

Care Quality Commission

Inspection Evidence Table

Boleyn Medical Centre (1-2379611272)

Inspection date: 26 October 2020

Date of data download: 30 September 2020

Overall rating: Good

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

Safe

Rating: Good

At the previous inspection of the 22 July 2019 and 25 July 2019 we rated safe as inadequate due to a range of fundamental safety concerns including safeguarding children, safety alerts, significant events identification and management, and arrangements in the event of a medical emergency.

At this inspection we rated safe as good because the practice had reviewed, and improved areas of concern found in the inspection on the 22 July 2019 and 25 July 2019 and taken steps to embed and complete improvements.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, community nurses, diabetes specialists, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The principal GP was the lead for safeguarding both adults and children and the long-term salaried GP was the deputy lead. Safeguarding was included in the induction pack for locum GPs.</p> <p>Staff were familiar with and had access to safeguarding protocols through the practice IT portal and shared folder.</p> <p>Children's and Adult's safeguarding policies were reviewed September 2019.</p> <p>Consultation and administrative rooms had a designated safeguarding drawer containing safeguarding guidelines.</p> <p>DBS risk assessments were carried out for clinical and non-clinical staff and related risk assessments were considered where new DBS checks were needed.</p> <p>The practice held a quarterly "Vulnerable Patient Day" (VPD) where a GP reviewed safeguarded adults and children on the child protection register/ list for any cases requiring review or referral actions. The safeguarded adults and children record, and lists were reviewed at the VPD, most recently September 2020.</p> <p>Non-clinical and clinical staff including chaperones were aware of safeguarding considerations and generally trained to a level appropriate to their role. The practice had a process and plan to ensure relevant non-clinical staff were trained to level 2.</p> <p>Safeguarding issues were discussed with allied health and social care professionals at multidisciplinary meetings.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection of the 22 July 2019 and 25 July 2019, some recruitment checks were undertaken for staff such as photographic ID checks and registration of clinical staff. However, arrangements for undertaking DBS checks were ineffective. There were no references, locum agreement, or job description for a locum GP.</p> <p>At this inspection, a comprehensive recruitment process was implemented. Immunity status, registration, DBS and references checks were in place for relevant staff.</p>	

Safety systems and records	Y/N/Partial
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There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: January 2020	Y
There was a record of equipment calibration. Date of last calibration: January 2020	Y
There were risk assessments for any storage of hazardous substances.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: June 2020	Y
There was a log of fire drills. Date of last drill: November 2019 and deferred due to COVID 19 in line with risk assessment.	Y
There was a record of fire alarm checks. Date of last check: Weekly, ongoing	Y
There was a record of fire training for staff. Date of last training: Annual, ongoing	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 5 August 2019 full premises plus weekly checks by staff.	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Fire safety arrangements were effective and related records were maintained. Leadership and management staff were aware of the findings of the premises risk assessments undertaken by the landlord and had followed up such as emergency lighting maintenance. Staff had been trained in fire safety and ensured actions such as a boiler room and clinical rooms tidying.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Weekly	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Weekly on site by staff, most recent comprehensive risk assessment - 22 October 2020	Y
Explanation of any answers and additional evidence: Staff escalated clearing / tidying of areas and addressed COSHH considerations for storage of emergency use oxygen.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: Systems to ensure effective infection control arrangements were in place. There was a delegated practice nurse lead for infection control that was trained, including regarding COVID 19 and infection control audits and follow up. Hand sanitiser stations were installed throughout the practice and staff worked in contained “bubble” groups. The practice was clean, well-organised and tidy and implemented a monthly “Environmental Cleanliness Checklist / Audit Tool for General Practice Audit Tool” undertaken by nursing staff.	

Risks to patients

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

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

The rota was well planned and managed and sufficient short-term contingency planning for the absence of the lead GP was in place. Mid to longer term plans were set out in the business strategy and development plan, including a nominated GP to provide clinical governance, and to review considering development of the practice Primary Care Network (PCN).

There was a reporting form for significant events that all staff were aware of.

There was a system for recording accidents and incidents that included consideration of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).

The number of patients “co-ordinate my care” plans in place had increased from five at the previous inspection to 34 at this inspection.

