Care Quality Commission

Inspection Evidence Table

Northumberland Park Medical Group, Shiremoor Resource Centre (1-569736875)

Inspection date: 22 and 29 January 2019

Date of data download: 05 December 2018

Overall rating: Requires improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Rating: Requires improvement

The practice was rated as requires improvement for providing safe services because:

- Some of the practice's systems and processes were not always reliable or implemented effectively, and could place people at risk of harm. In particular:
  - The arrangements for documenting the outcomes of the practice's multi-disciplinary team safeguarding meetings and significant events were not effective. Although staff told us lessons were learnt when things went wrong, it was not always clear whether agreed changes had been reviewed and implemented to make sure they had helped to drive improvements.
  - Immunisation histories had not been obtained for some non-clinical staff.
  - The practice's health and safety risk assessment did not comprehensively address risks to patients' safety. The practice had not carried out a comprehensive infection control audit.
  - The practice's locum GP pack was out-of-date and there was no lead GP to oversee the performance of locum and salaried GPs.

Safety systems and processes

Some of the practice's systems and processes were not always reliable and could place people at risk of harm.

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.	Partial
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
Systems were in place to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers, to support and protect adults and children at risk of significant harm.	Y

Explanation of any answers and additional evidence:

- Most of the practice's safeguarding systems and processes worked effectively and staff were aware of them. Leaders maintained a spreadsheet record of the outcomes of the multi-disciplinary team (MDT) safeguarding meetings they held at the practice. However, it was difficult to corroborate that learning took place as part of the MDT safeguarding process, because minutes were not formally recorded. Also, in the sample of records we looked at, actions detailed in the spreadsheet record were not assigned to a designated person. In addition, we did not see clear evidence that actions agreed at previous MDT meetings had been reviewed.

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 and if relevant to role.	Partial
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who required medical indemnity insurance had it in place.	Y

Explanation of any answers and additional evidence:

- The practice had obtained immunisation histories for clinical staff, as well as for those non-clinical staff handling specimens. However, immunisation records were not available for other non-clinical

staff.

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: 05/03/2018	Y
There was a record of equipment calibration. Date of last calibration: 15/01/2018	Y
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N*
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check: 22/02/2017	Y
There was a log of fire drills. Date of last drill: 23/06/2017 and 20/09/2018	Y
There was a record of fire alarm checks. Date of last check: 22/01/2019	Y
There was a record of fire training for staff. Date of last training: There were various dates on which fire training was delivered during 2018.	Y
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion: 13/10/2017	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: • Leaders told us that they did not keep any hazardous materials on their premises. They said these were kept centrally by the cleaning contractor employed by the building's owner. * • Leaders assured us that any actions that had been identified in the fire risk assessment had been actioned by the building's owner and their contractor.	

Health and safety	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/06/2018 The practice's risk assessment did not cover the security of the premises. However, leaders told us the day-to-day security of the premises was overseen by the local council.	Partial

Explanation of any answers and additional evidence:

- The practice had completed an overall health and risk assessment for the practice. However, this was not comprehensive because there were gaps. The assessment:
  - Did not specify who was responsible for carrying out the small number of actions that had been identified and when they should be completed.
  - Did not cover all risks associated with the operation of the practice. For example, it did not cover the risks associated with the clinical summaries of the paper records for patients who had either recently registered with, or been allocated to, the practice, not always being accurate or up-to-date. The assessment also did not cover: the arrangements for the security of the premises; accepting a DBS check from a previous employer, when appointing a new member of staff; the decision regarding which emergency medicines to stock; the arrangements for preventing the spread of infection.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met. However, the arrangements for assuring that appropriate systems were in place to prevent the spread of infection, were not robust enough.

	Y/N/Partial
An infection policy was in place. An infection control risk assessment had been completed.	Y N
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 26/08/2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- A legionella risk assessment had been carried out on 20/06/2017.
- The practice was visibly clean and hygienic throughout. Although various infection control audits had been completed, a comprehensive audit, covering all aspects of infection prevention, had not been carried out. Also, a specific infection control risk assessment had not been completed. The audits that had been completed included:

  1. An asepsis technique assessment within a clinical setting, in August 2018. (An asepsis audit focuses on how well clinicians carry out particular procedures which require a 'non-touch' technique.) The assessment also included a completed hand hygiene audit.
  2. An audit of the sharps and clinical waste arrangements in January 2019.
  3. A bi-monthly infection control audit of all treatment and consultation rooms, which covered the following areas: the sharps bins; whether clinical bins had been filled appropriately; the availability of hand gel and a hygiene poster at washbasins; the use of personal protective

equipment.

- The completed audits identified no concerns.

