Care Quality Commission

Inspection Evidence Table

Sunnyhill Healthcare C.I.C (1-520153601)

Inspection date: 14 October 2020

Date of data download: 07 October 2020

Overall rating: Inadequate

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

The practice was rated inadequate at the December 2019 inspection because:

- **Systems to support Infection Prevention and Control (IPC) were lacking.**
- **There was no analysis of significant events, complaints or patient safety that would lead to practice improvements. There was no clear learning form these events.**
- **The practice did not have a system for quality improvements. This included a lack of clinical audit and action planning.**
- **Documentation for appraisals needed strengthening.**
- **The system for following up children who may be at risk was disjointed.**

- **The practice was rated as inadequate at the October 2020 inspection because: The system to manage medicines that required additional monitoring was lacking. Clinical records that we looked at showed that not all patients had received appropriate monitoring prior to prescribing. The system to follow up patients with abnormal blood results that could indicate diabetes required strengthening as not all patients had received appropriate follow up.**
- **Documentation for completing medicine reviews was incomplete with no records of how these reviews were conducted or conversations with the patient.**
- **The business plan did not include succession planning or an action plan for practice improvements.**

The practice had made improvements in the areas of concern raised at the December 2019 inspection. We found:

- **Systems to support IPC had been strengthened and mitigating action were being taken.**
- **Significant events, complaints and patient feedback was discussed and learning was shared.**
- **Documentation for appraisals was thorough and included an analysis of learning and gave staff opportunity to raise concerns.**
- **The system for following up children who may be at risk, such as those who had missed immunisation appointments, was effective.**

Safe Rating: Inadequate

At the September 2019 inspection we rated the practice as inadequate for providing safe services because:

- **The systems and audits regarding infection prevention and control were lacking. The practice had not maintained the appropriate standard of hygiene. Some areas of the practice were in disrepair which posed a risk for infection prevention and control. There was no evidence of what cleaning had been completed.**
- **The practice had not completed a health and safety or security risk assessment. Shortly following the inspection, we received evidence that a health and safety audit had been carried out.**
- **The management of significant events was lacking with no evidence of learning or actions taken.**
- **There was limited oversight of medicine and safety alerts with no evidence of what actions had been taken in response to these.**
- **Emergency medicines were not accessible, and a risk assessment had not been completed to support the decision not to hold certain medicines.**
- **The recording of staff immunisations needed strengthening.**
- **The system to identify children who may be at risk, for example those who had not attended appointments, was disjoined.**

At the October 2020 inspection we rated the practice as inadequate for providing safe services however, we did find some areas of good practice.

- **The process to manage medicines that required additional monitoring was ineffective. Clinical records we looked at showed that patients did not consistently have blood testing prior to being issued a prescription.**
- **The documentation of annual medicine reviews was lacking. Clinical records we looked at did not detail how reviews were conducted or any conversations with patients or carers.**
- **The practice had strengthened systems regarding infection control and maintained an appropriate level of hygiene. There was evidence of cleaning of the building and non-single use items.**
- **The practice had completed health and safety risk assessments and some identified actions had been completed.**
- **Medicine and patient safety alerts were logged, cascaded and appropriately actioned. Records we looked at confirmed this.**
- **Emergency medicines were held in a place that was accessible to staff and a risk assessment had been completed to ensure they held the appropriate drugs.**
- **The practice held a record of staff immunisations.**
- **The systems to identify children who were at risk was effective and had been embedded into practice.**

Safety systems and processes

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

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

Explanation of any answers and additional evidence:

The practice safeguarding policy included details of how to escalate safeguarding concerns to safeguarding leads. However, the practice safeguarding lead was not included in the policy. Details of the community safeguarding leads were on posters within each clinical room.

