

# Care Quality Commission

## Inspection Evidence Table

### Camrose, Gillies and Hackwood Partnership (1-10472984618)

Inspection date: 22 July 2021

Date of data download: 14 July 2021

## Overall rating: Good

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

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 risk assessment processes, safety alerts, recruitment and training and safeguarding processes
- When things went wrong, reviews and investigations were not always sufficiently thorough. Improvement were not always identified.

At this inspection we found:

- The practice had improved the systems and processes to manage safety.
- Risk management had been improved.
- Improvements and actions were taken when things went wrong.

## 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.
- The practice was unable to evidence that staff had received safeguarding training in line with practice policy.
- The practice's safeguarding policy had not been updated to reflect national guidelines regarding the level of training required by staff.

At this inspection we found the practice had improved their safety systems and processes.

- Risk assessments were in place and actions had been completed.
- HR and training files all contained appropriate information were all updated and
- The complaints procedure was followed, and investigations carried out.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
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. HVs by email or on Teams meetings join SG meetings	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that the practice's safeguarding policy had not been updated to reflect national guidelines regarding the level of training required by staff. In addition, the practice was not able to evidence that all staff had undertaken safeguarding training.</p> <p>During this inspection, we saw the practice's safeguarding policy was up to date and was part of a regular review process. Also, we saw certification to show that all staff had completed training appropriate to their role.</p> <p>Practice policies had been updated and migrated over from the new provider's system and were held on the practice intranet.</p> <p>In addition, we saw that there was a system in place to ensure that any child who reached 18 years of age was transferred to the adults safeguarding team.</p> <p>Any non-attendance for appointments, screening and or vaccinations by vulnerable adults or children were followed up by the nursing team.</p> <p>During the COVID 19 pandemic the practice maintained regular communication with community teams for example, health visitors, the community mental health team and the frailty team.</p>	

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 previous inspection in March 2019 we found that the practice was not consistently following their recruitment policy with regard to obtaining references. Following the inspection, the practice sent us confirmation that the references had been retrospectively recorded.</p> <p>During this inspection the personnel files we reviewed had the appropriate references, identification, continuous employment history and up to date training records.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 15 May 2021 for all sites	Yes
There was a record of equipment calibration. Date of last calibration: 17 September 2020 for all sites	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N/A
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 17 February 2021 for all sites	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019, we found that processes to ensure fire safety were not embedded. For example, over the three sites there was a lack of up to date fire risk assessments, completed actions and fire drills.</p> <p>During this inspection we found that there were fire risk assessments in place for all three sites with identified actions. For example, at one of the sites it was noted that a fire door had been propped open. The action was for this to be rectified as a matter of urgency. The practice communicated with all staff via the weekly newsletter to inform them not to prop open fire doors. We saw evidence that this was added to the newsletter on a regular basis to ensure compliance.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 25 November 2020 for all sites	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 25 November 2020 for all sites	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that</p> <ul style="list-style-type: none"> <li>• The practice's health and safety policy had not been updated since the practice merged in 2018.</li> <li>• The practice did not have consistent oversight of premises/security risk assessments.</li> <li>• Not all staff had completed infection prevention and control (IPC) training.</li> </ul> <p>During this inspection we saw evidence that all policies were updated and reviewed and held on the practice's intranet. Risk assessments for security and other areas such as air conditioning systems, lift maintenance and Legionella had all been carried out within the previous 12 months. We saw training records which showed all staff had completed IPC training.</p>	

## 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: May 2021	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
<p>Explanation of any answers and additional evidence:</p> <p>During the previous inspection in March 2019, we found that although infection, prevention and control (IPC) risk assessments had been conducted for each location, these were not always complete and did not always accurately reflect possible concerns. We also found that not all staff had completed mandatory IPC training.</p> <p>At this inspection we found that:</p> <ul style="list-style-type: none"> <li>• The IPC policy had been updated.</li> <li>• An IPC audit had been undertaken and actions completed for example, it had been noted that two-meter social distancing signs were not all in place in waiting areas and COVID 19 cleaning posters were missing from the hot desking areas. We noted that these actions had been completed and we verified this when we visited the practice.</li> <li>• We saw evidence that all staff were up to date in IPC training.</li> </ul>	