Risks to patients

Overall, there were adequate systems to assess, monitor and manage risks to patient safety. However, there were some minor gaps in the practice's arrangements for managing GP locums and updating the locum GP induction pack.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an 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
Panic alarms were fitted and administrative staff understood how to respond.	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
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	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:

Managing staff absences and busy periods:

- Leaders were acting to recruit additional GPs, to cover planned GP departures in March 2019. In addition, contingency arrangements had been put in place to employ known locum GP staff, should the practice be unable to recruit further salaried GPs.
- Locum GP staff were covering a small number of clinical sessions. The practice manager told us the practice only ever used experienced locums that they knew and had used before, and who were very experienced. They said that new GP locums would be provided with access to the practice's GP locum pack, as part of their induction. However, leaders told us there was no designated lead responsible for overseeing the performance of the GP locums or salaried GPs, used by the practice. In addition, the practice's GP locum pack was out-of-date in some areas. *
- Leaders told us the administrative team was fully staffed. However, discussions were due to take place to decide whether the practice needed to recruit an additional member of administrative staff, to help provide extra support during busy periods. Plans were in place to

recruit an apprentice, to help improve the practice's digital systems.

Sepsis/managing emergencies:

- Clinical staff had access to a sepsis clinical toolkit, to help them identify patients at risk of developing sepsis. Clinicians had completed sepsis training.
- Non-clinical staff told us they had a good understanding of how to respond in an emergency.

Managing change:

- Before the practice introduced a nurse triage system in April 2018 to help them manage demand for same-day appointments, they had assessed the risks associated with this and considered what they could do ensure patient safety. This included identifying:
  1. The training needs of the nurse concerned, and supporting them to complete this training.
  2. What support mechanisms should be put in place to support them. For example, experienced GP staff shadowed the initial triage sessions. GP staff were allocated appointment free slots, to help ensure the nurse had access to prompt advice, support and expertise.

Information to deliver safe care and treatment

Overall, staff had the information they needed to deliver safe care and treatment, and processed it effectively. However, there were minor gaps in the practice's systems for sharing information with other professionals and for summarising new patient notes.

	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.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

Test results:

- The practice had a policy for handling pathology results. Satisfactory arrangements were in place to: check the results of test results; action abnormal test results; advise patients of the outcomes.
- Test results were handled in a timely manner.

- The practice had an electronic pathology protocol in place. This covered the arrangements for handling test results in the absence of the clinician who requested them.

Sharing information with other agencies:

- Appropriate arrangements were in place to share information with out-of-hours services and relevant professionals, when deciding care delivery for patients with long-term conditions. However, the GPs we spoke with were unclear about the systems in place for sharing information about some groups of patients with community and social services.

Summary of patient clinical records:

- Following the closure of a surgery in the same building in March 2018, 2000+ patients had registered with the practice over the course of approximately six months. This included approximately 500 patients who were allocated to the practice in April 2018.
- Leaders told us the electronic records they had received for these patients had been summarised. However, the practice manager said the summaries of these patients' paper clinical records were either inaccurate or required updating. To address this issue:

  1. The practice manager was summarising the paper clinical records. They had added the summaries to the patients' e-clinical record and had completed approximately 800 summaries to date. They told us there were approximately another 1000 records that needed to be summarised.

  2. The practice was recruiting a nurse to take over this role from the practice manager, so the remaining records could be summarised before they are removed from the building, at the end of March 2019.

- The practice manager:

  1. Assured us they had received specific training about how to summarise patients' clinical records.
  2. Had undertaken such work before.
  3. Confirmed an agreed protocol was in place.
  4. Told us they would seek advice from either their practice nurse, or one of the doctors, if they had any queries.

- However, the arrangements for summarising patients' medical records did not include a system for sampling and carrying out peer reviews, to help ensure consistency and accuracy.

Appropriate and safe use of medicines

The practice had effective 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) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	1.10	1.06	0.94	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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). (01/10/2017 to 30/09/2018) (NHSBSA)	7.2%	8.4%	8.7%	No statistical variation

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 in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process in place 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.	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 in place 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.	Y
For remote or online prescribing there were effective protocols in place for verifying patient identity.	N/A
The practice held appropriate emergency medicines. A risk assessment was in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems were in place to	Y

Medicines management	Y/N/Partial
ensure these were regularly checked and fit for use.	
Vaccines were appropriately stored and monitored in line with Public Health England guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- Overall, satisfactory arrangements were in place to monitor stock levels. However, we found one item of medicine that was out-of-date. The practice took immediate action to address this issue.
- Practice staff had access to a defibrillator that was kept centrally in the building. The defibrillator was shared with another practice.
- A range of emergency medicines was available and arrangements were in place to check stock levels and expiry dates. However, a risk assessment had not been completed to determine the range of emergency medicines the practice stocked.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, the arrangements for reviewing the effectiveness of any improvements made, following a significant event, were not sufficiently rigorous.

