff told us relevant professionals were invited but did not attend meetings and there were systems in place to discuss concerns and share information when required which included contact by telephone, email or by sending messages on the clinical system. However, the lack of sharing of information on an ongoing basis meant information in patients records and the practices safeguarding registers may not always be accurate and up to date. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We looked at three staff files including clinical, non-clinical and recently employed staff. There was evidence of checks undertaken as part of the recruitment process such as references, proof of identity and staff vaccination status in line with the relevant guidance, and policies. A formal induction program was provided on appointment. 	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: November 2020</p>	Y
<p>There was a record of equipment calibration. Date of last calibration: April 2021</p>	Y
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	Y
<p>There was a fire procedure.</p>	Y
<p>A fire risk assessment had been completed. Date of completion: December 2019</p>	Y
<p>Actions from fire risk assessment were identified and completed.</p>	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The fire risk assessment was reviewed in January 2021, to ensure completion of outstanding actions. • Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures. However, we saw a lack of prominent signage of the fire procedure with only one sign visible in the patient waiting area. • A risk assessment for Legionella (a bacteria found in water) had been completed by an external contractor in March 2021 and regular testing of the water systems were in place. 	

Health and safety	Y/N/Partial
<p>Premises/security risk assessment had been carried out. Date of last assessment: May 2021</p>	Y
<p>Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2021</p>	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There were risk assessment completed in areas such as lone working and the general environment. • Individual risk assessments were completed for staff to reduce risks associated with COVID-19 which took into account factors that may impact staff disproportionately. • Staff were offered the COVID-19 vaccination and the uptake was positive. A risk assessment was in place for staff declining due to hesitancy or medical reasons. 	

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: May 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Policies, procedures and audit templates were in place for infection prevention and control and COVID-19. The infection prevention and control policy included areas such as personal protective equipment, sharps management, hand hygiene and waste disposal. • Staff had completed infection control and prevention and hand hygiene training. • Covid-19 workplace risk assessments were completed to ensure the layout of the premises, use of space and hygiene promoted safety. • We observed the general environment to be clean and tidy. The layout and facilities of the premises were adjusted in line with COVID-19 guidance for infection prevention and control. • Records confirmed the regular cleaning of the environment including clinical rooms and equipment used for patients care and treatment. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had received training on managing a medical emergency including identifying signs and symptoms of sepsis. • Staff had access to equipment and medicines to deal with medical emergencies (including suspected sepsis). This included medical oxygen and a defibrillator which were regularly checked to ensure they were fit for use. 	

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
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.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed the arrangements in place to manage workflow such as incoming correspondence and the document management process. All correspondence was processed by administrative staff who were trained in clinical coding and scanning. Once appropriate codes were added, these were then scanned or uploaded into the patients records or forwarded to clinicians to review. However, there were gaps in the system, for example, we saw a letter for a patient following a review by a health care professional with recommendations for the practice, however, there was no clear audit trail to demonstrate the action taken in response to the letter. We also identified medications administered in secondary care were not always recorded in the patients records which meant staff did not always have the information needed. A GP specialist advisor to the Care Quality Commission (CQC) accessed the clinical patient records system to carry out searches of patient records. There was evidence that the practice had some oversight of patients prescribed high risk medicines which required monitoring and a recent shortage of blood testing tubes had impacted on progress. However, we found gaps and inconsistencies for example, searches of the clinical system identified 211 patients prescribed a high-risk medicine in the previous six months, of these 54 patients did not have the required monitoring in the last 12 months. The GP partners were fully aware of the back log in monitoring of patients on high risk medicines and there was evidence of assurance systems in place to identify and mitigate risks. This included opting out of a shared care agreement for Disease Modifying Anti-Rheumatic drugs (DMARDs) prescribing and monitoring to enable them to focus on the other high-risk medicines and a waiting list was in place to review patients who were due monitoring. 	