- There was a regular programme of IPC audits in place covering topics such as sharps handling, uniform and clinical waste disposal.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that:</p> <p>The practice did not always have an effective system to manage staff absences and busy periods. Feedback from staff during that inspection included that there was no adequate cover for holidays and sickness. The practice advised us that there were several staff vacancies and that they were in the process of trying to recruit new staff.</p> <p>At this inspection we found that there was a system in place so that cover for GP leave was planned well in advance. During the COVID 19 pandemic remote access was in place for staff who were unable to work from one of the sites. In addition, the practice used locums where necessary. There was a comprehensive locum pack in place which we reviewed on the day of inspection. Other clinical staff that we spoke with told us that there were sufficient cover arrangements in place and the administration had a system in place to cover each other for holidays and sickness.</p> <p>GP leave cover was planned in advance. Clinicians had remote access which they used where required and if required the practice would use agency locums. Locums were GPs that the practice had used for a number of years.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the	Yes

summarising of new patient notes.	
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.59	0.66	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	8.7%	11.5%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	5.16	5.87	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	99.8‰	110.8‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.70	0.62	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	7.9‰	9.0‰	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
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that:</p> <ul style="list-style-type: none"> <li>The practice's process to ensure medicines were stored securely was not consistent across the three sites. This meant the practice could not be assured that access was limited to authorised personnel.</li> </ul>	



Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>The practice's system to ensure staff had the appropriate authorisations to administer medicines was not embedded.</li> </ul> <p>During this inspection we saw evidence to show that:</p> <ul style="list-style-type: none"> <li>All areas where medicines were stored at each site were secure in locked rooms.</li> <li>All authorisations for staff to administer medicines were in date and signed by an appropriate person. We saw that this process was regularly reviewed to ensure the directives were up to date.</li> </ul>	

## 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:	28
Number of events that required action:	25
We saw evidence of regular meetings where significant events were discussed. Minutes of these meetings were available to staff.	

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

Event	Specific action taken
Prescribing error following hospital discharge.	A prescribing issue was identified by the clinical pharmacist. Staff reviewed the incident and escalated it. The patient involved was informed, and the prescription was changed to ensure the patient's safety. A new process was put in place to ensure more checks were carried out to check prescription changes following a hospital discharge. The event was reported to the Care Quality Commission (CQC).
Patient referral for 2 week wait appointment not submitted.	The system was checked, and an anomaly was found. This was investigated and a new process was put in place to send a notification from the GPs to secretaries. All staff were notified through the practice's weekly bulletin.

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



Explanation of any answers and additional evidence:

At the previous inspection in March 2019 we found that:

- The practice did not have sufficient oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The practice's process for acting on Medicines and Healthcare products Regulatory Agency alerts did not ensure patient safety.

During this inspection we saw evidence to showed that:

- The practice had reviewed the medicines alerts policy and the clinical pharmacist had the initial responsibility of checking the alert along with two senior managers. We saw minutes of meetings where alerts and appropriate actions were discussed. Alerts were also audited on a regular basis.

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff we interviewed told us that they used NICE guidelines and we found that protocols based on national guidance had been produced. These were reviewed yearly.</li> <li>Nursing staff carried out long term condition learning updates, these were recorded in their training records along with any attendance at forums or learning days.</li> </ul>	