Clinical risk management plans were in place including those specific to long-term conditions. Examples included asthma, diabetes, and chronic obstructive pulmonary disease (COPD). These were undertaken by nursing and healthcare assistant staff with risk factors or considerations that were escalated to a GP as needed. Non-clinical staff were aware of signs and symptoms requiring urgent or emergency treatment. There were sepsis awareness notices, such as posters, available for staff to use as quick reference guides.

Staff were trained in basic life support and sepsis and there were quick reference posters for staff reference on sepsis.

The practice used a frailty index tool including to identify patients that were regularly reviewed.

Patients clinical risk was assessed using relevant national guidelines.

The practice had a dedicated Patient Safety Day once a quarter where GP and administrative staff actioned issues identified through clinical audits and re-audits, policies protocols and those lists of patients that may pose a clinical risk to themselves. For example, those who may repeatedly miss blood tests, hospital outpatient appointments or poor medication compliance.

Best practice clinical care guidelines were referenced in clinical audits and discussed in clinical educational sessions and meetings. Relevant bulletins regarding topics related to General Practice were circulated.

A risk management framework was developed including considerations such as Covid-19, Sepsis, emergency equipment, and cardiovascular risk and frailty risk.

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff across all roles were appropriately trained and shared information appropriately.</p> <p>Staff were trained in data handling, GDPR, security, and confidentiality agreements were in place. Information was shared appropriately and securely such as with secondary care via ERS (Electronic Referral Service).</p> <p>Appropriate arrangements were in place for summarising patients records.</p> <p>Appropriate arrangements were in place for the tracking of urgent referrals such as potential cancer referrals under the urgent two weeks wait process, and staff responsible for monitoring and ensuring these were seen through and documenting appropriately.</p> <p>Clinical, practice and reception meeting minutes evidenced discussion of safeguarding, significant events and safety alerts.</p>	

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) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.89	0.70	0.85	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). (01/07/2019 to 30/06/2020) (NHSBSA)	9.2%	9.7%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2020 to 30/06/2020) (NHSBSA)	6.40	5.63	5.35	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit	2.30	1.22	1.92	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
(STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)				

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence:	
Blank prescriptions were kept securely and monitored included prescriptions distribution / usage. Appropriate Patient Group Directions were in place, as well as Patient Specific Directions for the healthcare assistants when administering B12 and flu vaccines.	

Medicines management	Y/N/Partial
<p>There were no non-medical prescribers employed by the practice. The Pharmacist received supervision via patient case reviews with the GP that were recorded for training and monitoring. The pharmacist discussed cases with a GP in the course of the working day, with a task recorded to further evidence medical supervision. The Pharmacist was limiting their work to auditing and asthma reviews in line with professional training and verified competence. Similar arrangements were in place for case supervision of for nurses and healthcare assistants.</p> <p>There were no controlled drugs on the premises and comprehensive and repeated cycle audits of controlled drugs prescribing were undertaken.</p> <p>The practice implemented a vaccine transport and storage check process during September 2020 to ensure safety.</p> <p>There was a policy for monitoring patient's health in relation to the repeat prescribing of medicines including high risk medicines. Our record checks and searches across a range of patients and medicines showed arrangements were effective. Medicines we checked included high-risk medicines requiring frequent monitoring. We also checked repeat medicines such as a disease-modifying anti-rheumatic drug (DMARD) that regulates the activity of the immune system, which may be overactive in some conditions; Non-steroidal anti-inflammatory drugs (NSAIDs). (NSAIDs are medicines that are widely used in a variety of conditions. NSAIDs are commonly used but are not suitable for everyone and can sometimes cause troublesome side effects); an ACE Inhibitor medicine (ACEI) where kidney function tests should be regularly checked, and contraception considered. (ACE inhibitors are medicines that are used to treat high blood pressure); and creatinine clearance level tests as needed for patients prescribed a (DOAC) medicine. (DOACs are anticoagulant medications that require dose adjustments according to creatinine clearance, the amount of blood cleaned of creatinine by your kidneys is called the creatinine clearance).</p> <p>The practice had undertaken a comprehensive "PINCER" audit that covered 11 areas of drug safety which had three cycles with good results for reduced medication errors and improved medication safety. These included NSAIDs and ACEI / ARBs medicines.</p> <p>There was evidence of sufficient consideration of relevant factors for patients prescribed medicines. Clinical oversight was implemented and completed cycle audits were undertaken to monitor and ensure appropriate prescribing of controlled drugs and antimicrobial medicines.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	26
Number of events that required action:	26
Explanation of any answers and additional evidence:	