The practice held monthly meetings with community safeguarding leads however, these meetings had not been taking place since the COVID-19 pandemic. There were no systems in place to conduct these meetings virtually. However, community teams such as district nurses and Macmillan nurses had been attending the Primary Care Network meetings, which the practice attended, to discuss any safeguarding concerns.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: We reviewed the process of collecting staff immunisation records at the December 2019 inspection and found that the process was effective.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 23/09/2020	Y
There was a record of equipment calibration. Date of last calibration: 02/09/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 20/08/2020	Y
There was a log of fire drills. Date of last drill: 06/10/2020	Y
There was a record of fire alarm checks. Date of last check: 26/10/2020 (conducted weekly)	Y
There was a record of fire training for staff. Date of last training: Ongoing	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 22/09/2020	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: At the time of the submission to CQC of the staff training matrix, one member of staff had not completed fire safety training however, this was completed prior to the site visit. The practice had completed several fire risk assessments and we saw that actions identified had been completed, such as moving cardboard from staff areas, however the process was disorganised and there was no clear record of actions that needed completing. One risk assessment identified that a full electrical wiring check was required however, the practice had been unable to complete all necessary remedial works and had contacted the landlord to review this action. Remedial actions had not been completed by the time of inspection.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 24/09/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 24/09/2020	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice had not completed a premises or security risk assessment.
- The practice had not completed a health and safety risk assessment at the time of inspection. This was received shortly following the inspection.

At the December 2019 inspection we found:

- The practice had used an external agency to conduct a health and safety and security risk assessment. An associated action plan had been developed and we saw that remedial work had taken place. For example, signage had been placed above hot water taps and display screen assessments had been completed for all staff.

At the October 2020 inspection we found:

- We saw that the practice had completed a further health and safety assessment and also employed an external company to complete a risk assessment. We saw that actions identified in these risk assessments, such as installing locks for staff areas, had been completed.

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.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: May 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- Actions arising from the practice infection prevention and control (IPC) audit had been completed, such as adjustments to the flooring, however the audit had not identified all the IPC concerns within the practice. For example, the lack of pedal bins and the lack of single use linings for baby change facilities. We also saw evidence of disrepair in the building, including cracked tiling, peeling paintwork and holes in ceiling tiles. These had not been reported in the IPC audit. Shortly after the inspection, the practice provided evidence that they had purchased pedal bins and colour coded mop heads.
- The practice used an external cleaning company. A cleaning audit had not been completed by the practice and we saw areas that required a deep clean. The practice was unable to provide evidence that the appropriate cleaning had been completed or that the cleaning agency was compliant with the IPC policy. Shortly after the inspection, we received evidence that a cleaning schedule had been devised with the cleaning company.
- The practice was unable to give evidence of cleaning of non-single use equipment such as ear syringing machines or blood pressure monitors. The schedule for cleaning these items was in the IPC policy however, this had not been completed.
- At the time of inspection, the practice was unable to provide evidence of a completed legionella risk assessment.

At the December 2019 inspection we found:

- The practice had completed a further IPC audit and had sought support from the clinical commissioning group who had also completed an audit. Action plans had been developed and we saw evidence that these were being completed.
- The practice had employed a new external cleaning agency and we saw that cleaning was completed to an adequate level. The practice had developed a cleaning schedule for the building and sign sheets were in place to ensure this was completed. Weekly audits of the cleaning were completed by the cleaning agency and the practice to maintain the standard of cleaning.
- The practice had developed cleaning schedules for non-single use equipment that was kept in each consultation room. We saw that this was completed on a daily basis.

- A legionella risk assessment had been completed in September 2019 and recommendations had been made to monitor water temperatures regularly. We saw that this was being completed. The practice had also requested documents from the council for the areas of the building that they did not manage, that included the boiler, to ensure the appropriate maintenance was being completed. (Legionella is a term for a bacterium which can contaminate water systems in buildings)

At the October 2020 inspection we found:

- At the time of the submission to CQC of the staff training matrix, one member of staff had not completed Infection Prevention and Control (IPC) training however, this was completed prior to the site visit.
- Actions identified in the IPC audit had been completed, for example replacing a damaged couch in the nurse's consultation room. We also saw a specific action plan regarding COVID-19 protections that were required such as use of Personal Protective Equipment (PPE) increased cleaning schedules and patient zoning for patients with and without symptoms. We saw evidence that these actions had been implemented. IPC was a standing agenda item for discussion at monthly Primary Care Meetings.
- We saw that mitigating actions to prevent the legionella, including monthly water temperature checks, were continuing.

