# Care Quality Commission

## Inspection Evidence Table

## Norvic Family Practice (1-561382719)

**Inspection date: 8 May 2019**

**Date of data download: 01 May 2019**

# Overall rating: Good

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

# Safe Rating: Good

We inspected the practice in September 2018 and rated the practice inadequate for providing safe services as not all risks had been assessed and managed, such as health and safety, infection prevention and control and the timely review of information relating to patients care and treatment. Risk assessments often lacked detail to ensure the effective management of the risk. During this inspection we rated the practice good as a number of positive changes were made resulting in significant improvements to safety systems and processes and the overall management of risks.

**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. | 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 |
| There were systems to identify vulnerable patients on record. | Y |
| There was a risk register of specific patients. | Y |

| Safeguarding | Y/N/Partial |
|---|---|
| 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 pro such as health visitors, school nurses, community midwives and social workers to support adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence:<br>The GPs had completed level three safeguarding children's training as well as the nurses in line with revised guidance published by the Royal College of Nursing in January 2019.<br>There were regular discussions between the practice and other health and social care professionals such as health visitors, and social workers to support and protect adults and children at risk of significant harm.<br>During this inspection we saw evidence that staff who acted as chaperones had enhanced Disclosure and Barring Service (DBS) checks in place (Enhanced DBS with a barred list check will identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). | |

| 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. | Y |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |
| Staff had any necessary medical indemnity insurance. | Y |
| Explanation of any answers and additional evidence: | |

| Safety systems and records | Y/N/Partial |
|---|---|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: March 2019 (both sites) | Y |
| There was a record of equipment calibration.<br>Date of last calibration: March 2019 (both sites) | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| There was a record of fire extinguisher checks.<br>Date of last check: August 2018 (Norvic Family Practice) May 2018 (Norman Road) | Y |

| | |
|---|---|
| There was a log of fire drills.<br>Date of last drill: February 2019 (Norvic Family Practice) March 2019 (Norman Road) | Y |
| There was a record of fire alarm checks.<br>Date of last check: May 2019 (Norvic Family Practice) April 2019 (Norman Road) | Y |
| There was a record of fire training for staff.<br>Date of last training: Various dates between March to December 2018 | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed.<br>Date of completion: July 2018 (Norvic Family Practice) February 2019 (Norman Road) | Y |
| Actions from fire risk assessment were identified and completed. | Y |
| Explanation of any answers and additional evidence:<br>Since the last inspection, the practice had completed an updated fire risk assessment for Norman road which included advice obtained from the fire service. There were no outstanding actions.<br>We saw a copy of the fire risk assessment for Norvic Family Practice which was completed by NHS property services in July 2018. There were three actions from the fire risk assessment which were ongoing and monitored by NHS property services. | |

| **Health and safety** | **Y/N/Partial** |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: March 2019 (both sites) | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: March 2019 (both sites) | Y |
| Explanation of any answers and additional evidence:<br>Improvements had been made in the risk assessment of health and safety. The practice had carried out an overall health and safety audit for both sites which covered a range of areas such as the general environment, information systems, staff welfare and the general environment. There were also individual risk assessments relevant for each site such as lone working and car park safety. The risk assessments included the level of risk identified, action and completion date. However, the risk assessment was not always updated to show the date the action was completed.<br>At Norman Road, there were blind cords in consultation rooms, the practice had not completed a formal risk assessment however, they told us that patients were never left unattended and the practice was in the process of refurbishment which would include replacing the blinds.<br>There were risk assessments and data sheets for the control of substance hazardous to health (COSSH) for the both sites which contained relevant information. | |

**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 |
| Date of last infection prevention and control audit: January 2019 (Norvic Family Practice)<br>April 2019 (Norman Road) | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |

Explanation of any answers and additional evidence:

The cleaning contract for Norvic Family Practice was managed by NHS property services. At our last inspection, the practice told us they had requested completed cleaning records from the contractor to assure themselves of the standard of cleaning however, they were not provided with any records. We were unable to see evidence that the practice had carried its own checks to monitor the standard of the cleaning undertaken of the general environment. There were also no records to confirm the cleaning of equipment used for patients care and treatment. During this inspection we saw evidence the practice had made further attempts to request cleaning records with no response. The practice now carried out regular visual checks of the environment to monitor the standard of cleaning. Records to confirm the cleaning of equipment used for patients were also now in place.

Norman Road premises was owned by the GP partners who employed their own cleaning contractors. There were cleaning schedules completed for the general environment and patient equipment and regular audits to monitor the standard of cleaning. A new practice nurse had been appointed and was the named lead for infection prevention and control (IPC) at Norman Road

The practice had completed an IPC audit at both practices using the GP self-audit tool in January and April 2019. The overall score from the IPC audit at the Norvic Family Practice was 95%. The overall at Norman Road Family Surgery was 92%. Actions had been identified from both audits and the practice had completed a number of the actions and there were plans in place for completion of others for example, ordering of new cupboards to increase storage space and reduce clutter.

**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 |
| Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment. | 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 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:<br>Since the last inspection all non-clinical staff had received sepsis awareness training | |

**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. | 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:

At the last inspection we identified gaps in the system for reviewing and acting on patient correspondences sent electronically to the practice. This included changes to patients' medicines which was not acted on. During this inspection, the practice demonstrated that improvements had been made. An updated version of the document management system had been installed and the overall system for reviewing patient correspondence was made efficient. Evidence seen showed correspondences were acted on in a timely manner. For example, a clinic letter for a patient received on 7 May 2019, was actioned on the same day, only those correspondence received on the day of the inspection were awaiting review, there was no current backlog of correspondences to review and action.