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

Explanation of any answers and additional evidence:

- Staff told us that lessons were learned following significant events, and that these were shared with the team. However, it was not always clear from the significant event records we looked at whether the improvements made were reviewed and implemented, to help ensure they were effective and had been sustained.

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

Event	Specific action taken
Delayed/rejected two-week-wait (2WW) referral	• Leaders reviewed the circumstances of the referral to identify what had happened. • Contact was made with the patient to explain the reasons for the delay and to make another referral. • Contact was made with the hospital concerned, to review what had happened and why. • The local clinical commissioning group was informed, so they could take appropriate action to support the practice. • The hospital reviewed its coding of 2WW referrals, to help GP practices refer patients promptly.
Delay in review of blood test results	• Leaders reviewed their system for handling blood test results and added an additional step in their protocol, to help prevent a similar occurrence. • Contact was made with the patient concerned to repeat the blood test.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

Effective

Rating: Requires improvement

The practice was rated as requires improvement for providing effective services because:

- The practice did not have a systematic programme of quality improvement.
- The practice did not have an effective staff appraisal system.
- The practice's arrangements for documenting staff inductions was not effective.
- The Quality and Outcome Framework long-term conditions clinical indicators relating to the treatment of patients with asthma and atrial fibrillation, were lower than the local clinical commissioning group and national averages.
- Follow-up consultations did not always take place following a patient's discharge from hospital.

Because these concerns impacted on all population groups, we have rated them as requires improvement for providing effective services.

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
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
Appropriate referral pathways were in place 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
Explanation of any answers and additional evidence:	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.76	0.69	0.81	No statistical variation

Older people

Population group rating: requires improvement

Findings

- The practice maintained a register of their frail elderly patients and used the Electronic Frailty Index tool to help them identify those at greatest risk.
- The practice held multidisciplinary meetings twice a month. Staff used these meetings to review the needs of older patients and patients with complex needs. Leaders told us there were currently no formal arrangements in place for monitoring unplanned, emergency hospital admissions, following changes to the practice's meetings structure in 2018. However, the practice's rate of unplanned, emergency hospital admissions was low, when compared to the local clinical commissioning group average.
- Arrangements had been put in place to support care planning. Emergency health care plans had been completed for those patients considered to be most at risk.
- Older patients were offered opportunities for immunisations via the practice's vaccination programme.
- Follow-up consultations did not always take place following a patient's discharge from hospital. Leaders told us that on receipt of discharge information, whether this was by paper or electronically, administrative staff scanned the document onto a patient's clinical record and forwarded to their usual GP, and the pharmacy technician in case changes were required to a patient's medicines. We were told that, if considered necessary by a clinician, appropriate follow-up would take place.
- As the practice did not have in place a systematic programme for quality improvement, a staff appraisal system and an up to date induction processes, we have rated this population group as requires improvement, as the absence of these processes affects all population groups.

People with long-term conditions

Population group rating: requires improvement

Findings

- Housebound patients could have an influenza vaccination in their own home.
- Practice leads had been identified for the key long-term conditions to help promote leadership and expertise.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation

(AF) and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with long-term conditions had a structured annual review, to check their health and medicines needs were being met. For patients with the most complex needs, clinical staff worked with other health and care professionals, to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received relevant training.
- GPs followed up patients who had received treatment in hospital, or at out-of-hours services for an acute exacerbation of asthma.
- The Quality and Outcome Frameworks (QOF) data referred to in this evidence table, shows the long-term conditions clinical indicators relating to the treatment of patients with asthma and atrial fibrillation, were lower than the local clinical commissioning group and national averages.
- Evidence obtained during the inspection demonstrated the practice had an effective recall process in place for the reviews of patients with LTCs. This included an initial invitation for patients, followed up by a further two requests to attend for a review. Patients were excepted by clinical staff, only after every effort had been made to contact and engage with them.
- As the practice did not have in place a systematic programme for quality improvement, a staff appraisal system and an up to date induction processes, we have rated this population group as requires improvement, as the absence of these processes affects all population groups.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	82.6%	81.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.9% (46)	14.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.9%	79.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	10.4% (40)	11.5%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	81.5%	82.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.1% (66)	15.9%	13.5%	N/A

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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	61.3%	75.8%	76.0%	Variation (negative)
Exception rate (number of exceptions).	7.3% (36)	10.5%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	77.6%	90.3%	89.7%	Variation (negative)
Exception rate (number of exceptions).	4.7% (8)	14.0%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.7%	84.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.3% (49)	4.8%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	76.0%	87.8%	90.0%	Variation (negative)
Exception rate (number of exceptions).	6.5% (7)	7.7%	6.7%	N/A

