

Care Quality Commission

Inspection Evidence Table

The Cambridge Practice (1-5522693627)

Inspection date: 8 September 2021

Date of data download: 27 August 2021

Overall rating: Good

At our previous comprehensive inspection in July 2019, we rated the practice as Requires Improvement overall because:

- There were gaps in the systems to assess, monitor and manage risks to patient safety, specifically gaps within the recruitment processes and safeguarding processes.
- Some governance systems were not operating effectively.

At this inspection in September 2021, we saw the practice had made significant improvements since our previous inspection in July 2019 and the new overall rating is Good.

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

Safe

Rating: Good

At our previous inspection in July 2019, we rated the practice as Requires Improvement for providing safe services because:

- There were inconsistencies in the recruitment processes and safeguarding arrangements. We also saw actions from various health and safety audits and assessments had not been completed.

At this inspection in September 2021, we saw the practice had made significant improvements in the provision of safe services, the new rating for this key question is Good.

Safety systems and processes

The practice had improved 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
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
Explanation of any answers and additional evidence: At the July 2019 inspection, we saw the practice had systems and processes to keep people safe and safeguarded from abuse, although some areas required a review. For example, safeguarding training needed a review and the process for checking and recording employees' backgrounds via a DBS check was inconsistent. At the September 2021 inspection, we saw improvements had been made, for example: <ul style="list-style-type: none">• A new role had been created to strengthen the safeguarding processes within the practice. This was a safeguarding administrator role and they worked alongside the clinicians and the management team to coordinate safeguarding reports and correspondence.• Staff spoke confidently of how and when to raise safeguarding concerns and all were trained to the appropriate training levels.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> To further improve and strengthen safeguarding processes we saw the practice had completed a range of additional safeguarding risk assessments. For example, we saw a risk assessment which evaluated the risk and safeguarding implications for children who did not attend a booked appointment. A revised process had been introduced, which had standardised employee background checks. During our review of recruitment records, we saw appropriate DBS checks had been completed and recorded. 	

Recruitment systems	Y/N/Partial
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 the July 2019 inspection, we saw from our review of recruitment files that key documents were missing, for example, evidence of clinical qualifications, identity checks and the vaccination status of clinical staff.</p> <p>At the September 2021 inspection, we reviewed three recruitment files and saw improvements had been made, for example:</p> <ul style="list-style-type: none"> We saw there was an appropriate recruitment policy that set out the standards the practice followed when recruiting clinical and non-clinical staff. We reviewed the recruitment files and process followed for three of the most recently recruited members of staff and found the practice had completed relevant and appropriate recruitment checks. This included the process to record staff vaccination and immunisations which had been revised. All existing staff had provided evidence of individual records and for all new members of staff, the recruitment process now included a section on vaccinations and immunisations. 	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <ul style="list-style-type: none"> Date of last inspection/test: August 2021 – both sites 	Yes
<p>There was a record of equipment calibration.</p> <ul style="list-style-type: none"> Date of last calibration: February 2021 – both sites 	Yes

There were risk assessments for any storage of hazardous substances for example, asbestos, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: May 2021 – both sites	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Both sites had a lead member of staff who managed the safety systems and assessments within each building. The Aldershot Centre for Health is a multi-occupancy building which included other health services, the practice lead worked with NHS Property Services and the other services to maintain the safety of the building. This included monthly Business User Group meetings which discussed and reviewed facilities and premises. 	

Premises, security and health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: May 2021 – both sites	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2021 – both sites	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Aligning to the improved general governance and approach to risk within the practice, there was a live and interactive 'key date calendar' built into the governance framework. This calendar covered key dates throughout the year for both the main practice and the branch practice and included various timetables of when the different checks and risk assessments required repeating. 	

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: <ul style="list-style-type: none"> 17 August 2021 – main site (Aldershot Centre for Health) 2 January 2021 – branch site (Lower Farnham Road) 	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: <ul style="list-style-type: none"> We saw from the infection control audits a high level of compliance to infection prevention and control (IPC) standards and this aligned to a practice specific policy and standard operating procedures to manage the COVID-19 pandemic. We also saw the practice had completed a variety of infection risk assessments for both sites throughout the COVID-19 pandemic, and this included an IPC audit for the Isolation Zone used at the main site. One of the significant events we reviewed featured a delay of collection of clinical waste. During our visit in September 2021, we saw clinical waste was stored safely and there hadn't been any further delays in collections. 	