Systems for Significant Events Analysis (“SEAs”) were generally effective. An internal SEA reporting form was used by staff that captured complaints and included actions to resolve individual significant events and learning points to improve. However, further development was needed to ensure reliable capture and management of all SEA considerations, such as the duty of candour, root cause analysis, and to consistently inform systemic improvement from identifying trends. This issue was raised as a concern at our previous inspection 22 July 2019 and 25 July 2019 and we have identified it as an area the practice should improve.

However, we saw individual examples where these considerations had been made and actioned where appropriate such as information governance and premises protocols and storage arrangements. The practice also reported and liaised with external bodies and partners where necessary including making NRLS (National Reporting and Learning System) reports and liaising with the IT system provider and local pharmacist.

There was evidence of discussion of significant events at clinical, practice and reception meeting minutes.

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

Event	Specific action taken
A wrong vaccine was administered in error.	<p>The error was identified immediately after administering the vaccine and the patient informed and apologised to. No harm came to the patient and relevant steps were taken immediately and subsequently to ensure their wellbeing.</p> <p>The significant event was a human error, it was discussed during a clinical meeting to raise awareness and prevent recurrence such as double-checking a vaccine just before administering.</p>
A patient from overseas was prescribed a medicine that was not in line with best practice in the UK.	The GP noticed, cancelled the medicine and contacted the patient to request appropriate confirmation of their specific clinical needs, prior to reconsidering of prescribing the medicine. This incident was reported to the National Reporting and Learning System (NRLS).

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence</p> <p>Safety alerts were reviewed, cascaded and followed up. We checked examples for three alerts where actions needed were taken.</p>	

Effective

Rating: Good

At the previous inspection of the 22 July 2019 and 25 July 2019 we rated effective as inadequate due to concerns including patient’s needs assessment, care and treatment across population groups. There were

gaps in arrangements to ensure effective staffing and a lack of oversight, monitoring and improving care and treatment that affected all population groups ratings.

At this inspection we rated effective as good because the practice had taken significant and comprehensive action to improve, including auditing and clinical governance since the inspection on the 22 July 2019 and 25 July 2019. Although there were some areas of clinical performance the practice should continue to review and improve including cancer, COPD and childhood immunisations. We rated the population group for people of working age as requires improvement due to lower than average performance data for cancer data and insufficient evidence of improvement.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Regular clinical meetings took place where best practice guidelines including NICE guidelines were discussed.</p> <p>Care and care plans were appropriate including for patients with asthma, diabetes, cardiovascular disease, mental health concerns and frail elderly patients.</p> <p>Staff across roles engaged with colleagues and referred to guidance to remain up to date such as nursing staff referring to the "green book" regarding the UK vaccination schedule, and diabetes multidisciplinary team meetings took place.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.20	0.30	0.70	Variation (positive)

Prescribing	Practice performance	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) <small>(NHSBSA)</small>				
Any additional evidence or comments				
The practice hypnotics antibiotic prescribing data indicates its performance was better than average.				

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 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 medication 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
<p>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.</p> <p>Staff who were responsible for reviews of patients with long-term conditions had received specific training.</p> <p>The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.</p> <p>The practice used 'Coordinate My Care' (CMC) care plans for patients with long-term conditions, which enabled information about patients' needs and care planning to be shared with a range of other health and social care professionals in the community.</p> <p>The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.</p> <p>Adults with newly diagnosed cardio-vascular disease were offered statins.</p> <p>Patients with suspected hypertension were offered ambulatory blood pressure monitoring.</p> <p>Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.</p>

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	71.9%	79.2%	76.6%	No statistical variation
Exception rate (number of exceptions).	1.3% (7)	7.2%	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)	53.2%	90.3%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	7.5% (5)	7.6%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	86.4%	89.9%	91.8%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.7%	4.9%	N/A

Any additional evidence or comments

The practice's performance on quality indicators from April 2018 to March 2019 for patients with long-term conditions was in line with national averages, except for patients with COPD who had had a review and breathlessness assessment in the last 12 months. The practice was aware of this and recruited a clinical pharmacist that was appropriately trained, and competence assessed. COPD reviews are taking place over the telephone during COVID 19 due to spirometry being an aerosol generating procedure. We saw the practice's current performance for this indicator. Although the data is unverified the practice system showed performance was 60%, which was an improvement on the previous reporting year and with five months to go until the end of the reporting year ending March 2021.