## Older people

## Population group rating: Good

### Findings

- The practice had an in house Frailty Team to manage this group of patients. This was a multidisciplinary team with prescribing staff and dedicated administrative support. The team had a separate telephone number for patients to use which bypassed the normal telephone system to give patients easy access to the team.
- The practice used a clinical template to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions	Population group rating: Good
Findings	
<ul style="list-style-type: none"> <li>Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.</li> <li>Staff who were responsible for reviews of patients with long-term conditions had received specific training.</li> <li>GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice system sent out appointments to patients for review appointments.</li> <li>The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. For example, patients had access to a pre-diabetes clinic outside the practice. Patients were coded as prediabetic and sent a letter offering them access to the service.</li> <li>The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.</li> <li>Adults with newly diagnosed cardio-vascular disease were offered statins.</li> <li>Patients with suspected hypertension were offered ambulatory blood pressure monitoring. The practice was part of a new project that gave 180 monitors to patients during the COVID 19 pandemic to monitor their blood pressure.</li> <li>Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.</li> <li>Patients with COPD were offered rescue packs. Telephone consultations had been undertaken through the COVID 19 pandemic and this had improved contact with patients.</li> <li>Patients with asthma were offered an asthma management plan. The practice only gave two repeat prescriptions at a time and had just employed an advanced nurse practitioner specialising in respiratory conditions.</li> <li>Patients who had multi co morbidities and the practice had a policy to ‘make every contact count’ so multiple appointments were made with clinicians.</li> <li>The practice had planned group consultations for diabetic patients as COVID 19 restrictions lift.</li> </ul>	

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)	81.9%	77.0%	76.6%	No statistical variation

(QOF)				
PCA* rate (number of PCAs).	39.6% (1,204)	17.8%	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)	93.5%	90.4%	89.4%	No statistical variation
PCA rate (number of PCAs).	36.3% (261)	16.2%	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)	80.3%	81.5%	82.0%	No statistical variation
PCA* rate (number of PCAs).	11.3% (97)	6.7%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	69.9%	68.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	27.6% (644)	18.2%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	72.6%	70.9%	72.4%	No statistical variation
PCA rate (number of PCAs).	16.0% (843)	8.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	87.4%	89.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.4% (26)	4.5%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	76.1%	77.2%	75.9%	No statistical variation
PCA rate (number of PCAs).	20.4% (476)	12.9%	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

#### Explanation of any answers and additional evidence:

We discussed Personalised Care Adjustments (PCA) rates with the practice and the system in place to try to ensure patients were actively contacted and encouraged to attend review appointments. Patients were written to on three occasions to invite them for a review and if a patient did not attend a review appointment a nurse would telephone them.

We were told that some patients were reluctant to attend review appointments due to the COVID 19 pandemic. In addition, less appointments were available due to infection, prevention and control measures in place during this time.

The GP's carried out audits to check that all clinicians were correctly coding patients to give an accurate picture of PCA rates.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice met the minimum 90% for all of five childhood immunisation uptake indicators. However, the practice had not met the World Health Organisation based national target of 95% (the recommended standard for achieving herd immunity) for all of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations. The practice offered walk in appointments for immunisations to increase availability and uptake.
- The practice liaised with the local school nurse teams to ensure girls were offered the Human papillomavirus (HPV) vaccine.
- The practice had a dedicated member of the administrative team to run monthly checks and follow up on failed attendances in relation to children's appointments following an appointment in secondary care or for immunization. They also liaised 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. Patients under the age of 18 always had face to face appointments for contraception and or 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)	375	403	93.1%	Met 90% minimum

(01/04/2019 to 31/03/2020) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	385	415	92.8%	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)	385	415	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)	386	415	93.0%	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)	443	486	91.2%	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>

## 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. This process had been adapted during the COVID 19 pandemic. Patients were called for a blood test and then had a follow up telephone call a week later with a health care assistant (HCA).
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery. The practice recommended patients to use the NHS App to request repeat medication where possible.
- The practice had continued to carry out cervical screening throughout the COVID 19 pandemic.
- The practice also used the practice website, local and social media to encourage attendance.
- Over the three sites the practice approached all patients who were due to attend for their first cervical screening appointment by sending a text message directly from the team to encourage attendance.