Risks to patients

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

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

Explanation of any answers and additional evidence:

The practice had a medical emergencies policy that included ‘red flag’ symptoms to identify patients who were acutely unwell and a process for ensuring these patients had urgent medical review.

All reception staff had received sepsis training and there was a poster in the reception area to ensure they were aware of all symptoms that could indicate acute illness.

The practice had conducted a full risk assessment regarding changes needed in light of the COVID-19 pandemic, such as reduced face to face contact with patients. This ensured patient safety and was cascaded to all staff.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment, however systems to identify abnormal blood results was lacking.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

All clinical correspondence into the practice was reviewed by a clinician with appropriate changes made or referred to relevant teams.

The practice had identified that there were repeated concerns regarding delays with referrals. They had developed a tracking system to ensure patients booked appointments through electronic systems and referrals were not delayed. Patients who had not booked appointments following referrals were contacted and encouraged to make the necessary appointments.

Clinical records we checked showed some patients with abnormal blood results, that could indicate diabetes, had not been appropriately followed up. We saw that the clinical risk to these patients was low however, there was no documented rationale as to why these patients had not been reviewed. The system for identifying these patients required strengthening.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization however, patients prescribed medicines that required additional monitoring had not consistently received appropriate blood testing.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	1.23	0.86	0.85	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA)	7.3%	8.8%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2020 to 30/06/2020) (NHSBSA)	5.64	5.23	5.35	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	2.01	1.95	1.92	No statistical variation

Any additional evidence or comments
The practice was aware of the higher than average level of antibiotic prescribing. The practice told us that this was due to the high level of locum staff. They told us they had advised locum staff of the CCG formulary and which medicines to prescribe. The practice also told us that they had a high number of older patients in nursing homes who may require repeat doses of antibiotics however, we did not see any evidence of this within the practice age profile in comparison to local and national averages.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

The practice told us that regular medicine reviews were conducted however, these were not detailed within clinical records. We looked at six records and saw there was no evidence of how these were conducted or if blood test results were reviewed. There was no documentation of any discussion with patients or carers as part of these reviews. The practice told us they did not record details of medicine reviews within clinical records. They told us this would be reviewed.

Medicines management	Y/N/Partial

Records we looked at showed that patients that were on medicines that required additional monitoring had not consistently had appropriate blood testing prior to prescribing. The practice told us that some monitoring was completed by local hospitals however, these were not always added to the practice clinical records. There was not an effective system to follow up patients who had not attended for blood tests. For example, the practice had 24 patients on methotrexate and five of these had not received the appropriate blood testing. (Methotrexate is a medicine to treat rheumatoid arthritis or certain other conditions). The practice told us that two of these patients had received blood testing at external hospitals however, this was not reflected within clinical records.

We reviewed the practice system for ensuring Patient Group Directions (PGD's) and Patient Specific Directions (PSD's) at the December 2019 inspection and found effective systems in place for ensuring that non-prescribing clinicians were authorised to administer medicines.

We saw that yearly audits were completed for non-medical prescribers, including locum staff, to assess their consultation and prescribing practices. Results of these were fed back to the individual clinician. Practice nursing competencies were also assessed yearly.

The practice was aware of the slightly higher than average level of antibiotic prescribing and told us that this was due to a higher percentage of patients with chronic long-term conditions and the level of locum staff. They had not conducted any quality improvement activity or audits regarding antibiotic use however, told us that they use the formulary developed by the Clinical Commissioning Group.

The practice held all recommended emergency medicines and relevant emergency equipment. This was checked on a weekly basis.

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:	5
Number of events that required action:	5

Explanation of any answers and additional evidence:

We reviewed systems for reporting and managing significant events at the December 2019 inspection and found effective processes.

The practice reviewed all significant events and analysed these for trends and learning. We saw that significant events were discussed at Primary Care meetings.

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

Event	Specific action taken
Prescribing error by member of clinical staff.	The incident was discussed at the Primary Care meeting with all staff. Staff were reminded to check discharge letters and ensure that patients understood all prescriptions.
Vaccination fridges were turned off by external contracted staff	The practice reviewed this incident and had labelled plugs to ensure they were not unplugged. The practice contacted Public Health England and ensured any damaged vaccinations were destroyed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

We reviewed systems in place for patient safety alerts at the December 2019 inspection and found effective processes.