Families, children and young people

Population group rating: Good

Findings

The practice contacted the parents or guardians of children due to have childhood immunisations.

The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

Young people could access services for sexual health and contraception.

Staff had the appropriate skills and training to carry out reviews for this population group.

The practice had undertaken an audit to assess appropriate blood pressure and BMI monitoring in women prescribed the combined oral contraceptive pill.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	125	145	86.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	105	137	76.6%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	107	137	78.1%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	108	137	78.8%	Below 80% uptake

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

Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Staff were aware of this and had implemented a strategy to improve the uptake of vaccinations which included:

- A dedicated member of staff calling parents to educate and encourage them to bring their child for timely vaccination.
- Where repeated refusals occurred, patients were added to the challenging patient list and further actions decided upon.
- The practice liaised with health visitors when necessary and used “child not brought” coding to

their systems and made safeguarding considerations where necessary.

The practice has a transient population and childhood immunisation rates are a challenge across the locality, in addition some patients tended to refuse vaccinations making reaching the target more challenging. There is a trend of below average Childhood immunisation uptake data for practices across the CCG.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England)	65.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	57.0%	44.9%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	43.2%	46.8%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	55.6%	76.4%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	66.7%	46.5%	53.8%	No statistical variation

Any additional evidence or comments

The practice's uptake for cervical screening as of March 2020 was 65%, which was below the Public Health England 80% coverage target for the national screening programme. The practice was aware they struggled with cervical screening uptake due to cultural reasons within their patient demographic,

including women in the patient demographic who are not sexually active. The practice performance was comparable to the CCG average of 62.9% at its previous inspection (there was no published CCG data available for the most recent reporting year).

The practice nurses monitored the cervical screening results and were aware of the inadequate sample rate, which was very low. Women who did not attend for screening had received a discussion opportunistically and appointments were available throughout the week with female sample-takers. Clinical staff also contacted patients personally to encourage them to attend for cervical screening.

The practice data for patients with cancer 6 month reviews and bowel and breast cancer screening was consistently below national averages. Improvement actions included bowel screening information in the reception area and participation in the National Cancer Diagnosis Audit which was positive but focused on factors relating to diagnosis.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

Same day appointments and longer appointments were offered when required.

Patients with a learning disability were offered an annual review.

End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The number of patients “co-ordinate my care” plans in place had increased from five at the previous inspection to 34 at this inspection.

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 held a quarterly “Vulnerable Patient Day” during which a GP and senior administrator reviewed all patients with a learning disability, experiencing domestic violence, with a “coordinate my care” plan, or needing palliative care, for any patients requiring review or referral actions.

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 reviewed care for patients with mental health conditions at the quarterly “Vulnerable Patient Day”.

Same day and longer appointments were offered when required.

There was a system for following up patients who failed to attend for administration of long-term medication.

When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Patients with poor mental health, including dementia, were referred to appropriate services.

We reviewed a sample of records for patients with a mental illness who had satisfactory care plans in place.

The practice demonstrated that they had a system to identify people who misused substances.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	85.5%	90.0%	85.4%	No statistical variation
Exception rate (number of exceptions).	6.8% (4)	8.6%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	77.8%	83.8%	81.4%	No statistical variation
Exception rate (number of exceptions).	5.3% (1)	7.4%	8.0%	N/A

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	CCG average	England average
Overall QOF score (out of maximum 559)	528.2	534.2	539.2
Overall QOF score (as a percentage of maximum)	94.5%	95.8%	96.7%
Overall QOF exception reporting (all domains)	4.7%	5.9%	5.9%

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

Examples of improvements demonstrated because of clinical audits or other improvement.

There was comprehensive evidence of clinical quality improvement initiatives including approximately thirty audits and an overarching audit program. We checked and verified 12 of the clinical audits undertaken since our previous inspection, five of these were repeated cycle audits, including a "PINCER" audit that covers 11 areas of drug safety which had three cycles with good results for reduced medication errors and improved medication safety.