Risks to patients

There were appropriate 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a workforce lead who reviewed busy periods and peaks in activity to ensure the number of required staff and the skill mix at both sites aligned to patient levels and safe staff workload. This information was shared each week at the executive team meeting and actions were taken if required. 	

- In July 2021, the practice introduced an 'urgent care triage system' – this system provided resilience for any short term GP absence.
- In June 2021, all of the reception and patient services team had completed additional training to identify and respond to medical emergencies. This training was called 'sign posting and prioritising medical emergencies' and there was an additional module which included urgent reception triage training. Staff we spoke to advised this training was useful and included a variety of medical emergency scenarios, including sepsis, stroke and suspected heart attack.

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
<p>Explanation of any answers and additional evidence:</p> <p>We saw the practice had created and introduced a colour coded activity dashboard which monitored and audited activities which managed the information used to deliver safe care and treatment. The dashboard included different elements which managed patient information, for example:</p> <ul style="list-style-type: none"> • An activity tracker which monitored workflow and information relating to new patient registrations. • A daily audit of referrals, test results and prescription requests. 	

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) (01/01/2021 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.64	0.63	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	10.9%	10.8%	10.0%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2020 to 30/06/2021) (NHSBSA)	6.25	5.56	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	111.0‰	71.8‰	120.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 30/06/2021) (NHSBSA)	1.09	0.63	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	6.0‰	5.3‰	6.7‰	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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
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
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.	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
Both sites 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> <ul style="list-style-type: none"> As part of our review of medicine management arrangements, we also reviewed a variety of medicine and prescribing audits. These were predominately completed by the clinical pharmacist with additional input by other clinicians. Several of these were single cycle/first cycle audits with confirmed second cycles planned. Since the July 2019 inspection, we saw the practice had continued to review prescribing and where required made improvements. For example, we saw the practice had improved their prescribing of antibacterial prescription items (more commonly known as antibiotic prescribing) and hypnotic medicines. (Hypnotic medicines are commonly known as sleeping pills; are a class of psychoactive drugs whose primary function is to induce sleep). The practice's most recent data indicated the prescribing of these medicines were more comparable to local and national averages. 	

Medicines management	Y/N/Partial
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During the September 2021 inspection we undertook extensive remote (offsite) searches on the practice’s clinical systems. These searches aligned to the findings of in-house medicine optimisation audits and reviews by the clinical pharmacist which identified that patient records were accurate and contained up to date recording of reviews of their medication. For example:

- The clinical searches identified 55 patients who had been prescribed Methotrexate (a type of medicine called an immunosuppressant, used to control the body’s immune response and help reduce inflammation) in the 12 months preceding the search, 53 of the 55 (96%) were coded as having received the necessary monitoring on the clinical system. We saw clear rationale for the two remaining patients who hadn’t had the monitoring, for example, one patient was outside of the UK at the time of their monitoring.
- The clinical searches identified 13 patients who had been prescribed Lithium (a medicine used to treat bipolar disorder and other long-term episodes of mania and depression) in the 12 months preceding the search. We saw all 13 (100%) were coded as having received the necessary monitoring on the clinical system. This included monitoring one week after starting treatment, one week after every dose change, weekly until the levels were stable then once levels are stable, levels measured every three months.

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:	17
Number of events that required action:	17

Explanation of any answers and additional evidence:

- Staff had access to an incident reporting procedure and a significant event record e-form, this was then shared to a designated email address for a full review. Significant events were recognised, recorded, investigated, and the learning identified and shared and reviewed.
- Significant event meetings were held monthly, and significant events were a standing agenda item at the bi-monthly corporate governance meetings.
- Staff we spoke with were able to share examples of significant events, including actions taken in response.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
<p>Vaccine refrigerator failed annual calibration –</p> <p>Practice alerted that a vaccine refrigerator had failed an annual calibration. This had happened despite twice daily checks being logged. The practice was unable to ascertain the date of start of concern, therefore all vaccines destroyed, and a new refrigerator ordered.</p>	<ul style="list-style-type: none"> • Reported to Public Health England (PHE) Screening Team. • Completed a vaccine storage incident check list. • Reviewed and submitted refrigerators temperature log recordings for the year to PHE. • Identified all patients who had received vaccines at the surgery since the previous calibration (October 2019). • Contacted all vaccine manufactures who supplied the vaccines to check and confirm vaccine safety/stability.
<p>Clinical waste – nine-day delay in collection</p>	<ul style="list-style-type: none"> • Practice team alerted to a delay in collection and the safety implications that this could create to staff, patients and visitors. • Immediate engagement with the clinical waste contractors and the local Clinical Commissioning Group. • An additional step added to the clinical waste audit trail, whereby a weekly check on the day of planned collection was scheduled to ensure this did not happen again.