Families, children and young people

Population group rating: requires improvement

Findings
• The practice had a designated safeguarding lead who provided expertise and leadership, to help ensure there was a co-ordinated response to concerns about vulnerable patients at risk of harm. Monthly safeguarding meetings, involving health visitor staff, were held to share information

about at-risk vulnerable children and adults.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. The practice provided a weekly immunisation clinic. The childhood immunisation indicators, for vaccines given to children aged two and under, referred to in this evidence table, show the practice's uptake rates were above the World Health Organisation (WHO) targets.
- The on-site midwife held weekly ante-natal clinics and clinicians at the practice completed the post-natal six-week check for new mothers.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. They also had arrangements for following up children who failed to attend appointments.
- The practice offered a full range of family planning services. These helped ensure young people could access services for sexual health and contraception. A nurse-led recall system was in place, to help ensure that where necessary, patients received a regular contraceptive review. Because some staff were unclear about the arrangements for delivering this service, leaders told us they would review these.
- As the practice did not have in place a systematic programme for quality improvement, a staff appraisal system and an up to date induction processes, we have rated this population group as requires improvement, as the absence of these processes affects all population groups.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)	76	76	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	96	96	100.0%	Met 95% WHO based target (significant variation positive)
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) (01/04/2017 to 31/03/2018) (NHS England)	96	96	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	96	96	100.0%	Met 95% WHO based target (significant variation positive)

Working age people (including those recently retired and students)
Population group rating: requires improvement

Findings

- The practice's uptake of cervical screening was 73.1%, which was below the 80% target of the national screening programme. The practice showed us verified QOF data, for 2017/18, which indicated their attainment level was 85.3%. This was above the local clinical commissioning group (CCG) and national averages.

- The practice's uptake rates, for breast screening and bowel cancer screening were in line with the national averages.
- The practice had arrangements in place for informing eligible patients, such as students attending university for the first time, to have the meningitis vaccine.
- Patients had access to appropriate health assessments and checks, including NHS checks for patients aged 40-74. There was appropriate 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.
- As the practice did not have in place a systematic programme for quality improvement, a staff appraisal system and an up to date induction processes, we have rated this population group as requires improvement, as the absence of these processes affects all population groups.

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) (01/04/2016 to 31/03/2017) (Public Health England)	73.1%	76.4%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) **(PHE)**	74.6%	74.4%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)**(PHE)**	53.7%	57.5%	54.6%	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. **(PHE)**	88.6%	70.9%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	48.4%	50.8%	51.6%	No statistical variation

People whose circumstances make them vulnerable
Population group rating: requires improvement

Findings

- End-of-life care was delivered in a coordinated way, which took account of the needs of those whose circumstances may make them vulnerable.
- The practice offered annual health checks to patients with a learning disability.
- The practice had arrangements in place for vaccinating patients who had an underlying medical condition, in line with the recommended schedule. As part of the practice's preparation for the influenza season, searches were carried out to identify and target 'at-risk' patients.
- The practice demonstrated they had a system to identify people who misused substances.
- As the practice did not have in place a systematic programme for quality improvement, a staff appraisal system and an up to date induction processes, we have rated this population group as requires improvement, as the absence of these processes affects all population groups.

People experiencing poor mental health (including people with dementia)
Population group rating: requires improvement

Findings

- The practice's performance, in relation to two of the mental health indicators, was comparable to the local CCG and national averages. Their performance was better than the local CCG and national averages, in relation to the number of patients with mental health conditions who had an agreed care plan in place. Also, although the practice had a higher than average exception-reporting rate for this particular clinical indicator, there were acceptable reasons for this.
- The practice assessed and monitored the physical health of people with a mental illness, by providing annual mental health reviews. Patients could also access a smoking cessation clinic at the practice.
- 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.
- There were systems in place for following up patients who failed to attend for the administration of long-term medication, and those who were misusing substances.

  The practice manager told us that, from time-to-time, the practice received information regarding patients at risk of suicide or self-harm, usually from the local crisis team and/or social services. Any concerning information received was READ coded onto a patient's clinical records, so clinicians were alerted and could take this into account when carrying out a consultation. Because some staff were unclear about the arrangements the practice had in place to identify patients at risk of suicide or self-harm, leaders told us they would review these.
- Clinical staff had received dementia awareness training.

- As the practice did not have in place a systematic programme for quality improvement, a staff appraisal system and an up to date induction processes, we have rated this population group as requires improvement, as the absence of these processes affects all population groups.

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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	91.7%	89.5%	Variation (positive)
Exception rate (number of exceptions).	28.6% (6)	13.3%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.4%	92.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	14.3% (3)	11.3%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	78.3%	83.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	8.0% (2)	6.3%	6.6%	N/A

Monitoring care and treatment

Clinical and prescribing audits had been carried out to review the effectiveness and appropriateness of the care provided. However, the practice did not have a systematic programme of quality improvement.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	536	-	537.5
Overall QOF exception reporting (all domains)	6.1%	6.3%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial

Any additional evidence

- A range of clinical and prescribing audits had been completed. These showed evidence of improvements. However, the practice did not have a systematic programme of quality improvement.
- Leaders told us they were not currently involved in any national quality improvement initiatives. However, the practice was currently participating in a local quality improvement initiative, to provide patients with better access to care and treatment out-of-hours.