Other audits included assessing the efficacy of the use of gliptins in management of type 2 diabetic patients, and prescribing of a) oral iron and b) antibiotics (various).

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example pharmacists.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed staff records across a range of clinical and non-clinical roles that demonstrated comprehensive and appropriate training had been undertaken, including competence assessments where necessary in areas of both mandatory training such as fire safety and safeguarding, and role specific training such as training for cervical screening sample takers.</p> <p>Regular staff appraisals were undertaken and there was oversight of staff training.</p> <p>Staff were able to manage data and by using internal systems effectively in accordance with their roles. For example, referrals to other services were prompt, well documented and followed up.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Monthly multidisciplinary meetings were held as well as additional communications as needed for palliative care, diabetic, and vulnerable patients.</p> <p>Patients were signposted to a local health club, for example patients with pre-diabetes or CVD.</p>	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	y
<p>Explanation of any answers and additional evidence:</p> <p>Some health promotion information in the reception area such as leaflets had to be removed due to COVID infection prevention and control. The practice placed information leaflet title labels where leaflets had been, to let patients know the leaflets were still available at reception on request.</p> <p>Posters were up such as to promote bowel cancer screening.</p> <p>Care plans indicated staff encouraged and educated patients appropriately to help patients live healthier lives.</p> <p>The practice identified carers and patients at the end of life that were regularly reviewed.</p> <p>Patients were referred to local pharmacists for stop smoking services.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	92.4%	95.3%	94.5%	No statistical variation
Exception rate (number of exceptions).	1.3% (23)	0.7%	0.8%	N/A

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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: Patient consent was sought and recorded, including to inform patients of minor procedure risks and benefits.	

Caring

Rating: Good

At the previous inspection of the 22 July 2019 and 25 July 2019 we rated caring as requires improvement due to concerns including insufficient arrangements for patient's privacy in the reception area and to identify carers.

At this inspection we rated caring as good because systems to identify carers had improved and privacy was maintained in the reception area.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was generally positive.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Source	Feedback
NHS Choices website	Five comments and star ratings were received in the last 12 months. Ratings were one five out of five, two four out of five, and two out of five stars. Patients comments expressed that staff are caring and the mixed and negative ratings and feedback did not relate to staff attitude, but to access to appointments.
Patient feedback	Patient feedback we received from members of the Patient Participation Group (PPG) was positive, stating that the practice meets the needs of its patients and listens to the PPG to improve the service.

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)	73.7%	82.4%	88.5%	Variation (negative)
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)	77.3%	79.0%	87.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	92.2%	91.6%	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)	70.6%	73.8%	81.8%	No statistical variation

Any additional evidence or comments

The practice GP Patient Survey result for patients who stated the healthcare professional was good or very good at listening to them was below average, and was trending towards a negative variation for the healthcare professional treating them with care and concern.

The practice was aware of this and had brought it to the attention of the whole staff team during meetings reflection and discussion, including clinical team meetings to ensure healthcare professionals engagement. The practice was monitoring its performance through the GP Patient Survey Results and its annual patient satisfaction survey. Feedback from members of the Patient Participation Group (PPG) was positive.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y
Any additional evidence	
The practice routinely carried out its own surveys as was evidenced at our previous inspection and on the practice action plan and scheduled date to do so November 2020, which was delayed due to clinical priorities and service changes due to COVID 19.	

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	84.1%	87.3%	93.0%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Explanation of any answers and additional evidence:

The practice GP Patient Survey result for patient's involvement in decisions about their care and treatment was trending towards a negative variation which had been discussed at staff meetings and was due to be discussed again in November 2020.

Information about national and local support groups was available on the practice website.

The practice had updated its website to include information about the COVID-19 pandemic and how patients could continue to access services.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 88, 1% of the practice list.
How the practice supported carers (including young carers).	The practice had updated an appointed patient key contact carers champion and offered an appropriate carers pack support resource. The practice offered annual reviews and flu vaccinations to carers. Carers information was available on the website.
How the practice supported recently bereaved patients.	Staff sent them a sympathy card and where appropriate/ desired offered a patient consultation at a flexible time and location to meet the family's needs. By giving the patient advice on how to find a support service.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	
Patient privacy was respected and numbers of patients on site at any one time was limited due to COVID-19	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y

Responsive

Rating: Requires improvement

At the previous inspection of the 22 July 2019 and 25 July 2019 we rated responsive as inadequate due to concerns including a lack of effective action to improve access, appointments not offered according to timings on the practice website and leaflet, and arrangements for receiving and acting on complaints were insufficient. These concerns affected all population groups and population groups ratings.