Cancer Indicators	Practice	CCG	England	England
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		average	average	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: 31/12/2020) <small>(Public Health England)</small>	68.3%	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) <small>(PHE)</small>	77.5%	71.5%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	63.1%	67.5%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>	94.4%	93.8%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	44.9%	52.7%	54.2%	No statistical variation

### Any additional evidence or comments

Explanation of any answers and additional evidence:

- We spoke with the practice about the figures and we saw that the current figures show that previously there had been incorrect coding, which was also the case for also for the breast screening results.
- The actual unverified cervical screening data showed:  
Women aged 25-49 was 91%  
Women aged 50-64 was 85%.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

### Findings

- All patients with a learning disability were offered an annual health check, these were carried out by the Physicians Associates.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Quarterly meetings were held with the palliative care nurses.
- Weekly meetings were in place for frail and palliative patients, who may need additional help and support from the team.
- The practice had a system for vaccinating patients with an underlying medical condition according



to the recommended schedule.

- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.
- During the COVID 19 pandemic, the social prescribers and receptionists rang all vulnerable patients to check on them.

## 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.
- The practice arranged for patients to have appropriate appointments either by telephone or in person during the current COVID 19 pandemic.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice was certified as Dementia Friendly and remained accessible for patients with dementia to access the practice.
- The practice had plans to create a specialist mental health team to help with this group of patients as the waiting list locally was in excess of nine months.

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>	100.0%	86.5%	85.4%	Variation (positive)
PCA* rate (number of PCAs).	27.3% (78)	23.3%	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	91.4%	80.8%	81.4%	Tending towards variation (positive)

31/03/2020) (QOF)				
PCA rate (number of PCAs).	9.8% (24)	8.0%	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)	554.7	533.9
Overall QOF score (as a percentage of maximum)	99.2%	95.5%
Overall QOF PCA reporting (all domains)	11%	5.9%

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

The practice carried out a review of female patients' prescribed Sodium Valproate (a medicine used to treat epilepsy and bipolar with side effect risks in pregnancy) in July 2021. Of the 25 female patients in the appropriate age range that had been prescribed this medicine in the past 12 months, 23 had an annual risk acknowledgement form (ARAF) in place. The practice reviewed all the patients to ensure that appropriate contraception and or advice was in place.

At the re audit in October 2021 the patients were again reviewed. There were 23 patients in total who all had an ARAF in place. The next re audit was scheduled in three months.

## 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, coaching, mentoring, and clinical supervision. They were supported to meet the requirements of their professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that:</p> <ul style="list-style-type: none"> <li>The practice did not have effective oversight of staff training and therefore could not be assured that staff had the necessary skills and knowledge. We reviewed the log of training considered necessary as determined by the practice and we found that not all staff had completed basic life support or fire safety training.</li> <li>Not all staff had received an appraisal. In some cases, appraisals had been scheduled but were overdue.</li> </ul> <p>However, at this inspection we found that:</p> <ul style="list-style-type: none"> <li>All staff appraisals had been completed in the previous 12 months.</li> <li>The staff training log was up to date. Some training had been completed online due to the COVID 19 pandemic, but the practice planned to arrange face to face training to be available as soon as this was possible.</li> <li>Peer support was in place for clinicians. The practice had a number of accredited trainers and accommodated student nurses. New staff were given a period of two weeks as supernumery (not counted as part of the substantive nursing staff on duty) to give them time to shadow other staff.</li> </ul>	

## 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-centered care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their	Yes

own health.	
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

### Consent to care and treatment

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

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

## Caring

**Rating: Good**

### Kindness, respect and compassion

**Staff treated 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.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

### 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)	88.6%	89.2%	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)	86.3%	87.6%	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)	92.5%	95.8%	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)	63.4%	81.8%	81.8%	Variation (negative)

## Any additional evidence or comments

Explanation of any answers and additional evidence:

Following the low results in one of the patient experience indicators, the practice put in place an action plan this included:

- The recruitment of more regular clinicians to provide patients with an increased sense of continuity of care.
- Launching an additional patient survey looking at the questions asked within the GP survey to see a trend of improvements prior to the 2022 survey results being released. This would allow the practice to gain an insight into the patient experience earlier.
- A continuation of the quarterly patient newsletter to highlight important news about the practice to patients.
- Patient facing team members had completed the customer care training modules.
- Patient feedback featured as a regular agenda item for practice meetings where they discussed recent results, any trends in feedback (positive and negative), how they planned to address these including who was responsible for each action and when they expected these to be completed by.