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

Clinical audit:

Examples of clinical and prescribing audit activity included:

- An audit to check the practice's compliance with national guidance, regarding the length of time for which antibiotics should be prescribed to patients diagnosed with Bronchiectasis. (Guidelines suggest patients with bronchiectasis (a lung condition) should be prescribed antibiotics for 10-14 days in the event of an infective exacerbation.)
  Following a search of the practice's clinical records system, 17 patients with bronchiectasis were identified. The search showed that 62 courses of antibiotics had been prescribed during 2016/17. Of these: six courses were for five days (9.6%); 33 courses were for seven or eight days (53.2%); 22 courses were for ten to fifteen days (35.5%).
  Following this initial audit, a visual prompt was added to the clinical records system, to help encourage clinicians to prescribe a 14-day antibiotic course for patients with this condition.
  A second audit was undertaken. This showed an improvement in clinicians' prescribing practice; 75% of prescriptions were for 14 days and 25% were for seven days.

- An audit to check the practice's compliance with national guidance regarding the prescribing of Valproate to females of childbearing age. (Recent guidance states that Valproate may cause birth defects and should be avoided, unless there is a pregnancy prevention programme in place.
  A search of the practice's clinical records system was undertaken in August 2018. This showed five patients had been prescribed this medicine, of which only one patient was of childbearing age.
  Actions taken included: contacting the patient and making them aware of the latest guidance and making sure they understood the risks; referring them to a specialist for ongoing review; a review of the findings at a practice clinical meeting, so all clinicians were aware of the revised national management guidelines.

Effective staffing

The practice was not able to fully 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.	Partial
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. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Partial
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice.	N/A
There was an approach for supporting and managing staff when their performance was poor or variable.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

Explanation of any answers and additional evidence:

- Although the practice manager said there was a documented protocol for managing poor or variable performance, which included access to an external employment consultant, one of the GP leaders told us there was no formal system in place.
- Leaders provided evidence that the GPs had received an external appraisal linked to their continuing registration with their regulating body. However, none of the staff, including the GPs, had received an internal appraisal during the previous two years.
- Staff had completed the training which the provider considered to be mandatory. The practice manager kept a spreadsheet which they monitored, to help make sure staff kept their training up-to-date. Most staff reported that they had protected time to undertake required training. However, the nurse lead for infection control told us they had not completed more advanced training in infection control, to help them carry out this role. Following the inspection, leaders confirmed that a clinical member of staff needed to complete their information governance training.
- New staff received an induction that was relevant to their role. For example, the practice had two healthcare assistants. One of these had commenced work at the practice prior to April 2015 and therefore did not have to cover the Care Certificate induction standards. We confirmed they had completed the training they required to carry out their roles and responsibilities. The second healthcare assistant had just started working at the practice and was undergoing an induction. However, some of the staff records we looked at did not contain a completed induction record. Reasons given for this included that staff had worked at the practice previously and/or were known to the practice. The practice manager confirmed the

practice's induction templates did not cover the Care Certificate induction standards.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment. However, there was a gap in their arrangements for sharing information with some key professionals.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed clinical and relevant non-clinical staff 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.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: • Leaders told us patient information was shared between the practice, and the healthcare professionals in attendance, during multi-disciplinary team (MDT) meetings. However, the practice's MDT meetings were not routinely attended by social services staff. One of the GP leaders told us there were no formal systems in place for sharing information with social services and community services professionals, but that this was done as and when necessary.	

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
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
Explanation of any answers and additional evidence:	

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 (01/04/2017 to 31/03/2018) (QOF)	96.5%	96.2%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (5)	1.0%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence:	

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	27
Number of CQC comments received which were positive about the service.	22
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC comment cards	Positive feedback: Words used to describe the service included: professional; always good; high quality; excellent care; lovely staff; excellent; polite and helpful; friendly, approachable and efficient; responsive; outstanding care; safe and hygienic; go above and beyond. Negative feedback: • Two patients expressed concerns about difficulties experienced trying to obtain an appointment. • One patient commented about the unhelpful attitude of a member of staff. • One patient commented that the practice had failed to return their telephone call. • One patient commented that the reception areas were cluttered, with too many repetitive posters. They also said there was no hand sanitizer in the reception area.
NHS Website (Choices)	The practice had received very positive feedback regarding the care and treatment patients received.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7917	322	114	35.4%	1.44%

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 (01/01/2018 to 31/03/2018)	95.3%	91.9%	89.0%	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 (01/01/2018 to 31/03/2018)	91.3%	90.5%	87.4%	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 (01/01/2018 to 31/03/2018)	98.6%	96.7%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	86.9%	87.0%	83.8%	No statistical variation

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

Any additional evidence
• Because of an influx of patients due to the closure of a neighbouring practice, leaders told us they had not conducted their own in-patient survey during the previous 12 months. Leaders told us the GPs had obtained patient feedback as part of their appraisal arrangements.