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> <ul style="list-style-type: none"> • There was a revised process to receive, cascade and review alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts within the practice. Alerts were reviewed to see if they were relevant to general practice, distributed and searches undertaken to identify patients affected. We saw appropriate action had been taken to address alerts and drug safety updates issued. During our clinical searches, the practice advised they were in the process of retrospectively running historic alerts through the new process to ensure all alerts and actions had been acted upon. 	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
<ul style="list-style-type: none">• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified were referred to the local multi-disciplinary team (consisting of a Consultant Geriatrician, a GP lead and the members of the Integrated Care Team) to provide interventions following 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.• Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.• The practice provided GP services to a local care home which includes a 'Discharge to Assess (D2A)' unit for older people (approximately 59 patients). We spoke with a manager from the home; they praised the practice, the designated clinicians and the level of 'two-way' communication with the practice to support effective care and treatment and improve treatment for their residents. This included direct access via a designated telephone line and electronic messaging service. They also highlighted the coordinated approach for the management of medicines and patient referrals.

People with long-term conditions

Population group rating: **Good**

Findings

- The practice had introduced a 'House of Care' to optimise the care for patients with long-term conditions. The House of Care is a framework for a coordinated service model that enabled patients with long-term conditions and practice clinicians to work together to determine and shape the support needed to enable patients to live well with their condition.
- Patients with long-term conditions were provided with appropriate care, for example, adults with newly diagnosed cardio-vascular disease were offered statins, patients with atrial fibrillation were assessed for stroke risk and patients with respiratory conditions were offered rescue packs and management plans.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

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%	76.6%	76.6%	No statistical variation
PCA* rate (number of PCAs).	12.9% (166)	10.8%	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)	91.4%	89.6%	89.4%	No statistical variation
PCA rate (number of PCAs).	4.2% (21)	10.9%	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)	75.7%	81.3%	82.0%	No statistical variation
PCA* rate (number of PCAs).	2.4% (11)	4.4%	5.2%	N/A

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	55.5%	66.2%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	5.1% (64)	14.0%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	61.0%	70.5%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.4% (75)	5.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	92.0%	92.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.9% (11)	5.2%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	58.8%	76.2%	75.9%	Variation (negative)
PCA rate (number of PCAs).	5.0% (63)	9.9%	10.4%	N/A

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

Any additional evidence or comments

As part of this inspection, we reviewed further clinical long term condition outcomes, specifically diabetes and hypertension. We saw the practice had a higher prevalence of patients with long-term conditions when compared to local and national averages. For example:

- Diabetes prevalence within the practice was 8.8%, compared to the local average of 6.8% and national average of 7.1%.
- Hypertension prevalence within the practice was 16.4%, compared to the local average of 13.6% and national average 14.1%.

We also reviewed additional sub-indicators recorded via QOF for diabetes and hypertension and saw:

- 87% of patients with a COPD diagnosis was confirmed by spirometry. This was higher when compared to the local CCG average (80.7%) and the national average (80.2%). Spirometry is a test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath.
- 84% of patients with diabetes, with a diagnosis of nephropathy (protein in the urine) were currently treated with an inhibitor. This was higher when compared with the local CCG average (82%) and the national average (78%). Inhibitors have been shown to reduce the progression of renal disease in patients with diabetes.

Findings

- The practice had made improvements and now met the minimum 90% for four of five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five of five childhood immunisation uptake indicators.
- The practice had arrangements for following up failed attendance of children’s appointments 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.
- Although co-located in the same building as a sexual health clinic, practice patients could access practice clinician’s sexual health and contraception advice.
- 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)	273	293	93.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	293	318	92.1%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	295	318	92.8%	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)	295	318	92.8%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	271	317	85.5%	Below 90% minimum

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

Any additional evidence or comments

At the July 2019 inspection, the practice highlighted a delay in the immunisation data submission for the collection period April 2018 to March 2019. We reviewed the most recent immunisation data for April 2019 to March 2020 and saw the immunisation uptake had increased significantly. For example:

- There had been a 13% increase in the uptake for children aged one who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b, Hepatitis B.
- There had been a 16% increase in the percentage of children aged two who have received their immunisation for Haemophilus influenza type b and Meningitis C.
- Although still below the WHO minimum, the percentage of children aged five who had received immunisation for measles, mumps and rubella (two doses of MMR) continued to increase each year. For example, in 2018 uptake was 70.6%, in 2019 uptake was 73.5% and in 2020 uptake was 85.5%.

