

# Care Quality Commission

## Inspection Evidence Table

### The Haven Practice (1-4459548375)

Inspection date: 15 September 2021

Date of data download: 19 August 2021

## Overall rating: Good

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

Following our previous inspection on 9 July 2019, the practice was rated requires improvement overall and for the safe and effective questions. It was rated good for caring and responsive key questions. All the population groups were also rated as requires improvement. Requirement notices were issued for regulation 12 safe care and treatment, regulation 19, fit and proper persons employed and regulation 17 good governance. At this inspection we found that the practice had made improvements and the requirement notices had been met. The practice is now rated as good in all key questions and population groups.

## Safe

## Rating: Good

At our previous inspection in July 2019 the practice was rated as requires improvement for providing safe services. This was because:

- Authorisation procedures were not always followed for repeat prescriptions.
- There was insufficient evidence of action to address all safety alerts.
- Not all staff had received appropriate training in basic life support and use of emergency equipment.
- Checks of the oxygen and defibrillator were not routinely carried out and recorded.
- Appropriate recruitment checks for locum GP staff had not always been undertaken.

At this inspection we found all of our concerns had been addressed. Therefore, The Haven Practice is now rated good for providing safe services.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes

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

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in July 2019 the records maintained for a salaried GP did not include evidence of satisfactory performance in a previous role. We were told this was because the GP was known to the practice prior to employment.</p> <p>At this inspection we saw that recruitment checks were carried out in accordance with regulations. The practice demonstrated that evidence of satisfactory performance in previous roles had been sought for all new clinical and non-clinical staff including locums.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person.	Yes
Date of last inspection/test: December 2020 and March 2021	
There was a record of equipment calibration.	Yes
Date of last calibration: September 2021	

There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: October 2020	Yes
Actions from fire risk assessment were identified and completed.	Yes

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: May 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2021	Yes
Explanation of any answers and additional evidence: Daily, weekly, monthly and annual checks were carried out to monitor fire safety, security and health and safety. We saw evidence that actions identified as a result of the checks were completed. For example, external primary lighting had been installed for the alternative means of escape in the event of a fire.	

### Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 17 December 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: We saw that actions identified from the infection control audit had been implemented, for example new wipe clean seating covers had replaced fabric ones in the waiting area. All staff had received training on infection prevention and control appropriate to their role and during the pandemic the practice ensured that staff were kept up to date with new guidelines. We saw that appropriate measures to prevent and control the spread of Covid-19 had been implemented within the practice. This included seeing patients face to face only when clinically necessary and increasing the number of telephone and on-line consultations. Staff had good supplies of personal protective	

equipment relevant to their role and enhanced cleaning and disinfection regimes were in place. Screening procedures had been introduced for patients before they entered the building and there was regular Covid-19 testing for staff.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in July 2019 we identified that not all staff had received role appropriate face to face training on resuscitation. Also, not all staff had received formal training on how to use the defibrillator.</p> <p>At this inspection we found that staff had received face to face training on how to use emergency equipment and basic life support in November 2019. Because of the Covid-19 pandemic it had not been possible to arrange any further face to face training in 2020, however we saw that face to face basic life support training had been arranged for all practice staff to take place in October 2021.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.39	0.58	0.70	Significant Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	8.1%	11.4%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	4.63	5.35	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	38.3‰	154.0‰	126.9‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.50	1.05	0.66	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes

Medicines management	Y/N/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.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in July 2019 we found that that repeat prescriptions were not always properly authorised by the GP. At this inspection we saw that there was now a safe, effective system in place to ensure the GP authorised all repeat prescriptions.</p> <p>At the last inspection, we also found that the practice did not conduct regular checks to ensure the oxygen cylinder and defibrillator were fit for use. At this inspection we saw that weekly checks were undertaken and recorded.</p> <p>A CQC GP Specialist Advisor accessed the practice's systems to undertake remote searches. These searches were indicative of the number of patients at risk due to a lack of monitoring or diagnosis and further investigation of the patient record was needed to assess risks. We sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients. Our searches indicated that the practice had an effective process for monitoring patients' health in relation to the use of medicines including high risk medicines. However, we also looked at medicines usage and found that for some patients prescribed asthma relieving inhalers, proper face to face reviews had not taken place where potential over use had been indicated. After the inspection the practice confirmed they had contacted these patients to arrange an urgent review.</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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <p>All staff we spoke with knew how to identify and report significant events. There was a clear system for recording these. We saw evidence that significant events were discussed routinely at practice meetings and that learning was shared. There was evidence that action was taken to prevent re-occurrence</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in July 2019 we found that not all alerts were recorded, and it was not always clear whether appropriate action had been taken was not consistently clear.</p> <p>At this inspection we saw that the practice had improved its system for recording and acting on safety alerts. All alerts were emailed to clinicians and there was a system to record when the email had been read. Alerts were also saved on the practice's shared computer drive so that they could be easily referred to. The practice kept a log of any action taken and safety alerts were a regular agenda item for discussion at clinical meetings.</p> <p>We saw examples of actions taken on alerts, for example sodium valproate.</p>	



## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

## 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: Good

### Findings

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

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, 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 asthma were offered an asthma management plan. However, we found for some patients prescribed asthma relieving inhalers, proper face to face reviews had not taken place where potential over use had been indicated

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)	73.0%	75.0%	76.6%	No statistical variation
PCA* rate (number of PCAs).	0.6% (1)	17.5%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	91.2%	90.0%	89.4%	No statistical variation
PCA rate (number of PCAs).	2.9% (1)	20.8%	12.7%	N/A

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

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	83.3%	79.1%	82.0%	No statistical variation
PCA* rate (number of PCAs).	7.7% (3)	8.0%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	80.0%	69.3%	66.9%	No statistical variation
PCA rate (number of PCAs).	15.1% (8)	20.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.2%	69.6%	72.4%	No statistical variation
PCA rate (number of PCAs).	6.4% (13)	9.2%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	95.2%	90.8%	91.8%	No statistical variation
PCA rate (number of PCAs).	8.7% (2)	8.3%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	83.7%	71.7%	75.9%	No statistical variation
PCA rate (number of PCAs).	18.9% (10)	15.7%	10.4%	N/A

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

## Families, children and young people

Population group rating: Good

### Findings

- The practice had continued to improve the uptake of childhood immunisations and now met the minimum 90% for all five childhood immunisation uptake indicators. The practice met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four out of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations and made sure that appointments were flexible. It followed up any appointments that were missed.
- 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, 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)	24	25	96.0%	Met 95% WHO based target
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)	24	25	96.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	23	25	92.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	24	25	96.0%	Met 95% 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) (NHS England)	33	34	97.1%	Met 95% WHO based target

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 worked hard to improve the uptake of childhood immunisations. They had set up a separate page on their website to provide information for parents and promote the benefits. They produced information leaflets on the immunisations for each age group. Telephone appointments to discuss any concerns were offered to parents so that any fears could be talked about and allayed. The practice followed up on missed immunisation appointments.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The practice had adjusted the services it offered to help ensure these were accessible, flexible and offered continuity of care.
- Where clinically appropriate patients were still seen in the practice, however the practice increased the number of telephone and on-line consultations in response to the Covid-19 pandemic.
- Patients could access evening and weekend appointments including practice nurse appointments on a Saturday.
- 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: 31/03/2021) (Public Health England)	77.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	69.1%	63.3%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	68.5%	60.1%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	90.0%	90.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	50.0%	50.6%	54.2%	No statistical variation

### Any additional evidence or comments

Since our last inspection in July 2019 the practice had increased the coverage of cervical screening from 74% to 78%. Staff routinely contacted patients who had not responded to their invitation for cervical screening to encourage attendance. Telephone appointments with the practice nurses were offered to patients to enable them to discuss any concerns. Longer appointments for screening were made for patients with additional needs.

**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 considered 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.
- Patients had access to a social prescribing service for support, guidance or help with issues including benefits, housing and social isolation.
- The practice was part of a 'safe surgery' initiative whereby patients don't have to their share immigration status.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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)	94.1%	80.6%	85.4%	No statistical variation
PCA* rate (number of PCAs).	0.0% (0)	25.8%	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)	100.0%	81.7%	81.4%	No statistical variation
PCA rate (number of PCAs).	50.0% (2)	14.1%	8.0%	N/A

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

## Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	554	533.9
Overall QOF score (as a percentage of maximum)	99.1%	95.5%
Overall QOF PCA reporting (all domains)	4.2%	5.9%

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

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

Examples of improvement activity included the increase in uptake of childhood immunisations and cervical screening. Because of additional pressure from dealing with the Covid-19 pandemic, the practice had not undertaken any clinical audit activity in the last year.