- Instead they said they had relied on feedback from the National GP Patient survey and the complaints they received to identify where they needed to make improvements. For example, in response to patient feedback, leaders had introduced a triage system to help them provide patients with better access to same-day appointments.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about their 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
Explanation of any answers and additional evidence:	

Source	Feedback
CQC comment cards	Of the patients who commented on their involvement in decisions about their care and treatment, all made positive comments about their experience.

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 (01/01/2018 to 31/03/2018)	98.3%	95.6%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting areas 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.	N
Explanation of any answers and additional evidence:	

- Clinical staff could print relevant information leaflets for patients, during consultations.
- The practice's website did not contain any details about how to access local or national support groups. Leaders acknowledged this and told us the website required updating. They said they were taking steps to address this.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 129 patients as carers (this equated to 1.6% of the practice list). Leaders told us they had not received satisfactory information about which patients were also carers, in the cohort of new patients that had either registered with them, or had been allocated to the practice.
How the practice supported carers.	• The practice had a designated carers' lead, to help provide leadership and expertise in this area. • Patients who were also carers, and who were identified as needing extra support, were referred to the local carers' organisation. In addition, the practice offered this group of patients access to flu immunisations and general health checks. • New patients who were also carers were encouraged to self-identify at the time of registering. However, leaders told us they did not have this information in relation to the patient cohort that had joined the practice, following the closure of a neighbouring GP surgery.
How the practice supported recently bereaved patients.	• The practice contacted bereaved families to check whether there was any support that could be offered. Referrals were made to relevant support organisations, where appropriate. • The practice informed relevant professionals of the death of a patient. • A condolence card was sent to bereaved family members.

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:

- Most patients who provided us with feedback raised no concerns about privacy at the reception desk.
- The practice had two waiting room areas (marked by poster as areas A and B), both were within a larger communal waiting area for other care services. The electronic sign-in system informed patients which area to go to.
- There was a bell at the reception desk in area A. Patients arriving at this reception desk could use this to get the attention of staff working in the rear office. We saw patients could get assistance from reception staff when they needed it. However, should a patient become unwell in either of the reception areas, this may not be immediately apparent to reception staff.

Responsive Rating: Good

The overall rating for this practice was requires improvement due to concerns in providing safe, effective and well-led services. However, the population groups were rated as good for responsive because patients could access timely care and treatment which had been tailored to meet their needs.

Responding to and meeting people's needs

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

	Y/N/Partial
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
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8:30am to 6pm
Tuesday	7am to 6pm
Wednesday	8:30am to 6pm
Thursday	7am to 6pm
Friday	8:30am to 6pm
Appointments available:	
Monday	8:30am to 11:30am and 2:30pm to 17:30pm
Tuesday	7am to 11:30am and 1pm to 17:30pm
Wednesday	8:30am to 11:30am and 2:30pm to 17:30pm
Thursday	7am to 11:30am and 1pm to 17:30pm
Friday	8:30am to 11:30am and 2:30pm to 17:30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7917	322	114	35.4%	1.44%

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 (01/01/2018 to 31/03/2018)	97.7%	95.6%	94.8%	No statistical variation

Older people

Population group rating: Good

Findings

- The practice was responsive to the needs of older patients, and offered home visits and urgent access for those with enhanced needs.
- All older patients had a named GP, who supported them in whatever setting they lived.
- Patients considered to be ‘at-risk’ had an emergency healthcare plan in place and staff worked with other professionals, to help these patients avoid unnecessary admissions into hospital.
- The practice hosted the community falls clinic and a diabetic eye screening clinic, to help provide patients with services closer to home.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in a single appointment.
- The practice liaised regularly with the local healthcare staff, to discuss and manage the needs of patients with complex medical conditions.
- 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