We saw evidence that patient safety alerts were discussed at Primary Care Meetings. Clinical records that we looked at showed appropriate actions had been taken in response to patient safety alerts.

Effective Rating: Requires Improvement

At the September 2020 inspection we rated the practice as requires improvement for providing effective services because:

- **The system for managing children who did not receive immunisations or were not brought to appointments needed strengthening.**
- **The system of staff appraisal was informal, and documentation lacked structure and detail.**
- **The practice had not completed any quality improvement activity, such as two-cycle audits. There were no audits of the prescribing practices or consultations of non-medical prescribers.**
- **The practice had not reached public health targets for the number of eligible patients receiving cervical screening.**

At the October 2020 inspection we rated the practice as requires improvement for providing effective services however, we did find areas of good practice.

- **The process for completing annual medicines reviews was unclear. The practice told us that previous blood results and prescribing history was checked however, this was not documented within clinical records. There was no evidence of discussion with patients or carers.**
- **The system to identify patients at risk of diabetes was ineffective and we saw that some patients had not received appropriate invites into the practice for further investigation or diagnosis.**
- **The systems for managing children who were not brought to appointments or receive immunisations had been strengthened and embedded into practice.**
- **The practice had a system to monitor staff training. However not all staff had completed mandatory training, as determined by the practice, when this evidence was submitted. All mandatory training had been completed by the time of the site visit.**
- **The appraisal system had been strengthened with staff receiving six monthly reviews and yearly appraisals. Staff had the opportunity to discuss learning needs, objectives and concerns. Staff told us they found this process supportive.**
- **The practice had completed two-cycle audits regarding prescribing practices however, some of these did not show improvements.**
- **Audits of consultations and prescribing practices of non-medical prescribers had been completed and we saw that this was conducted every three months.**
- **The practice had met public health targets for the number of eligible patients receiving cervical screening.**

The concerns found affect all population groups and therefore they have all been rated as requires improvement.

Effective needs assessment, care and treatment

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

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

Explanation of any answers and additional evidence:

The practice shared up-to-date guidance with staff at monthly practice meetings and also with individual clinicians as needed. Records we looked at showed care and treatment was in line with evidence-based practice.

Records we checked showed that annual medicine reviews were not clearly documented. We saw no evidence of what the reviews involved or discussion with patients or carers.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHSBSA)	1.31	0.77	0.70	Tending towards variation (negative)

Any additional evidence or comments
The practice was aware of the higher than average level of hypnotic prescribing. The practice told us they felt they prescribed appropriately, and the COVID-19 pandemic had increased anxiety within their patient population.

Older people

Population group rating: Requires Improvement

Findings

- The concerns found affect all population groups and therefore they have all been rated as requires improvement however, we did find areas of good practice.
- 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 told us they carried out structured annual medication reviews for older patients. However, clinical records for medicine reviews were not detailed and did not include a rationale for decisions made.
- 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. However, these were paused during the COVID-19 pandemic in line with NHS England guidance.
- 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

- The concerns found affect all population groups and therefore they have all been rated as requires improvement however, we did find areas of good practice.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met however, clinical records for medicine reviews were not detailed and did not include a rationale for decisions made. We looked at six records and saw there was no evidence of how these were conducted or if blood test results were reviewed. There was no evidence that this review was discussed with patients or carers.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The clinical team 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. However, in line with NHS England guidelines, this had been paused during the COVID-19 pandemic.
- 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.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	67.0%	77.2%	76.6%	No statistical variation
Exception rate (number of exceptions).	2.1% (6)	14.4%	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)	87.1%	89.6%	89.4%	No statistical variation
Exception rate (number of exceptions).	1.6% (1)	16.6%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	98.1%	94.4%	91.8%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.9% (1)	3.7%	4.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The concerns found affect all population groups and therefore they have all been rated as requires improvement however, we did find areas of good practice.
- The practice had met the minimum 90% for all of four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for two of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations. Following two contact attempts, children were referred to health visitors for review. These patients were also discussed at Primary Care meetings.
- 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. Coil and implant services were offered through the Primary Care Network of which the practice was a member.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	68	69	98.6%	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) (01/04/2018 to 31/03/2019) (NHS England)	68	72	94.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	69	72	95.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	66	72	91.7%	Met 90% minimum