At this inspection we rated responsive as requires improvement because, although we found the practice had sufficiently reviewed and improved some areas of concern found in the inspection on the 22 July 2019 and 25 July 2019, it had not sufficiently completed or evaluated improvements to demonstrate effective action to improve patients access.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Any additional evidence or comments

The practice's GP patient survey results for 2020 were in line with local and national averages for the question relating to responding to patients' needs.

Practice Opening Times	
Day	Time
Monday	8am-6:30pm
Tuesday	8am-6:30pm

Wednesday	8am-6:30pm
Thursday	8am-6:30pm
Friday	8am-6:30pm

National GP Survey results

Appointments are available:				
<ul style="list-style-type: none">Monday: 8.30am to 6.30pmTuesday: 8.30am to 6.30pmWednesday: 8.30am to 6.30pmThursday: 8.30am to 4pm (The GP Co-Op covers urgent issues in the afternoon)Friday: 8.30am to 6.30pm				
Off-site extended hours	Appointments are provided by the Primary care Network (PCN) Wednesday to Friday from 6.30pm to 9.30pm, and Saturday 9am to 12.30pm.			
In addition, the local Federation provides a wraparound service with GP appointments available between 8am and 8pm Monday to Sunday.				
Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	93.6%	91.1%	94.2%	No statistical variation

Older people

Population group rating: Requires improvement

Findings

The provider was rated as Requires improvement for responsive due to a lack of evidence of effective action to improve patients access. This affected all patients including this population group.

Patients had a named GP who supported them in whatever setting they lived.

The practice was responsive to the needs of older patients and offered home visits and walk in and urgent appointments for those with enhanced needs and complex medical issues.

In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Requires improvement

Findings

The provider was rated as Requires improvement for responsive due to a lack of evidence of effective action to improve patients access. This affected all patients including this population group.

Patients with multiple conditions had either a single appointment or separate appointments to review their care. Staff told us patients would request separate appointments at times.

The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The number of patients “co-ordinate my care” plans in place had increased from five at the previous inspection to 34 at this inspection

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.

Families, children and young people

Population group rating: Requires improvement

Findings

The provider was rated as Requires improvement for responsive due to a lack of evidence of effective action to improve patients access. This affected all patients including this population group.

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.

Additional nurse appointments were available in the evenings during the week and on Saturdays, so children did not need to miss school.

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.

All parents or guardians calling with concerns about a child were prioritised and offered a same day appointment when necessary.

There were baby changing and breast-feeding facilities available.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

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.

Telephone and online consultations were available.

Off-site after-hours surgeries were available through a local network hub of GP practices.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings
<p>The provider was rated as Requires improvement for responsive due to a lack of evidence of effective action to improve patients access. This affected all patients including this population group.</p> <p>People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.</p> <p>The practice adjusted the delivery of its services to meet the needs of vulnerable patients, for example by offering a double-appointment slot.</p> <p>The practice held a register of patients living in vulnerable circumstances such as those with a learning disability.</p> <p>The practice provided care coordination to enable patients living in vulnerable circumstances to access appropriate services.</p>

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

Population group rating: Requires improvement

Findings
<p>The provider was rated as Requires improvement for responsive due to a lack of evidence of effective action to improve patients access. This affected all patients including this population group.</p> <p>Priority appointments were allocated when necessary to those experiencing poor mental health.</p> <p>Staff had a good understanding of how to support patients with mental health needs and those patients living with dementia.</p> <p>The practice was aware of support groups within the area and signposted their patients to these accordingly.</p>

Timely access to the service

There was insufficient evidence of effective action to ensure patients timely access to the service.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when necessary.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection 22 July 2019 and 25 July 2019, the practice website was unclear about appointment availability. The practice GP patient survey results for 2019 were significantly below local and national averages for questions relating to telephone access, and all other GP Patient Survey indicators for timely access to services were lower than average. Advance appointments were limited, and the walk-in appointment system could have resulted in patients turning up for an appointment and being turned away, less mobile or patients that were too unwell not being able to queue long enough</p>	

and potentially outdoors for up to 90 minutes. There was no method of triage or guarantee walk in patients would be seen at any time the same day. There was no strategy or effective action plan to improve.