- The practice maintained close working relationships with community health and social care staff, to help provide more responsive care for younger patients.
- The practice's website included information about how to manage common illnesses that children and young people might experience.
- Early morning, out-of-hours appointments were provided twice a week, to help this patient group access care and treatment outside of school hours. The practice's nurse-led triage system prioritised children under five, offering a same-day appointment when necessary.
- Contraceptive and family planning services were provided for those who needed them.
- Women could access ante-natal and post-natal care at the practice.
- The practice's premises were suitable for children and babies.
- There were systems to identify and follow up children living in disadvantaged circumstances at risk. For example, the needs of vulnerable patients were reviewed at the practice's multi-disciplinary and safeguarding meetings.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- NHS health checks were offered to eligible patients and the practice provided written advice about the results. Routine health checks were not provided for new patients.
- The needs of this population group had been identified and the practice had adjusted the services it offered, to help ensure these were accessible and flexible. Early morning, extended opening hours were provided twice a week, to offer patients greater flexibility when booking appointments. Patients could also access out-of-hours appointments via the local GP Extended Access Hub, between 4pm and 8pm each weekday evening, Saturdays between 9am and 2pm, and on Sundays between 9am and 1pm. Leaders had introduced an online e-consult template, to provide patients with better access to advice and support, without them having to visit the practice. Patients completing the form were provided with links to general health advice about a range of conditions. If this did not meet a patient's need, the patient was provided with deadline by which the practice would contact them either by telephone or email.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances, including those with a learning disability.
- The needs of vulnerable patients were discussed at the practice's monthly safeguarding and palliative care meetings and, where appropriate, during the weekly clinical meetings.
- The practice had a designated learning disabilities lead, to help provide leadership and expertise for this group of patients. Patients with learning disabilities had access to an annual healthcare appointment, where their needs were reviewed to ensure they were being met.
- All consultation and treatment rooms were accessible to patients with physical disabilities.
- Staff had access to an interpreter service, should this be needed.
- Vulnerable patients were 'flagged' on the practice's clinical IT system, so that clinicians could take this into account during a consultation. At a recent practice meeting, leaders had made a decision that nursing staff would check with patients who had long-term conditions, whether they had any memory issues.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Staff we interviewed had a good understanding of how to support patients with mental health needs, including those patients living with dementia. Clinical staff had completed dementia awareness training.
- Patients with dementia were invited to attend for an annual review, to help ensure their needs were being met appropriately.
- Clinical staff actively carried out opportunistic dementia screening, to help ensure patients were receiving the care and support they needed to stay healthy and safe.
- Where staff identified that patients had memory problems, clinicians referred them to the local memory clinic.
- Alerts had been placed on the clinical system to 'flag' patients with dementia, so clinicians could take this into account during a consultation.
- Information about dementia support services was available in the practice.
- Carers, including those looking after patients with dementia, were invited to attend for a general health check.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	

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 (01/01/2018 to 31/03/2018)	80.3%	77.2%	70.3%	N/A
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	68.6%	71.7%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	62.9%	66.8%	65.9%	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 (01/01/2018 to 31/03/2018)	76.9%	75.7%	74.4%	No statistical variation

Any additional evidence or comments
• Most patients who provided us with feedback expressed no concerns about access to appointments. • In response to patient feedback about access and, to help the practice manage patient demand for same-day appointments, a nurse-led telephone triage system had been introduced.

Source	Feedback
NHS UK	• Where patients had commented about access to appointments, their

(Choices)	feedback was very positive.

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.	11
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Explanation of any answers and additional evidence:

- We looked at one complaint record as part of this inspection. This had been handled in a timely manner, an apology was offered and an invitation given to the complainant to discuss their concerns face-to-face with a clinician.
- We also looked at a concern that had been raised by a patient, who did not wish for it to be treated as a complaint. Leaders told us the concern had been followed up with both the clinician and the patient concerned. They said that because it was treated as a concern, a formal record of how it had been handled had not been kept in line with the practice's complaint policy. They told us they would review how the concern had been handled to see what lessons could be learnt.
- Detailed information about the practice's complaints policy was available on their website. Staff we spoke with were clear about how they should respond to a patient wishing to make a complaint. There was no information about how to complain on display in the reception areas.

Well-led

Rating: Requires improvement

Leadership capacity and capability

Leaders demonstrated compassionate leadership and clearly understood the challenges they faced regarding the quality and sustainability of the service. However, they had not identified the actions necessary to address these challenges.

	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.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	Partial
Explanation of any answers and additional evidence: • Leaders we spoke with demonstrated they were knowledgeable about the challenges the practice faced delivering high-quality, sustainable care and treatment. They confirmed there was no agreed plan in place to address these challenges. • Most staff told us the practice's leaders were visible and approachable. • A leadership development programme was not in place. Also, although it was clear that leaders were actively taking steps to recruit sufficient staff to cover planned vacancies in March 2019, there was no formal succession plan in place.	

Vision and strategy

The practice did not have 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.	N
There was a realistic strategy in place to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial

Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: • Leaders told us the practice did not have a documented strategy in place to help them achieve their priorities. The leaders we spoke with demonstrated their commitment to delivering high-quality patient care. However, there was no documentary evidence available that there was a clear vision and set of values for the practice, that prioritised quality and sustainability, and which has been developed in collaboration with staff, patients and external partners.	

Culture

The practice had a culture which encouraged improvements in patient 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 an 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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial
Explanation of any answers and additional evidence: • The practice had a whistleblowing policy. However, the contents of this policy were not fully in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. Relevant staff feedback: • Staff told us they were encouraged to report errors, near-misses and incidents. • Most staff told us they felt well supported and that leaders took an interest in their health and well-being.	