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

Any additional evidence or comments
The practice was aware of the child immunisation indicators that had not met the 95% World Health Organisation (WHO) targets. They told us they had worked with the Clinical Commissioning Group to review lists of children that had not attended for immunisation and invite them into the practice.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The concerns found affect all population groups and therefore they have all been rated as requires improvement however, we did find areas of good practice.
- 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. However, these healthchecks were paused during the COVID-19 pandemic in line with NHS England guidance.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the practice. Online appointments had been paused in line with NHS England guidance throughout the COVID-19 pandemic.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England)	80.1%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	66.3%	73.2%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	53.6%	56.8%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (to) (PHE)		-		N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	80.0%	54.9%	53.8%	No statistical variation

Any additional evidence or comments
The practice had improved the uptake of cervical screening since 2018/19. The practice had developed late evening clinics for patients who were unable to attend during working hours. The practice sent text messages to make eligible patients aware of these clinics.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The concerns found affect all population groups and therefore they have all been rated as requires improvement however, we did find areas of good practice.
- Same day appointments and longer appointments were offered when required.
- The practice told us that all patients with a learning disability were offered an annual health check. However, of the 14 patients on the learning disability register, four had received a review in the previous 12 months. The practice told us that this was because they were unable to invite these patients into the practice during the COVID-19 pandemic.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The concerns found affect all population groups and therefore they have all been rated as requires improvement however, we did find areas of good practice.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Not all staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	77.8%	79.8%	85.4%	No statistical variation
Exception rate (number of exceptions).	3.6% (1)	27.1%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	85.4%	81.2%	81.4%	No statistical variation
Exception rate (number of exceptions).	10.9% (5)	13.6%	8.0%	N/A

Monitoring care and treatment

The practice had completed some quality improvement activity however, this was not always structured or focused on areas of concern.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	524.1	540.8	539.2
Overall QOF score (as a percentage of maximum)	93.7%	96.7%	96.7%
Overall QOF exception reporting (all domains)	2.1%	6.3%	5.9%

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

The practice had conducted medicine audits, for example, regarding the use of high dose opioids. The initial audit was conducted in August 2019 indicated that 111 patients were identified as being on repeat prescriptions of high-level pain relief. The practice discussed this and sought help from the Clinical Commissioning Group who identified that patients were being authorised for twice as much pain relief as recommended. Training for staff was completed and alerts were placed on relevant patient records. The audit was repeated in October 2019 and 98 patients were still receiving repeat prescriptions of high dose opioids.

The practice conducted a clinical audit regarding the recording of blood pressure for patients on hypertensive medication. We saw that in January 2020, the practice identified that 56% of patients had received annual blood pressure checks. The practice added the relevant recalls onto the clinical records and repeated the audits in October 2020 and found 60% of patients had received an annual blood pressure check. The practice told us that this change had been unsuccessful due to reduced patient interaction because of the COVID-19 pandemic.

The practice had conducted an audit regarding the level of inadequate cervical screening results as this was highlighted through data received by the practice. An audit completed in September 2019 showed that eight samples were inadequate and had to be repeated. The practice increased the length of nurse appointments, ensured senior nurses were available to support these appointments and increased the range of equipment available. The audit was repeated in March 2020 and the number of inadequate results had decreased to two patients.

The practice planned to share the results of clinical audits with the practice team at the coming practice meetings. However, the practice tell us these had not been shared because meetings had been shortened because of the COVID-19 pandemic.

Any additional evidence or comments

The practice did not have a schedule of audit of quality improvement. Any quality improvement activity was determined by the lead GP and the clinical pharmacist. This was discussed as a practice team during monthly meetings however, the practice told us these discussions had not taken place during the COVID-19 pandemic.