The practice advised that despite the pandemic, the revised processes and engagement with the parents and guardians of children due to have immunisations had continued. We also saw, following successful practice nurse recruitment and training, there were now five nurses available and dedicated clinics to deliver the immunisation improvement action plan and one trainee practice nurse training in the administration of immunisations.

Early unverified data from Sept 2021 has indicated further improvements had been made, for example:

- 90% of children aged five had received immunisation for measles, mumps and rubella (two doses of MMR) (Snapshot: 02/09/2021). This was a 5.5% improvement from the previous data collection point and had met the WHO minimum threshold.

We also saw the practice used the branch site at Lower Farnham Road as a 'cold' site for all newborn baby checks and vaccinations to keep newborn babies as safe as possible. Wherever possible these appointments coordinated the eight-week check with the eight-week vaccination to avoid additional visits to the practice during the pandemic.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients had a range of online options available including access to appointments and repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	68.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	69.6%	71.0%	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)	62.9%	62.2%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	86.9%	94.2%	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)	35.4%	47.1%	54.2%	Variation (negative)

Any additional evidence or comments

The practice team, specifically the nursing team understood the challenges facing the practice to increase uptake rates for eligible women requiring cervical cytology screening. There was an improvement plan to increase the uptake for cervical screening, however this action plan had several different pauses throughout the COVID-19 pandemic, this included the delivery lead for the improvement plan shielding during the peaks of the pandemic. The improvement plan included:

- A review of the cancer screening programmes within primary care in the local area. This review highlighted the practice used several different codes to record a completed screening and not all the codes fed into the overall submission. Following the review, it was agreed the practice would use one single code for a completed screening which did align to the submission.
- The use of case tracker and case finder software to highlight any potential missed patients and ensure these patients were included in recall and reminder correspondence.
- Participation in the national cancer diagnosis audit to provide a new insight into cancer screening and diagnosis.
- An increase in the number of trained nurses who can complete the cervical screening.
- Education sessions for non-clinical staff to highlight the importance of cancer prevention and screening.

- The creation of cervical screening clinics included clinics during extended hours opening hours.

The practice presented live unverified data during the September 2021 inspection and we saw the improvement plan, although in the first phase had delivered gradual improvement. For example, the combined uptake rates were 71.5% (women aged 25 to 49 was 65% and women aged 50 to 64 was 78%). This was a three-percentage improvement on the March 2021 snapshot data.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- The practice had a designated team with three separate leads to support people with a learning disability. Three leads completed home visits, checks, reviews and assessments to this cohort of patients. We saw there was a learning disability register with 133 patients and all 133 (100%) had been offered an annual health check. In the last 12 months, 80 patients in this group of 133 (60%), had received a health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances and referred to local substance misuse services when appropriate.
- Health promotion activities and translation services had been improved and enhanced for members of the Nepalese community registered with the practice, approximately 3,000 and continuing to increase. This included health promotion videos and the appointment of a Nepalese support worker to join the practice team. On appointment, the Nepalese support worker highlighted several key projects to improve the support, care and treatment for this community. These projects aligned to the values and beliefs of the Nepalese community. For example, one project highlighted a stigma of declared mental illness within the Nepalese community, with patients often describing mental illness as physical symptoms – frequently as pain. As a result, this cohort of patients often presented very late in their mental health journey, often at crisis point to Emergency Departments at the local hospital or to other emergency services including the police. We saw several Nepalese members of the practice team, including a Nepalese health care assistant (HCA) and GP appeared at a large community event to raised awareness of mental health issues and dementia. Following this event, the HCA also was interviewed on Gurkha radio about mental health to communicate the messages and health campaigns to a wider local and national audience.
- Being in the centre of Aldershot (an Army town), the practice was a ‘Veteran Friendly Practice’ and identified all Veterans to deliver the best possible care and treatment for patients who have served in the armed forces, in line with the Armed Forces Covenant. This information was collected on the veterans register which at the time of the September 2021 inspection had 145 patients on the register. To further support Military Veterans, the practice had close links with a national charity for Veterans’ mental health.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required. There was also a quieter waiting area within the main practice, should a patient require a quiet, calm, distraction free waiting area prior to their appointment.
- 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. This included ongoing reviews of prescribing rates which highlighted opiate and other analgesics as a potential marker of hidden mental illness (opiates and analgesics are medicines used to control and ease moderate to severe pain).
- 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 to the local memory clinic for diagnosis.
- All staff had received dementia training.
- The practice had reviewed locally commissioned services for Mental Health. This review had highlighted a gap between the Community Mental Health Recovery Services (CMHRS) and Improving Access to Psychological Therapies services (IAPT). One of the GPs, who had a special interest in mental health, prepared and presented a business case for a new mental health Integrated Care Service, the local Primary Care Network (PCN) accepted and funded this proposal. This new service sees all patients who fall between mental health services, their notes are shared to enable cohesion of care and has since expanded to include a consultant psychiatrist to help with medicines.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	95.4%	87.6%	85.4%	No statistical variation
PCA* rate (number of PCAs).	13.8% (21)	11.2%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	66.7%	81.1%	81.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	6.5% (10)	6.4%	8.0%	N/A