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

Source	Feedback
CQC questionnaires completed by non-clinical staff	Staff reported they: • Knew how to raise concerns and were encouraged to do so. They also said they were told about changes made in response to reported errors. • Were clear about their safeguarding responsibilities, knew how to report a concern and who the safeguarding lead was. • Felt they had a good understanding of how to manage emergencies.

	Most staff said: • They received protected time to complete their training. • Their professional development was encouraged and supported. • Completion of training was monitored. • Staff had clear roles and responsibilities. • The systems and processes for handling incoming information and test results worked well. • They felt their work was valued, were asked for their opinions and received clear feedback on their performance. • Staffing levels were sufficient when all posts were filled. • They were not involved in strategic planning. Staff also said: • The provider took concerns raised by patients seriously and provided feedback to staff, if this was relevant to their role. • There was a process in place for triaging home visits.

Governance arrangements

The practice's governance arrangements were not fully ineffective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

There were governance structures and systems in place. However, these did not always work effectively.

- A planned programme of staff meetings helped to promote patient safety and the sharing of information within the practice team.
- A system was in place to identify, respond to and learn from significant/adverse events. However, the practice's system for documenting learning arising from significant events was not fully effective.
- Staff had received the training they needed to carry out their roles and responsibilities, and this was monitored by the practice manager.
- There were established policies and procedures in place, which could be easily accessed by all staff. There was a system in place to review and, where necessary update, these. Most of those we looked at were up-to-date. However, there were exceptions indicating that this system was not always implemented effectively and consistently. For example, the induction pack for locum GPs was out-of-date and the practice's induction templates had not been updated to reflect the Care Certificate induction standards.
- The arrangements for providing leaders with assurance that their policies and procedures were

being implemented, were not always effective. For example: the provider's appraisal policy had not been implemented for over two years; a systematic programme of quality improvement was not in place; the provider had not always implemented their induction policy in a consistent and effective manner.

Managing risks, issues and performance

Some of the practice's processes for managing risks, issues and performance, were not effective.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	Partial
There were processes in place to manage performance.	Y
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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

Explanation of any answers and additional evidence:

- The practice had quality assurance systems in place. However, some of these did not always work effectively.
- Although clinical and prescribing audits had been carried out, there was no systematic programme of quality improvement.
- The practice had arrangements in place for identifying, managing and mitigating risks to patient safety. However, the practice's health and safety risk assessment did not cover all the key risks to patient safety.

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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

- Leaders had completed an overall health and safety risk assessment for the practice. However, this was not comprehensive. We found gaps where leaders had not assessed risks to patient safety. For example, it did not cover the risks associated with the clinical summaries of the paper records for patients who had either recently registered with, or been allocated to, the practice, not always being accurate or up-to-date. The assessment also did not cover: the arrangements for the security of the premises; accepting a DBS check from a previous employer, when appointing a new member of staff; the decision regarding which emergency medicines to stock; the arrangements for preventing the spread of infection.

Engagement with patients, the public, staff and external partners

The practice's arrangements for involving staff, patients and external partners, to sustain high quality and sustainable care, were not always effective.

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

Explanation of any answers and additional evidence:

- Because of an influx of patients joining the surgery due to the closure of a neighbouring practice, leaders told us they had not conducted their own in-patient survey during the previous 12 months. However, they told us they had relied on feedback from the National GP Patient survey and the complaints they received, to identify where improvements needed to be made.
- The practice did not have an active patient participation group (PPG). Leaders told us the practice used to have an active PPG but, for a variety of reasons, the group had disbanded. Leaders told us they were committed to reforming their PPG group, and that a patient had recently expressed an interest in participating.
- Regular clinical meetings were held. Administrative meetings had just been re-instated, following changes to the practice's meetings structure. These provided opportunities for staff to comment on the operation of the practice.
- One of the GP's attended meetings of the local clinical commissioning group, to help ensure the practice could participate in local healthcare decision-making.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial

Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

- There was evidence of learning and improvement. For example, leaders had introduced an online e-consult template to provide patients with better access to advice and support, without them having to visit the practice. Educational sessions were held on a regular basis, to help promote shared learning. Staff had completed the training they needed to carry out their roles and responsibilities. Training opportunities were provided for trainee doctors and medical students.
- Although staff told us lessons were learnt when things went wrong, it was not always clear from the records of the significant events we looked at, whether agreed changes had been reviewed, to make sure they had helped to drive and sustain improvements.
- Clinical and prescribing audits had been carried out, and showed evidence of improvement in patient outcomes. However, the practice did not have a systematic programme of quality improvement.
- The practice did not have an effective staff appraisal system to help ensure staff had the opportunity to review their individual performance and developmental needs, and contribute to developing and improving the service.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	No statistical variation	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.

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

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.