Appropriate and safe use of medicines

The systems for the appropriate and safe use of medicines, including medicines optimisation was not fully effective

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.75	0.67	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	9.0%	10.6%	10.0%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	5.32	5.54	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	104.4‰	97.0‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.39	0.77	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	8.5‰	6.9‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y

Medicines management	Y/N/Partial
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Prescribing data available at the time of the inspection showed the practice was within local and national averages for prescribing indicators in areas such as the number of antibacterial prescription items issued. • There were policies in place to support appropriate and safe use of medicines, these included repeat prescribing, prescription security, high risk medicines and non dispensing. However, these were not always fully embedded in practice. • The practice employed allied health professionals (AHP) and nurses who were non-medical prescribers and they were provided clinical supervisors for support and advice. Discussions relating to patients care and treatment were discussed informally with the supervisor and documented in patients' records with competency assessments in place. However, the practice 	

Medicines management	Y/N/Partial
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was unable to demonstrate that regular reviews were undertaken of prescribing practice as these were not documented or audited.

- We saw a high number of medication reviews were completed and these were structured and detailed. The practice employed a clinical pharmacist who supported with medicines management systems and conducted medicines reviews. However, further work was required to align health conditions with prescribed medicines to aid patients and other health care professionals.
- We reviewed the arrangements in place to manage workflow such as incoming correspondences. We saw gaps in the system for example, a correspondence related to a patient had not been processed accordingly including adding medicines prescribed in secondary care.
- A GP specialist advisor to the CQC accessed the clinical patient records system to carry out searches to identify patients prescribed Disease Modifying Anti-Rheumatic drugs (DMARDs) and high-risk medicines that require routine monitoring due to the potential risk of harm from taking them. The practice had opted out of DMARD prescribing and monitoring and therefore no shared care arrangement was in place. However, we saw patients' records did not always indicate DMARDs prescribed in secondary care services for the practice to have knowledge of prescribing such as contraindications.
- There was evidence that the practice had some oversight of patients on high risk medicines which required monitoring and a recent shortage of blood testing tube had impacted on progress. However, we found gaps and inconsistencies for example, there were 58 patients prescribed a high-risk medicine of these 22 patients did not have the required monitoring in the last six months. For another high-risk medicine prescribed to eight patients, five patients did not have the required monitoring in place in the last six months. We also saw patients prescribed medicines which were not always aligned to their health condition. The GP partners were fully aware of the back log in monitoring of patients on high risk medicines and there was evidence of assurance systems in place to identify and mitigate risks. This included opting out of a shared care agreement for Disease Modifying Anti-Rheumatic drugs (DMARDs) prescribing and monitoring to enable them to focus on the other high-risk medicines and a waiting list was in place to review patients who were due monitoring.
- The system for monitoring of vaccines was not in line with Public Health England (PHE) guidance or the providers policy. We raised this at the time of the inspection and action was taken to address the issue. This included, the implementation of a new template to record temperature readings, in addition to staff training and evidence from the data loggers that demonstrated vaccine fridge temperatures had been maintained within the recommended ranges.

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:	46
Number of events that required action:	44
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff were able to describe the system in place to report incidents. • Clinical governance meeting minutes showed that significant events were shared and discussed with staff. 	

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

Event	Specific action taken
Patient prescribed a medication in error	Alert added to patients record to ensure medication is not prescribed.
Test request form sent to incorrect patient	Both patients informed of error, reinforced to staff the need to check details are correct and potential for data breach.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Patient safety alerts were discussed in clinical governance meetings. • The practice manager and clinical pharmacist had responsibility for checking that all alerts were actioned with a system in place to maintain oversight. • A GP specialist advisor to the CQC accessed the clinical patient records system to carry out searches of patient safety alerts for linked to medicines. We saw alerts were being acted upon with further work in progress to re visit old alerts. 	