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

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	525.4	533.9
Overall QOF score (as a percentage of maximum)	94%	95.5%
Overall QOF PCA reporting (all domains)	3.6%	5.9%
Any additional evidence or comments		
<p>In February 2021, the practice recruited a quality lead into the practice team. This role was created to monitor performance and quality outcomes to improve the overall quality of services provided, both clinically and through patient satisfaction.</p> <p>We saw the quality lead had reviewed previous QOF submissions to ensure outcomes either remained high or the outcomes that required improvement had the required actions to address these areas of low performance.</p> <p>Early interventions had resulted in the appointment of designated clinical and administrative leads for different conditions, the creation of detailed reports and plans, both action plans and recovery plans to improve outcomes, including those outcomes recorded via QOF submissions.</p> <p>Furthermore, we saw individual conditions, including a range of long-term conditions (asthma, COPD, hypertension and diabetes) and mental health conditions including dementia had specific action and recovery plans. For example:</p> <ul style="list-style-type: none"> The diabetes action plan included actions such as enhanced diabetes training for clinicians and a work stream to review potential new or missed diabetes diagnosis. This included all patients diagnosed with Gestational Diabetes, to review possible new diabetes diagnoses and provide targeted health promotion advice including the importance of weight loss and exercise to mitigate risk of developing diabetes. 		
		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.		Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.		Yes
Any additional evidence or comments		
<p>As a training practice, the practice demonstrated a long tradition of completing improvement activities including clinical audits. We saw evidence of clinical audits, undertaken by the GP Registrars with the support and mentorship of a practice GP, as a GP Trainer.</p>		

We reviewed one of the audits completed by a GP Registrar and saw the first cycle of audit had highlighted an area of improvement in the management of blood chemistry (electrolytes, urea, and creatinine) in older patients and patients with renal impairment. An intervention was made, 40 additional patients had been invited for an annual review/blood test. The intervention also highlighted two patients had developed additional needs and were now housebound, these patients were referred to the district nurse team and added to the practice's cohort of vulnerable/housebound patients.

We saw the findings had been discussed and evaluated to fully assess the effectiveness of the intervention. The preliminary results did suggest that the intervention was effective in helping to combat the backlog of missed biochemistry tests monitoring due to the COVID-19 pandemic.

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

Any additional evidence or comments

Nepali health outcomes audit

- One of the practices strategic objectives was to tackle health inequalities. The GP lead for health inequalities worked with the practices Nepalese Support Lead to review and improve health outcomes for the Nepalese community, approximately 3,000 patients and continuing to grow.
- This audit reviewed disease prevalence in the Nepalese patient population over an eight-year period, between 2013-2021. The most recent cycle of audit highlighted prevalence rates for all long-term conditions had increased, notably rates of patients with diabetes and hypertension had increased, a 4% increase in diabetes prevalence and a 5% increase in hypertension prevalence.
- Audit findings, existing patient engagement and the COVID-19 pandemic highlighted further health inequalities and as a result the practice recruited a Nepali support worker to coordinate work for this cohort of patients.
- A further cycle of audit was completed in August 2021 and reviewed the impact of the appointment of the support worker and coordinated approach in health promotion and engagement. This cycle highlighted improvements had been made in controlling diabetes, for example the number of patients with controlled blood sugar levels (HbA1C below 60) had increased.
- Furthermore, the audit highlighted the impact the support lead had in increasing both COVID-19 vaccinations and completing COVID-19 tests when patients had known contact with a positive case or when displaying symptoms.
- The practice advised, although only a six-month snapshot it was satisfying to see the reversal of some of the health inequalities previously observed and the impact of the Nepalese Support Lead.