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

## Involvement in decisions about care and treatment

**Staff helped patients to be involved in decisions about care and treatment / patients were not 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Easy read and pictorial materials were available for patients.	

## 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)	87.0%	94.0%	93.0%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: Staff told us there was a local Nepalese community with a number of patients on the practice list and that support measures were in place to help this group including interpreters where required.	

Carers	Narrative
Percentage and number of carers identified.	689 carers were identified which represented 2% of the practice population.
How the practice supported carers (including young carers).	The practice had identified five young carers and recognised that they required different support. There was information available for them in the waiting area and on the practice website.
How the practice supported recently bereaved patients.	The named GP would contact the family to offer support following a bereavement and if appropriate, signpost them to external agencies.

## 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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes



## Responsive

## Rating: Good

At the previous inspection in March 2019 we found that:

- People found it difficult to use the appointment system to access services by telephone. This was reflected in the National Patient Survey results.
- When people raised complaints or concerns, the practice did not always identify a way to improve their services.

Immediately following the last inspection in 2019, the practice put in place changes to increase accessibility and in turn improved patient satisfaction.

At this inspection we found that there was an ongoing process to improve patient survey results and give patients a better experience.

### 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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The practice used one of the three sites a COVID 19 Red Site to allow patients to be seen and keep other patients safe. This site was used to accommodate patients who may have COVID19. The other two sites were set up as amber and green. This meant that they minimised the risk of other patients contracting Covid 19. Those patients who had difficulty in accessing vaccination sites were able to access them via pop up sites that the practice provided.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	0800-1830
Tuesday	0800-1830
Wednesday	0800-1830
Thursday	0800-1830
Friday	0800-1830
Saturday	0800-1200
Appointments available:	
Monday	0800-1830
Tuesday	0800-1830
Wednesday	0800-1830
Thursday	0800-1830
Friday	0800-1830
Saturday	0800-1200
Improved Access:	
Monday	1830-2000
Tuesday	1830-2000
Wednesday	1830-2000
Thursday	1830-2000
Friday	1830-2000
Saturday	0800-1200

## Older people

## Population group rating: Good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and throughout the COVID 19 pandemic, continued to offer home visits and urgent appointments for those with enhanced needs and complex medical issues where required.
- The practice provided effective care coordination to enable older patients to access appropriate services.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment. The practice used the Making Every Contact Count (MECC) approach. This was an evidence-based approach to improving people's health and wellbeing by helping them change their behaviour. It enabled health and care workers to engage patients in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. During the COVID 19 pandemic the practice had set up online meetings with community staff.
- The practice had a Leg Club, for patients with leg ulcers. These patients had access to exercise sessions which also gave social support to this group of patients.
- 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

- 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.
- Parents or guardians calling with concerns about a child were offered a same day appointment where necessary.

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

## Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it

offered to ensure these were accessible, flexible and offered continuity of care.

- The practice was open until 6.30pm between Mondays and Fridays, with additional access appointments available until 8pm each evening. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available on Saturdays from 8am until 12pm.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and people 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.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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

Population group rating: Good

### Findings

- Priority appointments were allocated where 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. This was a Dementia Friendly practice.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
There were systems in place to support patients who face communication barriers to access treatment.	Yes
Patients with urgent needs had their care prioritised.	Yes
The practice had systems to ensure patients were directed to the most appropriate	Yes

person to respond to their immediate needs.	
Explanation of any answers and additional evidence: The practice had a generic email address that patients could use for prescription requests. Patients were encouraged to use the NHS App, and the electronic consultation (E Consult) function if appropriate.	