Effective

Rating: Requires improvement

We inspected the practice in August 2019 and rated the practice requires improvement for effective services as the practice was not pro-active in following up patients who did not attend reviews, the practice had not met the minimum target for uptake of childhood immunisation and there were gaps in staff training. During this inspection the rating remained unchanged. There was a lack of a consistent approach to the management of patients care and treatment. The practice continues to perform below national averages for cancer screening and the uptake of childhood immunisations.

Effective needs assessment, care and treatment

Patients' needs were not always fully assessed, and care and treatment was not consistently 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Provider policies and procedures were in place which promoted evidence-based practice. The practice utilised standardised clinical templates for care and treatment accessed in the clinical system which reflected evidence-based practice.• Clinical staff spoken with were able to describe how they kept up to date which included discussions in clinical and clinical commissioning group meetings.• On reviewing a sample of patient records we saw that patients' records were not always up to date and action taken as a result of changes made by other services.• Searches of the clinical system showed that patients prescribed some high-risk medicines were not receiving appropriate monitoring to ensure their treatment was up to date and in line with best practice guidance.	

Older people

Population group rating: **Good**

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: **Requires improvement**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received training for example in areas such as diabetes and respiratory conditions.
- Quality indicators for long-term conditions were mostly within local and national averages.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with long-term conditions were offered an annual review to check their health needs were being met. However, some patients with long term conditions and prescribed high risk medicine had not received appropriate monitoring.
- Patients with asthma had a care plan in place although these were mostly generic.

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)	92.3%	78.3%	76.6%	Significant Variation (positive)
PCA* rate (number of PCAs).	23.4% (214)	15.8%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an	87.1%	87.8%	89.4%	No statistical variation

assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
PCA rate (number of PCAs).	35.3% (89)	17.4%	12.7%	N/A

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

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	75.2%	78.9%	82.0%	No statistical variation
PCA* rate (number of PCAs).	4.5% (12)	6.8%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	63.3%	65.6%	66.9%	No statistical variation
PCA rate (number of PCAs).	17.9% (132)	17.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	65.5%	68.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	5.2% (79)	8.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.6%	93.8%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.0% (6)	3.8%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	60.1%	72.8%	75.9%	Variation (negative)
PCA rate (number of PCAs).	21.4% (158)	14.0%	10.4%	N/A

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

Any additional evidence or comments

- The practice was working to improve diabetes care which included support from a diabetes specialist nurse and developing skills within the practice such as a lead nurse for diabetes who was undertaking specialist diabetes training. The local integrated community diabetes service team had weekly sessions at the practice that the clinicians could refer directly to.
- We discussed the Personalised Care Adjustment (PCA) rates for some of the long-term health condition indicators such as asthma and COPD, PCA allow practices to remove a patient from

the indicator for limited, specified reasons. The practice demonstrated that since the data was published (2019-2020) they had actively engaged with patients to encourage uptake of reviews which included the use of digital solutions such as video consultations and online access. For example, patients were sent health questionnaires to complete and return which were populated into patient records and coded. This could also be uploaded securely on to the practice website.

- Patients who were digitally excluded, invitation letters were posted to either the patient or carer with reminders with the associated challenges due to the impact of COVID-19. The practice had also engaged with the National Service for Health Improvement (NSHI) and a respiratory nurse undertook clinics at the surgery providing comprehensive reviews during 30-minute appointments for Asthma and COPD patients.
- We reviewed the registers for patients with asthma and saw work was in progress to review patients with 489 out of 733 patients reviewed to date and for COPD register 166 out of 220 have had a review to date.

Families, children and young people

Population group rating: Requires improvement

Findings

- The practice has not met the minimum 90% for all five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five childhood immunisation uptake indicators.
- 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.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	136	166	81.9%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	140	161	87.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for	142	161	88.2%	Below 90% minimum

Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	139	161	86.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	148	167	88.6%	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 had not met the minimum 90% for all childhood immunisations at the last comprehensive inspection.
- The practice was aware that uptake of childhood immunisation was low and that non attendance rates and COVID-19 had impacted on the delivery of the service. Action taken to increase uptake included offering flexibility with appointments and putting on extra clinics, sending reminders and proactively following up non attendance. However, at the time of the inspection this had not resulted in improvements.