Effective staffing

The practice was able to demonstrate that most staff had the skills, knowledge and experience to carry out their roles, however some training was completed after it was highlighted to the practice.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

The practice maintained a tracker to monitor staff training however, not all staff had completed all mandatory training as set out in practice policy including, basic life support, health and safety, and information governance. Some training was completed after this was highlighted to the practice. Staff told us their training was monitored and they were given protected time to complete this.

The practice had strengthened their approach to staff appraisals since the September 2019 inspection and had created a tracker to identify when reviews were due. We saw that staff had six monthly reviews and yearly appraisals where they had the opportunity to discuss learning, objectives and concerns.

The practice used an external agency to complete disciplinary procedures for staff with poor performance.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives however, there was no evidence that medicine reviews were discussed with patients.

	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.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Explanation of any answers and additional evidence:

The Primary Care Network had recently employed a social prescriber to increase patient access to wellbeing and lifestyle services.

The practice had not completed all annual reviews for patients with learning disabilities in the last 12 months.

Records we looked at showed clinical records of medicine reviews were not detailed and thorough. There was no evidence that changes were discussed with patients or carers.

The practice told us that they used video consultations to enable patients to manage their own health conditions, for example, teaching patients with asthma to conduct their own peak flow readings. (Peak flow is a simple measurement of how quickly you can blow air out of your lungs. It's often used to help diagnose and monitor asthma.)

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	93.4%	94.2%	94.5%	No statistical variation
Exception rate (number of exceptions).	0.5% (4)	0.8%	0.8%	N/A

Consent to care and treatment

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

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

Caring Rating: Good

At the September 2019 inspection, the practice was rated as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental 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: Patients told us that they were treated with kindness and compassion by both clinical and non-clinical staff.	

Due to the COVID-19 pandemic, CQC comment cards were not able to be used. Prior to the inspection, patients were encouraged to complete 'Share your experience' forms through the CQC website.

CQC comments cards	
Total comments received.	40
Number of CQC comments received which were positive about the service.	37
Number of comments received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	2

Source	Feedback
CQC 'Share your Experience Forms'	Most patient feedback was positive regarding the standard of care, helpful and friendly reception staff, the practices' response to the COVID-19 pandemic and the effectiveness of the flu immunisation programme.
CQC 'Share your Experience Forms'	The negative feedback received was regarding the implementation of a telephone triage system and a delay in referrals.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	86.0%	86.1%	88.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	87.4%	84.2%	87.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	95.3%	94.1%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	84.3%	76.7%	81.8%	No statistical variation

Any additional evidence or comments
The practice was aware of the GP patient survey scores however, had not created an action plan to further improve patient satisfaction.

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

Any additional evidence
The practice had conducted a survey using social media regarding the service provision during the COVID-19 pandemic. These were largely positive with only one negative response regarding the telephone call back service. The practice told us about examples of changes made before the pandemic, following patient feedback, such as increasing the number of chairs in the waiting room. The practice also received 93% positive results for the August NHS Friends and Family test. Links to complete the NHS Friends and Family test were sent to patients following appointments. The practice had not developed an action plan to further improve patient feedback.

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

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	98.0%	91.9%	93.0%	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:

The practice had access to translation services and several members of staff who were multi-lingual.

The practice also held leaflets in easy read formats and multiple languages for patients with varying communication needs.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 56 carers which equated to 1% of their practice population.
How the practice supported carers (including young carers).	The practice completed carers assessments however, had only completed 50% of these in the last 12 months. Staff were aware of patients who had caring responsibilities and offered support opportunistically. The practice had invited 'Carers in Bedfordshire' to promote their services within the practice waiting area. The practice did not have any additional support in place for young carers.
How the practice supported recently bereaved patients.	The patient held leaflets in reception areas to signpost bereaved families to local support systems. The practice also send sympathy cards to bereaved families.

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

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence: The practice had adjusted the policies regarding telephone and video consultations in light of the COVID-19 pandemic.	