At this inspection, we noted the practice had undertaken swift actions to improve immediately after the previous inspection such as updating its website, urgently reviewing arrangements / appointments demand and usage, doubling advance appointments availability. During September 2019 the practice also provided an extra staff member to answer the telephone at peak call times and undertook a patient satisfaction survey to evaluate the impact on patients experiences including views on the walk in appointments. The practice continued to make changes to improve patient access prior to and at the onset of COVID-19 March 2020 by changing its appointments system again to accommodate new requirements and patients needs.

For example:

- Two additional new telephone lines at the end of January 2020.
- New telephone queuing system February 2020.
- Online triage system shifting to a majority telephone, video and clinical photo communication and appointments with a response to the patient within 48hours. March 2020
- Embedding document management systems to further release GP capacity and appointments.
- Meetings across clinical and non-clinical teams to raise staff awareness and discuss methods and target areas for improvement.
- Ongoing engagement with the Patient Participation Group (PPG) whose feedback was positive overall, and about patients access improvements.
- The daily duty GP system for urgent access was maintained.

The practice undertook a survey of 100 patients specifically to consider patients experiences following adding extra telephone lines and a telephone queuing system in January 2020, and the results were positive and encouraging. However, the practice GP Patient Survey results for patient access that were captured 1 January 2020 to 31 March 2020 were all lower than average, trending to becoming statistically below average, or already statistically below average compared to local and / or national averages which was an issue repeated from the previous inspection.

A practice led patient satisfaction survey was due to be undertaken November 2020 to inform outcomes in terms of patient's experiences, and evaluation of changes and next steps. However, there was no evidence to verify improvements were delivered in terms of patients experience at the time of our inspection. All four GP Patient Survey results relating to timely access to services were lower than both local and national averages, which was the most verifiable overall indicator of patients access experiences at the time of our inspection

The most recent period GP patient survey results were collected 1 January 2020 to 31 March 2020 which is a lagging indicator, and may not capture changes in patients experiences since the practice implemented some of the changes to access it had made. The results were statistically comparable to the national average for telephone access, but below average for patient's satisfaction with the type of appointment/s they were offered and trending towards being below average for patient's overall experience of making an appointment.

A practice led patient satisfaction survey was due to be undertaken November 2020 to inform outcomes in terms of patients experiences, and evaluation of changes and next steps. However, there was no evidence to verify improvements were delivered in terms of patients experience at the time of our inspection. No practice led survey had been undertaken since September 2019 and all four GP Patient Survey results relating to timely access to services were consistently lower than both local and national

averages, which was the most contemporaneous and verifiable indicator of patients experience at the time of our inspection.

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)	46.2%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	42.0%	57.3%	65.5%	Tending towards 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)	53.7%	60.0%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	48.2%	64.0%	72.7%	Variation (negative)

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.	9
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	All inspected
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

We saw evidence that complaints were fully investigated with transparency and openness. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. Information about how to complain was readily available including on the practice website and the Patient Participation Group (PPG) members were aware of the complaints system. The practice response letter to complaints included the Parliamentary and Health Services Ombudsman (PHSO) details in case a patient remained dissatisfied with the outcome. Complaints were a standing agenda item in staff meetings and escalated through the significant events process, if appropriate.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient referral where the patient did not get an appointment at secondary care option offered of their choice.	The practice responded quickly and apologised to the patient and investigated the complaint which showed proper process was followed but one secondary care provider had rejected to referral due to only accepting referrals from a specialist care clinician. The explanation was shared with the patient and discussed within the staff team to prevent recurrence.
A task on the clinical system was missed that resulted in a delay in communication to the patient.	The patient contacted the practice to complain and staff investigated. An internal task to contact the patient was missed before archiving and the practice apologised to the patient. There was no harm to the patient, the issue was discussed with staff for learning and to prevent recurrence and the patient was also offered an appointment to further discuss their concerns with a GP.