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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- Cervical screening uptake was significantly below the national target of 80%.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	59.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	74.1%	70.2%	70.1%	N/A

Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	57.8%	59.2%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>	85.4%	90.6%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	68.0%	57.3%	54.2%	No statistical variation

Any additional evidence or comments

- Cervical screening uptake was significantly below the national target of 80%. This was identified as an area for improvement at the last inspection when the uptake was 69%. The practice told us that COVID -19 had impacted uptake rates along with high non-attendance and challenges with patient engagement. Action taken since the previous inspection to increase uptake included increasing clinical capacity, offering flexibility with appointments and staff engaging with patients in various languages to reinforce the importance of screening. However, at the time of the inspection this had not resulted in improvements.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- There was evidence of Gold Standard Framework (GSF) meetings with members of the multi-disciplinary team to ensure end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Same day appointments and longer appointments were offered when necessary. The practice explained some of the challenges with access as a result of COVID -19 which had resulted in changes to the delivery of the service. However, at the time of the inspection the practice performance in relation to access was below local and national averages since March 2019
- Patients with a learning disability were offered an annual health check and we saw the practice had completed half of all reviews.
- 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.

**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.
- Same day and longer appointments were offered when required. However, at the time of the inspection the practice performance in relation to access was below local and national averages since March 2019
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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) <small>(QOF)</small>	91.7%	80.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	55.1% (59)	27.2%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	81.6%	80.3%	81.4%	No statistical variation
PCA rate (number of PCAs).	10.6% (9)	11.6%	8.0%	N/A

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

Any additional evidence or comments

- The practice was within local and national averages for mental health quality indicators. However, we discussed the Personalised Care Adjustment (PCA) for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the last 12 months. PCA allow practices to remove a patient from the indicator for limited, specified reasons.
- The practice was not aware of the high PCA rate but explained some of the challenges they had experienced with a lack of patient engagement. We reviewed the register for patients with mental health needs, there were 138 patients on the register, 49 out of 79 patients had comprehensive care plans in place.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	530.7	533.9
Overall QOF score (as a percentage of maximum)	94.9%	95.5%
Overall QOF PCA reporting (all domains)	9.8%	5.9%

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

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

- Audit completed on recurrent urine tract infections and the use of prophylactic antibiotics to improve care and treatment. There were 17 patients prescribed prophylactic antibiotics and only two of the patients had been reviewed after 6 months of initiation. The outcome of the audit was to ensure patients were reviewed and offered a medicine holiday after 6 months which reflected best practice guidance.
- Audit completed on patients with an overactive bladder and prescribed a specific medicine. The audit identified 20 patients over 80 years of age, the outcome was to ensure plans were put in place for these patients which reflected best practice guidance.
- Quality improvement activity for supporting patients with a learning disability. A number of areas were identified for improvement with actions in place such as the accuracy of the learning disability register, increasing the uptake of the flu vaccine and checking preferred means of communication and utilising this to invite patient's for their annual review. The year end update showed improvements in areas such as the uptake of the flu vaccine and medicines reviews.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, the oversight of staff employed in advanced clinical practice required strengthening.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A system was in place to monitor and review staff training and we saw a high levels of completion rates training for core areas. Staff in advance roles were given in house training by their clinical supervisor in the management of some medical conditions • Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding, consent and responding to an emergency. • There was evidence of staff appraisals and staff reported they were encouraged and given opportunities to develop for example, prescribing, specialist diabetes courses and training for advance nursing. The practice was a designated training practice for trainee GPs. These are qualified doctors who are learning the role of a GP. The trainee GPs' had allocated supervisors with debriefs built into their days. • Non-medical prescribers had allocated clinical supervisors. Discussions around patient care and treatment were conducted and documented in patients' records. However, the performance of staff employed in extended roles could not be demonstrated through audit of their consultations, prescribing and referral decisions. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Multi-disciplinary team meetings took place with various agencies to look specifically at complex patients and high attenders of A&E service (avoidance admission). Patients were also referred to the social prescriber to provide support wellbeing. 	