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)	18.7%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	27.8%	63.5%	65.5%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	31.8%	60.5%	63.0%	Significant Variation (negative)
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)	48.4%	71.8%	72.7%	Variation (negative)

#### Any additional evidence or comments

Explanation of any answers and additional evidence: In addition, the action plan that the practice had put in place following the National Patient Survey results included the following:
<ul style="list-style-type: none"> <li>Using the analytics tool on the appointment system to review on a monthly basis, the number of appointments provided, to increase service provision where needed to ensure that the demand for the service was met.</li> <li>Increasing the number of staff members available to speak with patients on the phone at peak times in order to increase access to and provide patients with a better experience. This was achieved by recruiting more staff and upskilling current team members.</li> <li>Increasing continuity of care for patients through the implementation of the 'Team of Teams' way of working.</li> </ul>

Source	Feedback
Friends and Family survey	We saw evidence of results from the Friends and Family survey carried out between July 2020 to July 2021 which showed that of 2554 responses 92% of patients said that they would recommend the practice.

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## 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.	23
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	12, 11 still underway at time of inspection
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: The practice had a system in place to highlight ongoing complaints still at review stage with updates noted. All complaints had been investigated and outcomes relayed to complainant.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding waiting time for an appointment.	Staff listened back to a recording of the call to ensure what action reception staff had taken. The patient had been offered an on the day appointment but had declined.
Patient unhappy with the outcome of consultation and care.	The practice contacted the patient and apologised. They gave the patient an appointment for a second opinion, with a follow up arranged within a few weeks.

## Well-led

## Rating: Good

At the previous inspection in March 2019 we found that

- The arrangements for governance and performance management were not always operated effectively.
- Risks, issues and poor performance were not always dealt with appropriately. The risk management approach was applied inconsistently.
- Improvements were not always identified, and action was not always taken.
- The practice had organised team building events for clinical and non-clinical staff.

At this inspection we found:

- The merger with the new organisation had been completed.
- This had added central support to the practice for area such as HR, IT and finance.
- Practice policies and procedures had been updated and adjusted to incorporate the changes.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate 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
The practice had put in place a Team of Teams approach with was a multidisciplinary approach to managing and giving patients the best possible service. The patient list was divided into coloured teams. Each team had lead GPs, a mix of nurses with a range of specialisms, health care assistant (HCA) support, care coordinators and dedicated administrative support. The Frailty team was in addition to the other teams.	
Care coordinators had been recruited and specific training had been undertaken to reduce the amount of admin time for GPs. This role included checking appointments were appropriately allocated, sending messages to patients via the new text system, system checking test results and booking review appointments. GPs were able to send messages electronically to the care coordinators to complete tasks.	

### Vision and strategy

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



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

## 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:	
<p>The practice produced a weekly information bulletin for all staff, the 'Friday Flyer'. This was a useful tool to get messages to all staff including:</p> <ul style="list-style-type: none"> <li>• On call manager contact details</li> <li>• 'In the spotlight', a short fun profile of a staff member</li> <li>• Clinical team updates</li> <li>• Health and safety and training information</li> <li>• The 'Trumpet Box', an opportunity to praise teams or individuals for exceptional work.</li> </ul> <p>In addition, the practice had put in place a short weekly call for all staff to dial in to update them on any changes.</p>	