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> <ul style="list-style-type: none"> • There was a member of staff designated to manage, allocate and resource training and development for practice staff. Staff provided feedback that there had been an increased focus on developing staff and more opportunities had become available. Staff also told us how the practice had encouraged and supported them to develop in their roles, for example two of the three health care assistants (HCA) had completed their care certificate and two HCA's were currently completing the required modules. • Throughout our review of information and through discussions with staff we saw a variety of opportunities were offered, this included formal training sessions, job shadowing, job rotation, training provided by the local CCG and Wessex Local Medical Committee (LMC) training courses. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> One of the audits we reviewed during this inspection was an audit of referrals for patients referred into the COVID-19 'Hot Site'. A COVID-19 'Hot Site' is a designated location for the face-to-face assessment of patients with suspected coronavirus symptoms. The purpose of this audit was to ensure patients were safely moved into and between services. 	

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: <p>We saw that due to the local area being in an area of high deprivation, and high morbidity, the practice had a focus on early identification and prevention of developing chronic diseases and supporting people to improve their health and wellbeing. For example:</p> <ul style="list-style-type: none"> The lead GP had a special interest in health promotion and presented regular awareness sessions to practice staff to improve the practice populations health. These sessions aligned to the different outcome improvement action plans, topics included smoking cessation (in line with the respiratory conditions asthma and COPD action plans) and tackling obesity (in line with the diabetes, stroke, hypertension and cancer action plans). There had been a meeting with the local college head to work with younger people on health issues and jointly promote health prevention. 	

- We also saw a recent osteoporosis prevention update for all staff (osteoporosis is a health condition that weakens bones, making them fragile and more likely to break). This update included information for patients and staff such as regular weight bearing and muscle strengthening exercises, adequate calcium and vitamin D intake, avoiding smoking and alcohol in moderation. The next osteoporosis update was planned for the end of 2021 and will be led by a Consultant Rheumatologist from the local hospital trust.
- As part of the diabetes action plan and implementation of the 'House of Care' to improve diabetes outcomes, we saw the practice made full use of an online self-management support programme for those living with type 2 diabetes. We also saw the practice now accessed the 'very low-calorie total diet replacement programme' for diabetic patients who met the criteria. Following training, the practice completed a search on the clinical records system and identified 336 eligible diabetics, invitations to join the programme had been sent and at the time of our September 2021 inspection 40 patients had accepted and joined the programme. One of the first patients had lost over five stone in weight, reversed their diabetes diagnosis and was no longer on diabetes related medicine.
- We also saw the practice had worked with other practices within the PCN, CCG and Integrated Care System (ICS) to review health promotion post COVID-19. This included changes in patient behaviour as a result of the pandemic and lockdown restrictions.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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 Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • One of the new processes that had been introduced was an audit which searched and reviewed consent documentation for minor operations, coil fitting and contraceptive implants. 	

Well-led

Rating: Good

At our previous inspection in July 2019, we rated the practice as Requires Improvement for providing well-led services because:

- There were inconsistencies in the governance around recruitment processes and safeguarding arrangements. We also saw actions from various health and safety audits and assessments had not been completed.

At this inspection in September 2021, we saw the practice had made significant improvements since our previous inspection in July 2019 and the new overall rating is Good.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels and leaders demonstrated that they had the capacity and skills to deliver high quality sustainable care.