## 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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the practice's training records and saw that all staff had undertaken essential training at a level appropriate for their role in areas such as safeguarding, health and safety, fire safety, information governance and infection control. We saw that clinical staff were mostly up to date with role specific training, however, because of the Covid-19 pandemic update training had been put on hold in some competency areas. It was noted that training records for role specific training were not maintained centrally but with the individual clinicians. This meant the practice did not maintain an overview or monitor renewal dates. The practice told us they would include roles specific training in their central records from now on and monitor it accordingly.</p> <p>We saw that all staff had an up to date annual appraisal. We also saw that clinical supervision took place, however the records for this did not always include details of observations and clinical notes reviews that had taken place.</p> <p>The practice closed for one afternoon every six to eight weeks to enable protected learning time for all staff.</p>	

**Coordinating care and treatment**

**Staff worked 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: The practice included a range of health promotion information on their website and supported national campaigns, for example it had a separate tab for 'Stoptober' which was aimed at helping people to quit smoking. The practice produced a regular newsletter, which focused on different health campaigns such as mental health and cervical screening.	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

## Well-led

## Rating: Good

At our previous inspection in July 2019 the practice was rated as requires improvement for providing well led services. This was because we found gaps in safety and governance processes in relation to safety alerts, repeat prescribing, and emergency equipment training and checks.

At this inspection we found all of our concerns had been addressed. Therefore, The Haven Practice is now rated good for providing safe services.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice had a business development plan, which sets out some of the key challenges to quality and sustainability, the main one being the premises that had limited space to enable growth. Acquiring a new premises and remaining as a small single-handed practice were the main challenges for the practice going forward. The practice had embraced becoming part of the local primary care network, which supports it with staff and additional services for patients.	

## Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The practice mission statement was to provide 'a quality health care service and to work with our patients to improve health and well-being and to meet new challenges for the future'. Its vision is to keep up with changes in health care delivery but to maintain its small, traditional family doctor ethos. Staff were aware of and supported the vision. The practice updated its five-year business development plan on annual basis.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: There was a recognition of the mental health impact on staff as a result of the Covid-19 pandemic. The practice had recently employed an occupational health company that offered six counselling sessions to staff. It was planning a team building event for staff with a focus on resilience.	

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

Source	Feedback
Staff interviews	Staff told us they enjoyed working at the practice. They said they felt encouraged, supported and valued. They told us they worked closely as a team. They said their training needs were met and they were encouraged to develop in their roles.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection July 2019, we found gaps in governance systems in relation to checks of emergency equipment, repeat prescribing authorisation, recruitment and records relating to safety alerts.</p> <p>At this inspection we found that the practice had reviewed its governance systems and that the gaps had been rectified. For example, we saw records to show that weekly checks of emergency equipment were undertaken.</p>	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection July 2019, we found that processes for managing risks, issues and performance were ineffective, for example in relation to recruitment checks. At this inspection we found that improvements had been implemented and effective system were in place.</p>	

Due to pressure from the Covid-19 pandemic the practice did not have a formal quality improvement plan. However, it had improved follow up systems for childhood immunisations and cervical screening and uptake rates had increased as a result.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>The practice re-organised the way it delivered services to try and meet demand during the Covid-19 pandemic. This included changing the number and type of appointments available, for example increasing the number of telephone and on-line appointments. Face to face appointments were available throughout and had increased in line with the relaxing of restrictions.</p> <p>The practice had begun to implement a catch-up plan, for example additional nurse appointments had been made available for the backlog of blood tests. As a small practice staff had not been required to work from home. Appropriate infection control procedures, which included social distancing, personal protective equipment and enhanced cleaning and disinfection regimes had been implemented.</p>	

### **Appropriate and accurate information**

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

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

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

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
The practice had an active PPG and had held six monthly 'virtual' meetings. All patients were invited to join the group at registration. The practice regularly shared information with members of the group and sought feedback. The group also linked with the primary care network patient PPG. A representative from the practice PPG attended the PCN group on a quarterly basis.	
The practice also produced a newsletter in which it shared the results of the national GP patient survey. They also used the newsletter to focus on various health promotion topics, for example cervical screening and mental health.	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
The practice had improved cervical screening and childhood immunisation rates since our last inspection. It had also been involved in local innovations which included working with the primary care network to set up the first Covid-19 vaccination service in the locality for patients over 70. It was also part of a 'safe surgery' initiative whereby patients don't have to their share immigration status.	



## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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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- $\text{‰}$  = per thousand.