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

Source	Feedback
Staff interviews	<p>Staff we spoke with told us of regular meetings and good communication within teams and the wider team. There were opportunities for staff progression, and we were told that the organisation put staff first. The organisation also took into account the views of the practice staff if there were issues identified and would look for solutions that worked best for the practice and its staff.</p> <p>The practice put in place a Coffee Time break each morning at all sites and all staff were encouraged to join, workloads permitting. We were told that this was a good opportunity for staff of all levels to interact in a more informal setting.</p>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that:</p> <ul style="list-style-type: none"> <li>• Policies at the practice were not always easily accessible.</li> <li>• The practice was in the process of updating policies and putting them on the new intranet system, and practice staff were not always able to access the policies required.</li> <li>• We found that the practice's complaints policy and procedures did not ensure patients had all the necessary information should they wish to escalate their complaint further.</li> <li>• Practice policies did not always reflect current guidelines.</li> <li>• We found that recruitment checks were not consistent. We saw two staff files where there was no record of references prior to employment. The practice advised that they had received verbal references for the staff members, but this had not been recorded.</li> </ul> <p>However, at this inspection we found that:</p> <ul style="list-style-type: none"> <li>• The practice had adopted and or merged policies with those of the new organisation and all were accessible on the practice intranet. Staff showed us that they were able to locate them easily.</li> <li>• During the last inspection the practice updated their complaints policy to ensure this information was included in response to complaints. We saw that this had been embedded and the policy was current and relevant.</li> <li>• Practice policies we reviewed and contained the correct information in line with national guidance.</li> <li>• We undertook a review of six personnel files, and all were in a concise and relevant order. All six files were complete and contained all relevant and appropriate information for example, references, photographic identification and full previous employment history.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found</p> <ul style="list-style-type: none"> <li>• The practice did not maintain effective oversight of staff training in line with the practice policy.</li> <li>• There was no oversight of staff appraisals.</li> <li>• Governance arrangements to mitigate risk were not embedded in practice in particular risk assessments for health and safety including legionella. At the previous inspection in March 2019.</li> </ul> <p>During this inspection we found that:</p> <ul style="list-style-type: none"> <li>• Staff training was up to date albeit face to face training had been suspended during the COVID 19 pandemic.</li> <li>• There was an appraisal schedule in place, which was up to date and all staff we spoke with told us that they had had an appraisal.</li> <li>• All risk assessments were up to date for all sites and actions identified had been completed.</li> </ul>	

### The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the COVID 19 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	Yes

response to findings.	
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had adjusted the way that it provided services to ensure that patients were able to have appropriate access at this time. As there were three sites, they set up one site as a 'Red Site' to accommodate patients who were or may have COVID19. The other two sites were set up as amber and green.</li> <li>Staff we spoke with said that they felt safe and supported through this time and had access to personal protective equipment (PPE) and felt protected with the measures that had been put in place at each site for example screens and social distancing measures.</li> <li>The practice had enabled staff to work at home if appropriate.</li> <li>During the COVID 19 pandemic the locality had joined to run a central service known as, CO@H - COVID oximetry at home. At the time of inspection, the practice had approximately 106 patients across Basingstoke who were being managed out of hospital. This number was increasing by 20 per day with 300 COVID 19 positive patients being identified each day.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2019 we found that risk assessments did not always accurately reflect possible concerns and actions had not always been completed. We checked this at this inspection and found that all actions had been signed off and correctly completed.</p>	

## 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 (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
The practice had an active patient participation group (PPG). The group had recently undergone a lot of change, but meetings had been held between the group and the practice was involved. The practice shared information with the group for example, staffing changes, call waiting data, patient feedback and COVID updates.	

Feedback from Patient Participation Group.

Feedback
Several changes had taken place recently including the election of a new chairperson and a number of new recruits. The group were very keen to work with the practice to improve areas such as patient access.
At the last meeting in August 2021 the group gave the practice a number of suggestions to improve the patient experience of access, which the practice manager agreed to take to the partners and report back on at the next meeting.

## 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

### Examples of continuous learning and improvement

- To support the increased need for additional mental health support the practice was working on a joint venture with a local health trust to identify additional mental health workers to better support patients.
- Audits of clinical notes had been introduced and staff we spoke with explained that this was a really useful process to assess and review their clinical note taking and was a useful learning tool.
- The practice had been selected to be part of Primary Care Network (PCN) to run a breast pilot scheme. This would enable women under 30 years of age with a suspected breast lump to be referred directly to the Breast Pilot and be offered an appointment on the same day.
- The practice had made a decision to replace the usual NHS slogan regarding zero tolerance of abuse of staff, and were adopting the wording 'Be kind and respectful to each other'

#### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

#### Glossary of terms used in the data.

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