	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:	
<ul style="list-style-type: none">• Since the last inspection in July 2019, there had been a number of changes in the leadership of the practice. For example, the appointment of a head of nursing and quality who had recently become the executive manager and joined the partnership. We also saw a new operational manager had been appointed and more recently in July 2021, eight new team leader roles had been created.• The leadership team had a comprehensive understanding about the changes in general practice, with a view to improve patient care and access, and invested in new ways of providing primary care. This included the challenges faced during the COVID-19 pandemic and closer work with the other practices within the Primary Care Network.• Interviews and feedback from staff confirmed that the local and wider leadership team were approachable and had been proactive in supporting the practice team during the pandemic and making changes to improve the practice. Further staff feedback advised the changes in the management and leadership of the practice had improved morale and communication.• We saw different managers; team leaders and supervisors had commenced a variety of leadership and management training programmes. We were told this training was a vital part of the practice's succession plan.	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had several themed business plans which fed into the larger business strategy; however, practice staff advised the main priorities in the last 17 months had been providing accessible primary care throughout the pandemic and working towards their action plan in relation to areas for improvement highlighted at the previous CQC inspection. The practice vision was '<i>Working in partnership with patients, staff and our community to improve health and wellbeing for all</i>' and through our engagement with staff, they could all describe how their roles contributed to the practice vision. Staff told us they were involved in the creation of the five practice values – 'One Team, Safety, Courage, Accountability and Respect' which when linked formed 'The OSCAR's'. We saw the 'The OSCAR's' had been embedded into various different elements of the practice to ensure the practice values were central to everyday life in the practice. For example, they were linked to training, recruitment processes, meeting etiquette and social staff engagement. 	

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:	
<ul style="list-style-type: none"> • Staff we spoke to told us they felt able to raise concerns with the management team and were confident their concerns would be handled appropriately. Significant events and complaints information showed the practice was open and honest when things went wrong, and we saw the practice apologised to patients where appropriate. • We saw all members of staff had an individual risk assessment which assessed the risk of COVID-19 and their personal circumstances. The risk assessments also highlighted workplace adjustments and additional support that could be offered for practice staff and their families. Staff told us, at times during the pandemic, it was 'scary and frightening', however the support and leadership offered by the practice reduced any safety fears • The practice highlighted recruitment and retention concerns across the NHS and primary care, these concerns had increased during the different stages of the pandemic. We saw there was a GP Wellbeing Lead within the practice to support practice staff, this included the promotion and facilitation of two mental health meetings for practice staff. We saw records which shows the events were well attended and staff told us there was an opportunity for individual staff members to share difficult experiences of their own mental health issues experienced during the pandemic. Following the success of these two events, the practice arranged several of the reception team and two GPs to attend respectively, 'Mental Health First Aid' courses and 'Mental Health in the workplace' courses. 	

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

Source	Feedback
Staff feedback – verbal and written	<ul style="list-style-type: none"> • Staff highlighted the new improved culture within the practice and a variety of actions taken to improve both in terms of patient experience and staff experience. Staff told us they were looking forward to further work with patients to make additional improvements. • Staff told us that they felt well supported and that the morale had improved. They felt they belonged to a good team, who looked out for each other. Staff told us they felt involved in decision making within the practice and felt safe at work. • There were both new members of staff and members of the team who had been with the practice for many years. Staff advised the blend of new staff alongside experienced staff had created a positive combination and there was a sense of togetherness despite being in two different sites (Aldershot Centre for Health and Lower Farnham Road) and staff spoke of being in one team.

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
Explanation of any answers and additional evidence:	
<p>Evidence and staff feedback collected during this inspection highlighted the previous governance concerns had been addressed, improved and were now sustained, despite the COVID-19 pandemic. Staff told us the changes in the leadership and management of the practice had helped formalise procedures, assist with clinical, safety and governance aspects and ensured risks were assessed and managed. For example:</p> <ul style="list-style-type: none"> • Safeguarding – systems and processes had been revised to govern safeguarding within the practice. This included the appointment of a safeguarding administrator, role specific training to the correct safeguarding levels had been completed and additional safeguarding related risk assessments embedded. • Recruitment – the processes and policies used to recruit new members of staff had been improved and now reflected national guidance and regulation for safe recruitment. This included completion of background checks and documented records of staff vaccinations and immunisations. • Health and safety – we saw the governance of the practice facilities, specifically the health and safety of both sites had improved. There was a designated manager who led on health and safety at each site and there was a live and interactive health and safety ‘key date calendar’ built into the governance framework. 	