Helping patients to live healthier lives

Staff were 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.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice worked with various services and organisations to support patients and ensure care was delivered in a coordinated way. For example, community mental health services, the palliative care teams and the community midwife. There was a blood pressure pod in the patient waiting area which enabled patients to have their blood pressure taken and provided a print out of the readings to give to reception staff. Any readings that were out of range were referred to a GP. Patients were able to submit self-monitoring health reviews such as for blood pressure or asthma (if requested by the doctor or nurse) via the practice website. These were then reviewed by the relevant clinician although patients were advised to make an appointment if they had any concerns. We identified gaps and inconsistencies in the monitoring of patients prescribed high risk medicines. 	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Discussion with staff showed that verbal consent was always obtained before care and treatment and where relevant written consent for example, for minor surgical procedures. Clinical staff had received training in the Mental Capacity Act. Staff spoken with were aware of the importance of consent and showed understanding of areas such as best interest.• We reviewed the DNACPR decision in the records for four patients and found some gaps and inconsistencies in two of the records. For example, the rationale for the decision was not clear and discussion with the person and or their representative was not recorded, there was also no evidence of a review date for the decision.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Discussions with staff demonstrated understanding and awareness of the importance of person-centered care. Staff had received training in equality and diversity.• There were information and support within the practice and on the website, sign posting to various services.	

Source	Feedback
CQC Enquiries	Since the last inspection in February 2020, enquiries we received mostly related to patients experiencing difficulty accessing the service, with some reporting staff were unhelpful and not understanding at times.
NHS Website	There were 14 new reviews completed since the last inspection. These mostly related to patients experiencing difficulty accessing the service, being unhappy with care and treatment received. Some comments reported staff were unhelpful and not understanding at times. The practice had responded to all of the comments.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	84.8%	86.0%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	78.1%	85.1%	88.4%	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 (01/01/2021 to 31/03/2021)	95.9%	94.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	65.0%	77.8%	83.0%	Variation (negative)

Any additional evidence or comments

- At the time of the report, the recent national GP survey results for the period 01/01/2021 to 31/03/2021. The results showed patient satisfaction in questions related to patients experience of healthcare professional showing care and concern and overall experience was below local and national averages. There was a slight improvement in response to these questions from the previous GP survey results.
- An action plan had been developed to improve patients experience which included a new telephone system installed in August 2021, ongoing engagement with the patient participation group (PPG), increasing clinical capacity and active discussions with staff to understand and act on any issues.

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

Any additional evidence
<ul style="list-style-type: none"> The practice told us they had not completed an in-house patient survey due to the competing demands on the service as a result of the COVID-19 pandemic. They told us access and patients understanding, and expectations of the service were contributing to patient's experience. However, plans were in place to undertake a survey to review the impact of the new telephone system alongside other actions taken to help improve patients experience. Feedback from patients had been gathered through the NHS website, the NHS Friends and Family Test (FFT) and comments and complaints received.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There was information and support within the practice and on the website, sign posting to various services such as support for carers. Easy read and pictorial materials were available on request. The practice had access to a social prescriber employed within the Primary Care Network (PCN) who undertook sessions at the practice. Patients were referred for support with their health and wellbeing. There was a designated carers champion in the practice as a point of contact for sign posting and support. 	