Responsive Rating: Good

At the September 2019 inspection the practice was rated as requires improvement for providing responsive care because:

- **Complaints management was lacking with no evidence of how complaints had been investigated or resolved.**
- **There was no analysis of trends or themes from complaints to enable learning and improvement.**
- **Details of how to escalate concerns to the Parliamentary and Health service Ombudsman was not available to patients.**
- **Patient feedback, such as through the suggestion box, was not analysed for themes to enable service improvements.**

At the October 2020 inspection we rated the practice as good for providing responsive services because:

- **The practice had strengthened the complaints procedure and we saw that complaints were managed in a timely way with evidence of how these had been resolved.**
- **Practice complaints were analysed for themes and learning was discussed at monthly Primary Care meetings.**
- **Details of how to escalate concerns to the Parliamentary and Health Services Ombudsman was included within the complaints leaflet and complaints response letters.**
- **Patient feedback was analysed for trends and discussed at monthly Primary Care meetings.**

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: The practice held leaflets in various languages and pictorial format for patients with varying communication needs. The practice had translation services and multi-lingual staff to support patients who did not speak English.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	7am - 6.30pm
Tuesday	8am – 6.30pm
Wednesday	7.30am -6.30pm
Thursday	8am – 6.30pm
Friday	7am - 6.30pm
Appointments available:	
Monday – Friday	Telephone, face-to-face, on the day and pre-bookable.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	94.7%	92.7%	94.2%	No statistical variation

Older people — Population group rating: Good

Findings

- Older people were offered longer appointments or home visits where appropriate.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice worked closely with a local pharmacy who provided a medicine delivery service.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions were unable to have their needs reviewed in one appointment. The practice told us they had plans to improve this.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues however, during the COVID-19 pandemic these meetings had been shortened and one meeting was held across the Primary Care Network.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- Additional nurse appointments were held after school hours for children who had become unwell during the day. All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- 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.

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice had identified that it had a higher than average number of commuters and therefore opened from 7am two mornings a week. This service had been paused during the COVID-19 pandemic in line with NHS England guidance.
- The practice ran Saturday clinics for working patients to receive flu immunisation.
- The practice was aware that it only had a male GP and therefore aimed to have a female healthcare professional available on most days. Chaperones were offered when appropriate.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• The practice held a of patients living in vulnerable circumstances including homeless people, Travellers 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 some of the delivery of its services to meet the needs of patients with a learning disability, for example longer appointments and home visiting however, not all reviews had been completed. Following the inspection, the practice told us they had plans to conduct these remotely if needed.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• The practice was able to directly book two appointments a fortnight with community mental health teams to expediate assessment for those suffering from mental health conditions. • 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. However, not all staff had completed dementia training. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: The practice used locum GPs where necessary to ensure appointments were not cancelled. During the COVID-19 pandemic, the practice triaged all patients via telephone appointments. Those who required face to face appointments were invited into the practice as appropriate. Reception staff were aware of the symptoms of COVID-19 and other acute illnesses and signposted to the necessary pathways.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	77.9%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	73.6%	58.4%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	72.7%	56.8%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	77.1%	67.5%	72.7%	No statistical variation

Source	Feedback
The NHS Website	There had been no new reviews on the NHS website since the last inspection.

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.	7
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: We reviewed the complaints process at the December 2019 inspection and saw the process was effective. We saw that complaints were analysed for themes and trends and learning was discussed at the monthly Primary Care meeting.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Delay in referral	Patients were reminded to highlight delays to the practice, and this was escalated to a specific member of staff to chase with the relevant hospital. Following a theme of complaints regarding referral delays, the practice had revised this process to ensure all referrals were tracked.
Complaint regarding clinician attitude during an appointment	Reception staff were reminded to book double appointments for those with multiple concerns. This was also discussed with the relevant member of staff.

Well-led Rating: Inadequate

At the September 2019 inspection, we rated the practice as inadequate for providing well-led services because:

- **There was a lack of analysis of significant events, complaints and patient feedback.**
- **There were no action plans in place for service improvement or how to deal with challenges to providing high-quality care.**
- **Some systems were disorganised meaning there was a risk of patient care not being followed up appropriately.**
- **There was no process for organisational audit or risk assessment.**

At the October 2020 inspection, we rated the practice as inadequate for providing well-led services however, we did find areas of good practice:

- **There were some action plans in place to manage patient risk however, there was no clear action plans for overall business and practice improvement.**
- **Clinical systems for ensuring required blood testing was completed and abnormal blood results were followed up was lacking.**
- **Medicine reviews were not adequately documented and did not include evidence of discussion with patients or carers.**
- **At the initial submission of the practice training matrix, not all staff had completed the practice identified mandatory training, such as Infection Prevention and Control and Fire Safety. This had been completed by the time of the site visit. However, not all staff had received dementia training.**
- **We saw that the practice analysed significant events, complaints and patient feedback and discussed these at Primary Care meetings.**
- **Systems had improved to ensure children at risk had been followed up appropriately**
- **There were processes in place for organisation risk assessment.**

Leadership capacity and capability

There was compassionate, inclusive and effective leadership however, there was no succession planning in place.

	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.	N
Explanation of any answers and additional evidence: We reviewed the practice strategy and improvement plan at the December 2019 inspection. We saw that risk assessments were in place to identify actions that were needed. However, some action plans were disorganised and needed strengthening. There was no succession planning in place.	

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.	N
Explanation of any answers and additional evidence: The practice had a business plan in place however, they had not developed an associated action plan to make improvements. We saw that this business plan was not discussed at board meetings. Staff we spoke with were aware of the practice vision and felt involved in practice improvements. Significant events, complaints and patient feedback were shared with all staff at practice meetings.	

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.	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.	Partial
Explanation of any answers and additional evidence: We reviewed the whistleblowing policy at the September 2019 inspection and found the process was effective. At the first submission, to CQC, of the staff training matrix, not all staff had received equality and diversity training, however all training had been completed by the site visit. Staff told us they were able to raise concerns with management teams and they were confident these would be addressed.	

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

Source	Feedback
Staff interviews	Staff told us they felt proud to work at the practice and were able to raise concerns and suggestions to improve care. They told us their well-being had been considered during the COVID-19 pandemic.
Staff Questionnaires	Staff told us that they were supported by management teams and received feedback regarding significant events, complaints and patient feedback. They told us there was a caring culture that encouraged teamwork.

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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: At the December 2019 inspection, we saw that there had been improvements in governance structures. We saw that complaints, significant events and patient feedback was discussed at regular meetings and improvements were made.	

Managing risks, issues and performance

They had clear processes for managing risks, issues and performance however, did not have an action plan for service improvements.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial

Explanation of any answers and additional evidence:

At the December 2019 inspection we found that the practice had a system of audits and improvement activity. We saw that risks, such as health and safety and infection control and prevention (ICP) were managed and mitigating actions taken.

The practice had a major incident plan in place however, this had not been updated to include learning from the COVID-19 pandemic.

The practice had a business plan in place however, this did not include a clear action plan to make practice improvements.

Appropriate and accurate information

The practice demonstrated that data was reviewed however, there was not consistent action taken from this data to improve practice.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: The practice did not have fully a established system to drive improvement. This included through audit for example to improve antibiotic and hypnotic prescribing. Systems to manage risk also required development. Whilst there was learning from significant events, complaints and patient feedback the arrangements for medicines monitoring and managing blood test results were lacking.	

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

At the December 2019 inspection, we saw that the practice had improved communication with the Patient Participation Group (PPG), and they met regularly. During the COVID-19 pandemic, the PPG had met virtually.

We saw that the practice reviewed patient feedback and discussed this at Primary Care meetings.

Staff told us they felt part of service improvements and had regular updates regarding any changes to the practice processes.

Feedback from Patient Participation Group.

Feedback
The Patient Participation Group (PPG) met quarterly. This had been moved online during the COVID-19 pandemic. The PPG told us they felt involved in practice developments and were able to give feedback regarding care and treatment provided. They told us they were involved in patient feedback and the practice was open to suggestions of improvement. The PPG told us that the practice had kept them informed of all changes to service delivery throughout the COVID-19 pandemic and felt the practice had worked hard to keep patients and staff safe.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation, however the overall business plan needed strengthening.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

The practice had made improvements following the inspection in December 2019 and we saw evidence of learning and improvements from significant events and complaints. However, there was limited improvement planning regarding patient feedback and lower than average clinical indicators.

The practice had a business plan in place however, this did not include succession planning or an overarching action plan for service improvements.

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 practices 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:,

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.