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.	Yes
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
Explanation of any answers and additional evidence:	
<p>Throughout the inspection we discussed the management of risks with the practice team. The management team spoke confidently of how they were identifying, managing and mitigating risks, this included practice specific risks, national risks within primary care and risks highlighted during the COVID-19 pandemic. Furthermore, our discussions included how the practice was making the required improvements following our July 2019 inspection.</p> <p>Several workstreams had been created to mitigate known risks, for example:</p> <ul style="list-style-type: none"> The practice had acted on feedback from patients and staff regarding access to appointments, the phone systems and subsequent long delays for incoming calls to enter the practice phone system. As a result, the number of inbound call lines had doubled, from five lines to ten lines, including the creation of a back office at the branch practice which could also receive inbound calls. Early feedback from staff advised these changes had been positive but the practice sought further improvements and introduced e-Consult (e-Consult is an online triage platform that allows patients to make medical or administrative requests to their NHS GP practice). Despite the launch of e-Consult, the practice advised there had been a recent and sustained peak in inbound calls to the practice. To further mitigate and reduce waiting times, there was a new escalation process whereby team leaders could log on and temporarily join the reception team to manage the inbound calls. The practice had also consulted with staff and created two separate sub teams, to manage inbound calls, one team of 'care navigators' and one team of 'medical call handlers. At the time of the September 2021 inspection, we saw the practice was working with NHS England and NHS Improvement to further improve access. 	

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.	Yes

Explanation of any answers and additional evidence:

- We heard during one of the spikes in the COVID-19 pandemic, one of the care homes which accessed GP services from the practice had a high number of positive cases, resulting in an outbreak. We saw GP clinical leads contacted the service to review the patients daily and offered further management and anticipatory care as needed.

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
Explanation of any answers and additional evidence:	
We saw systems to establish a programme of regular review of information and performance was in place and effectively implemented. This included:	
<ul style="list-style-type: none"> • The use of the Quality and Outcomes Framework (QOF) and subsequent use of action/recovery plans to improve clinical performance and outcomes for patients. • The implementation of daily reporting through to the CCG and PCN to improve access across the local area. This reporting highlighted areas to benchmark and review whilst pinpointing capacity. 	

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.	Partial
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 recently started to engage with patients via social media channels. The last of which was a letter from the partners advising of the current climate within primary care.
- Given the high population of Nepalese patients, we saw a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met those needs and promoted equality. The practice had recognised the need to communicate effectively with the community elders in order that the population were willing and able to access appropriate healthcare. Tailored education programmes had been delivered relating to self-management of diabetes. Non-English-speaking Nepalese patients were supported by effective use of available translator services and the practice employed various members of staff who spoke Nepalese and understood the cultural barriers preventing patients from accessing health care. To further build rapport practice staff had involved themselves in charity projects in Nepal and encouraged all their practice population to support them in these ventures.

Feedback from Patient Participation Group (PPG)

There was a Patient Participation Group (PPG) and as part of this inspection we spoke with two members from the group.

Both members commented that over the last few years there had been many changes within the practice, this included changes in management and changes made following the merger of the two original practices.

The PPG advised patient feedback was sought through discussions and engagement. However, at times the PPG felt that some of the feedback wasn't taken onboard or acted upon, specifically in recent times about access to the practice.

During our inspection we reviewed various examples of PPG correspondence which included the meeting agenda and meeting notes from the last meeting which was held virtually in August 2021. Themes from the most recent meeting included access to the practice now some COVID-19 restrictions had been removed, the telephony system and moving forward how to ensure a variety of appointments were available.

Both the PPG and the practice independently advised they were looking forward to working with each other to make further improvements to the overall patient experience.

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:	
<ul style="list-style-type: none"> Staff from different teams within the practice had special interests and additional qualifications in 'Quality Improvement' (QI). We saw practice specific risks alongside local and national challenges within general practice had been evaluated using a QI methodology to make improvements. Staff spoke of a culture of improvement and development at the practice. When changes in service or new services were introduced the practice monitored implementation and sustainability. 	

Examples of continuous learning and improvement

- The practice planned to roll the 'House of Care' system out to all the chronic disease areas over the next five years in order to streamline the care people with chronic disease receive. This would help patients manage their own condition and learn to live effectively with their chronic condition.
- The practice was part of the pilot for the new care home directed enhanced service. For this pilot the practice had a weekly multi-disciplinary team meeting, consisting of the GP care home Lead, one of the Physician Associates and the clinical pharmacist. These meetings allow staff at the different homes to address any patient concerns they might have, as well as an opportunity for the practice's clinical team to identify any patients who they have concerns about or wish to discuss further. The clinical pharmacist had also organised a process mapping session in April 2021, to listen to ideas and concerns from care home staff regarding medication. With the success of the pilot, including the impact on reducing hospital admission rates, the practice was rolling the MDT approach and weekly meetings out to the other care homes in the local area.
- The practice reported positively on the IT software improvements in assisting and transforming practice workflow systems such as patient recall, reminders and clinical outcomes.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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