Source	Feedback
CQC Enquiries	Since the last inspection in February 2020, enquiries we received mostly related to patients experiencing difficulty accessing the service, with some reporting staff were unhelpful and not understanding at times.
NHS Website	There were 14 new reviews completed since the last inspection. These mostly related to patients experiencing difficulty accessing the service, being unhappy with care and treatment received. Some comments reported staff were unhelpful and not understanding at times. The practice had responded to all of the comments.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	88.3%	90.8%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice website had a section on wellbeing with information and links to various groups such as support for drugs and alcohol use, domestic abuse, bereavement and mental health services. 	

Carers	Narrative
Percentage and number of carers identified.	233 (1.7%)
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The practice had a register to ensure all carers were easily identified and could be offered an annual health assessment, the flu vaccination and support and advice. There was information available on the practice website and patient waiting area signposting carers to support groups and encouraging carers to identify themselves, so support could be offered. The practice had carer's champion to coordinate identification and support within the practice.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> A member of the administrative team also provided bereavement support to families and carers. They had received training to support their role.

	<ul style="list-style-type: none"> • The practice contacted patients to offer support and referred patients to support services and bereavement counselling where necessary. • Patients receiving end of life care were on the palliative care register. • There were regular meetings with the palliative care team to ensure information was shared and that support could be offered to carers who were also included on the carers register.
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Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Requires improvement

We inspected the practice in August 2019 and rated the practice requires improvement for responsive services as patients were not always able to access the service in a timely manner and the management of complaints was not effective. During this inspection the rating remained unchanged as patient feedback indicated that access continues to be a challenge. The practice was taking action to improve access, however at the time of the inspection this had not improved patient satisfaction.

Responding to and meeting people's needs

Services did not always meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Results from the national GP survey showed patients were not always able to access the service which impacted on flexibility and choice. 	

Practice Opening Times

Day	Time
Opening times:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm
Appointments available:	
Monday	8.30am to 6pm
Tuesday	8.30am to 6pm
Wednesday	8.30am to 6pm
Thursday	8.30am to 6pm
Friday	8.30am to 6pm
Extended opening	6.30pm – 8.00pm Monday to Friday

Extended GP Access Service

The practice is part of the Chiltern Vale locality that provides an extended access service for all the patients registered at a Chiltern Vale locality practice. Patients could book an appointment by contacting their own GP practice however, patients could be seen by a clinician at another practice.

Appointments available as follows:

Monday to Friday 6.30pm to 8pm

Saturday and Sunday 8.30am to 12.30pm (pre-booked telephone consultations available on Sunday)

Bank holidays 8.30am to 12:30pm

Older people

Population group rating: Requires Improvement

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 including referring to a social prescriber to assist with signposting to relevant services.
- There was a medicines delivery service for housebound patients.
- This population group has been rated as requires improvement as national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- This population group has been rated as requires improvement as national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Additional nurse appointments were available until 8pm throughout the week for school age children so that they did not need to miss school.
- 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.
- This population group has been rated as requires improvement as national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- Appointments offered included pre-bookable, face to face, telephone and video consultations. Patients were also able to complete an online form with details of symptoms or requests for triaging by the practice.
- The practice provided evening appointments as part of extending opening and evening and weekend appointments as part of the extended GP access service.
- This population group has been rated as requires improvement as national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

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 Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice had a designated lead for carers and bereavement to offer support and be a point of contact for these patients.
- This population group has been rated as requires improvement as national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- This population group has been rated as requires improvement as national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner.