Well-led

Rating: Good

At the previous inspection of the 22 July 2019 and 25 July 2019, we rated well-led as inadequate due to concerns including a lack of strategy and planning, insufficient systems of accountability to support good governance and management, and a lack of effective action to manage risks and issues and improve performance.

At this inspection, we rated well-led as good because the practice had prioritised and improved all areas of high risk concerns identified at our previous inspection 22 July 2019 and 25 July 2019, and had improved and initiated processes to embed ongoing improvements to its strategy, organisational structure, risk management, and performance.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:
The practice closed its list after our previous inspection to focus resource on delivering improvements required.
Leaders and managers had developed and delivered an effective action plan that appropriately focused on risks and priorities, this was in tandem with emerging changes and demands due to COVID 19.
Staff told us all leaders and managers were supportive and friendly.
There was a satisfactory contingency plan to cover the absence of the lead GP that remained under review and considered wider changes such as within the Primary Care Network.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
Staff were able to articulate the values and priorities of the practice. Practice staff confirmed they wanted to do all they could to ensure patients had the right care when they needed it most.	
The practice had appropriate continuous professional development arrangements in for both clinical and non-clinical staff which maintained the quality of care afforded to all patient groups. The practice was aware of areas it needed to improve and had taken steps to do so.	
The practice strategy had been formulated with reference to relevant risks and sustainability considerations and the clinical and management teams engaged appropriately with staff and patients to underpin its delivery, such as through meetings.	

Culture

The practice had a culture which drove high quality care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y

There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Arrangements to support staff wellbeing included flexible working hours.</p> <p>The practice staff team was cohesive, motivated and felt supported and listened to. Staff told us there was an open and accessible leadership and management team.</p> <p>Complaints and significant events information showed the practice was open and honest with patients and apologised to patients, where appropriate.</p>	

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

Source	Feedback
Staff	There are good relationships between leaders, managers and the whole 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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had applied to CQC as required to register the regulated activities appropriately since our previous inspection.</p> <p>The practice was continuing to build on opportunities alongside another six practices in its Primary Care Network (PCN).</p> <p>There were a variety of internal and external meetings, including where staff discussed complaints, patient satisfaction survey results, safety alerts and significant events and NRLS reports were made as needed.</p> <p>Practice specific policies were in place and reviewed such as safeguarding and prescribing.</p> <p>There were organisational arrangements including delegated staff and lines of accountability in areas such as infection control.</p>	

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was an overarching risk log that was reviewed and actioned by relevant staff including COVID 19.</p> <p>Clinical and non-clinical performance indicators were known and used to make improvements and future plans in line with urgency including GP Patient Survey Results and clinical audits.</p> <p>The practice systems of internal significant events that were generally effective and individual significant events were identified and managed appropriately. There was evidence of discussion of significant events at clinical, practice and reception meeting minutes.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice used data such as QOF performance and GP Patient survey data to monitor and improve care, and was aware of areas it needed to continue to focus on such as childhood immunisations and cervical screening uptake.</p> <p>The practice used the findings of our previous inspection to hold itself accountable at all levels including to lead and manage changes and improvements required. Staff performance appraisals were undertaken annually.</p> <p>The practice implemented a "Reviewing and Acting on Correspondence, Reports and Results" protocol</p>	

for reviewing and acting on correspondence, reports and investigation results received and these arrangements were effective.

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was aware of and provided its services in line with local needs and in line with best practice guidelines.</p> <p>The practice considered patients survey feedback to identify some improvement actions but it had not established whether changes it had made to improve patients access were effective, as no recent evaluation was undertaken in terms of patients experiences. There was no assurance of improved access and GP Survey Results were consistently lower than average for two years.</p> <p>Staff told us they were listened to and had made suggestions that were used to inform improvements, such as through the significant events process.</p>	

Feedback from Patient Participation Group.

Feedback
The Patient Participation Group (PPG) was complimentary about the practice. The PPG meeting was conducted through virtual meetings. The PPG met regularly, and examples of improvements made by the practice as a result of engagement with its PPG included improving the telephone system with a patient queueing system and two additional lines.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>The practice implemented improvement measures over the last two years including:</p> <ul style="list-style-type: none"> • A range of continuous improvement activity such as clinical audits. • A document management system to improve workflow productivity and release GPs capacity and appointments provision. • Maximising patient's online access and transitioning to all e-referrals. 	

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.