Access to the service

People were not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The national GP survey results indicated that patients were not satisfied with access to the service which included getting through to the practice by telephone, overall experience of making an appointment, the appointment times and appointment offered. 	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	32.8%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	35.2%	62.9%	70.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	44.0%	59.7%	67.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	57.5%	76.9%	81.7%	Significant Variation (negative)

Any additional evidence or comments

- The practice was aware that telephone access was a concern for patients. An action plan had been developed to improve patients experience which included a new telephone system installed in August 2021, ongoing engagement with the patient participation group (PPG) to improve communication, increasing clinical capacity and active discussions with staff to understand and act on any issues

Source	Feedback
CQC Enquiries	Since the last inspection in February 2020, enquiries we received mostly related to patients experiencing difficulty accessing the service, with some reporting staff were unhelpful and not understanding at times.
NHS Website	There were 14 new reviews completed since the last inspection. These mostly related to patients experiencing difficulty accessing the service, being unhappy with care and treatment received. Some comments reported staff were unhelpful and not understanding at times. The practice had responded to all the comments.

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.	43
Number of complaints we examined.	Four
Number of complaints we examined that were satisfactorily handled in a timely way.	Four
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	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:	
<ul style="list-style-type: none"> There was a complaints policy and procedure and information on raising a complaint was available in the practice which included details of the parliamentary and health services ombudsman. There was also information on the website. Complaints were discussed with staff during team meetings and relevant learning shared. There was a system in place to record complaints to ensure themes and trends could be acted which included a quarterly audit. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
A number of complaints about difficulty accessing the practice by telephone	Increased staff capacity, new telephone system to be implemented August 2021

Well-led

Rating: Requires improvement

We inspected the practice in August 2019 and rated the practice requires improvement for providing well-led services as there was a lack of comprehensive assurance systems. During this inspection the rating remained unchanged as systems and processes were not always embedded to ensure risks were assessed and managed. Not all areas for improvement were progressed or sustained.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Leaders understood and acknowledged the challenges impacting on the delivery of the service which included staffing levels and access to appointments which were further impacted by COVID-19. Action taken to improve patients experience included, reviewing staffing levels and skill mix which resulted in employing additional clinical staff, joint working with local practices to provide extended access service and a new telephone system installed in August 2021. However, at the time of the inspection this had not yet resulted in improved patient experience of the service. The practice had not sustained improvements demonstrated at the last inspection in February 2020.• The practice was a designated training practice for trainee GPs. This provided potential recruitment and development opportunities on completion of training.• Staff spoke positively of leaders and reported they were approachable and supportive.	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

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

- Discussions with staff reflected the practice’s vision and values. Staff told us that they took pride in ensuring patients received a caring compassionate service. The aim was to deliver high quality care and promote good outcomes for patients. However, feedback from patients suggested this was generally not their experience of the service.
- The vision and values were not effectively monitored and delivered consistently. Issues identified at the previous inspection were not fully addressed. Actions taken to date had not resulted in improved outcomes for patients.
- The practice had a business development plan for the period 2021-2024. The plan detailed the strategic goals for the forthcoming three-year period. At the time of the inspection work was in progress to ensure the priorities and progress against delivery could be achieved.

Culture

The practice continues to develop a culture to support high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice’s speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There were provider policies for whistle blowing and duty of candour with a delegated speak up guardian which allowed staff to understand the process and refer any concerns. • We saw that team meetings took place which provided an opportunity for staff to discuss issues. • Staff said they were confident to raise any concerns locally and felt they would be listened to. 	

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

Source	Feedback
Staff interviews	There was positive feedback from staff about how the practice team worked together in the delivery of the service. Staff said they were confident in raising any issues and felt supported if they did so. Managers and clinicians were approachable and staff ideas and areas for improvement were acted on. Learning and development opportunities were encouraged and supported.

Governance arrangements

There were systems of accountability to support good governance and management. However, some areas lacked effective oversight.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Clinical and governance meetings provided the opportunity to share information and inform staff on key issues. These were minuted meetings with standing agenda items such as such as significant events, patient safety alerts and complaints. Provider policies and procedures were available in paper format and on an electronic system which were accessible to all staff. Discussions with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing. However, during the inspection we found the governance arrangements were not always embedded at practice level as policies were not consistently followed. For example, the practice was unable to demonstrate that regular reviews were undertaken of prescribing practice of non-medical prescribers as these were not documented, staff had not followed the cold chain procedure for monitoring of fridges where vaccines were stored. 	

Managing risks, issues and performance

The processes for managing risks, issues and performance were not always supported by fully embedded assurance systems.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y

Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a range of risk assessments in place, such as fire, health and safety, and legionella. However, the practice did not always have fully embedded assurance systems. For example, the performance of staff employed in extended roles could not be demonstrated through audit of their consultations, prescribing and referral decisions. There were gaps and inconsistencies in the monitoring of patients prescribed high risk medicines. The system for monitoring of vaccines was not in line with Public Health England (PHE) guidance or the providers. These risks had not been effectively managed by the practice's own quality assurance system. Leaders shared with us plans to improve access to the service however, the impact on quality and sustainability at the practice had not been fully assessed. Feedback from patients demonstrated patients were not always able to access the service in a timely manner. Staff had not received formal training in preparation for a major incident but were aware of responding to an emergency. 	

The practice did not have fully effective systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Partial
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Partial
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Partial
The practice actively monitored the quality of access and made improvements in response to findings.	Partial
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice told us that during the pandemic, there were systems in place to ensure patients who needed to be seen face to face were given appointments to attend the surgery. This was done with consideration for COVID-19 guidance for infection prevention and control. However, national patient survey results and other sources of patient feedback demonstrated patients were not always able to access the service in a timely manner. The practice was taking action 	

to improve however, at the time of the inspection this had not resulted in improved patient experience of the service.

- Leaders were aware of clinical areas for improvement and there was evidence that work was in progress to manage backlogs and improve clinical care such as monitoring of patients prescribed high-risk medicines.

Appropriate and accurate information

There was a commitment to using data and information proactively to drive and support decision making. However, this had not resulted in improvements to patients experience of the service.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
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: <ul style="list-style-type: none"> • There were systems in place to monitor performance, for example regular governance meetings. However, we identified gaps and inconsistencies in patient care and treatment and ongoing concerns with access. • The practice's use of performance information had not resulted in improved experience to patients experience of the service. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y

The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There were policies in place to support and guide staff with utilising digital services securely and effectively. This included the process and procedures for telephone, email and video consultations and for use of photographs during remote consultations. • The provider had a Data Protection Impact Statement in place to support the use of remote consultation. This included the processing of patient data, compliance and proportionality measures with reference to NHS best practice guidelines. 	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care. However, this had not resulted in improvements to patients experience of the service.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Partial
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:	
<ul style="list-style-type: none"> • Results of the recent national GP survey demonstrated that patients were not always able to access the service in a timely manner. The practice acknowledged access was an area for improvement and developed an action plan to address the issue which included implementing a new telephone system. • The practice had a patient participation group (PPG), the group had not met in person in the last year due to the COVID-19 pandemic but held virtual meetings. The PPG was a small group and there had been difficulties in recruiting new members due to lack of interest. • There were regular team meetings which included weekly clinical meetings and whole team meetings every 4-6 weeks which provided opportunities to share information and for staff to provide feedback. • The practice worked with the local primary care network (PCN) and the Clinical Commissioning Groups (CCG) to deliver services for the local practice population which included extended access and services to care homes. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • During the inspection we spoke with a member of the patient participation group. They told us of there had been some difficulty in accessing the service, this included getting through to the practice by telephone and access to appointments. The PPG acknowledged the challenges

associated with access and were aware of actions taken to help improve patients experience of the service.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Learning and improvement was encouraged through staff appraisals and meetings.• The practice made use of internal and external reviews of incidents and patient safety alerts and learning was shared and used to make improvements.	

Examples of continuous learning and improvement

- The practice was aware of the difficulties patients had experienced with accessing the service and taking action to improve by increasing staff capacity and the installation of a new telephone system.
- Clinical and non-clinical audits were completed and provided the opportunity to learn and improve for example, in the areas of prescribing.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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