**Appropriate and safe use of medicines**

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

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA) | 1.16 | 0.96 | 0.91 | 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). (01/01/2018 to 31/12/2018) (NHSBSA) | 7.9% | 5.7% | 8.7% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA) | 6.65 | 5.16 | 5.60 | Tending towards variation (negative) |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA) | 2.03 | 1.70 | 2.13 | 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 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 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. | 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 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 |
| 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 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:<br>We discussed with one of the GP partners, the prescribing of the antibiotic Nitrofurantoin (treatment of | |

| Medicines management | Y/N/Partial |
|---|---|
| Urinary tract infections) as data indicated this was tending towards a negative variation. The practice was aware, and an audit had been completed on the prescribing of antibiotics in general (undertaken between November 2018 to January 2019), actions were identified for example, delayed prescriptions for urine infections where it had been assessed as appropriate and following the relevant pathway. A re audit was scheduled to take place between May and June 2019. A newly appointed GP partner was taking the lead role to ensure local antibiotic guidelines were adhered to. Local antibiotic guidelines were displayed in all clinical rooms as a reminder to clinical staff.<br><br>The practice had recently appointed a pharmacist who undertook three sessions a week, their role involved medication reviews of patients on long term conditions and reviews of patients on high risk medicines to ensure appropriate monitoring was in place.<br><br>Since the last inspection the practice had purchased a thermometer for use in the cool bag used to maintain the correct temperature during the transportation of vaccines. | |

**Track record on safety and lessons learned and improvements made**

## The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|---|
| The practice monitored and reviewed safety using information from a variety of sources. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Y |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | 16 |
| Number of events that required action: | 15 |
| Explanation of any answers and additional evidence:<br><br>The practice was using the CCG electronic reporting system ‘Datix’ to record all incidents including significant events. There was evidence that significant events were shared with staff in meetings and minutes were available to staff. | |

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

| Event | Specific action taken |
|---|---|
| Breach in patient confidentiality | Reported to the information commissioner's office, all staff given a copy of the confidentiality agreement again to read and sign to ensure they understood the importance of maintaining patient confidentiality |
| Patient booked for appointment at the wrong site | Issue added to staff newsletter and reinforced to all staff the importance of double checking where a patient is normally seen when booking. |

| 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:

Patient safety alerts such as information from the Medicines and Healthcare Regulatory Agency (MHRA) were sent to all the clinical staff by email. There was a GP who had the lead role and would assess the relevance of each alert and then ensure any actions were completed and learning shared with staff. We saw examples of safety alerts that had been received and acted on by the practice. Safety alerts were discussed in clinical meetings and there was evidence of this.

# Effective Rating: Requires improvement

We inspected the practice in September 2018 and rated the practice requires improvement for providing effective services as improvements were required in the uptake of screening for cervical and bowel cancer and the reviews of patients with asthma and diabetes. During this inspection we rated the practice requires improvement for providing effective services overall, as we rated population groups people with long-term conditions, families, children and young people and working age people (including those recently retired and students) as requires improvement. We have rated the population group people with long-term conditions as requires improvement as there had been a decrease in the achievement for some of the diabetes indicators and improvements were required in the monitoring of people with high blood pressure. We have rated families, children and young people as requires improvement as the practice was below the World Health Organisation minimum range for the uptake of childhood immunisations. We have rated working age people (including those recently retired and students) as requires improvement as although the practice was promoting and encouraging the uptake of cervical and bowel cancer screening, at the time of the inspection significant improvements had not been made. The practice had increased the number of asthma reviews completed and reduced the rate of exception reporting for diabetes.

**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 |
| There were 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) (01/01/2018 to 31/12/2018) (NHSBSA) | 0.73 | 0.73 | 0.79 | No statistical variation |

## Older people

## Population group rating: Good

**Findings**

- 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.
- Health checks were offered to patients over 75 years of age.
- Older patients were offered the annual flu and pneumonia vaccinations and those meeting the age criteria the shingles vaccination.

## People with long-term conditions

## Population group rating: Requires Improvement

**Findings**

- 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, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The practice achievement for the diabetes indicators had decreased compared with the previous year.
- The practice achievement for the target blood pressure reading for patients with hypertension was tending towards a negative variation and current data showed this remained unchanged.

| 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) | 87.2% | 79.2% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 20.7% (134) | 11.2% | 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) | 81.0% | 78.2% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 15.4% (100) | 8.8% | 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) | 83.5% | 78.7% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 18.7% (121) | 11.4% | 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) | 69.5% | 77.5% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 1.5% (8) | 4.5% | 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) | 84.2% | 90.5% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 4.8% (9) | 12.7% | 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) | 76.3% | 81.4% | 82.6% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 5.2% (68) | 4.3% | 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) | 92.6% | 90.8% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 4.4% (5) | 5.4% | 6.7% | N/A |

**Any additional evidence or comments**

At the previous inspection in September 2018, the practices QOF achievement for diabetes indictors were comparable to the local and national averages. However, the exception reporting rate was higher than the local and national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). At the time the practice was unable to provide a clear explanation as to why there was high exception reporting in this area. The practice QOF achievement for asthma reviews was also lower than local and national average. The practice told us that this was due to staff shortages. However, they had appointed a practice nurse in May 2018, and anticipated this would increase the number of reviews.

The available published data at the time of this inspection for the year 2017-2018 showed the exception reporting rate for diabetes indicators were similar to the previous inspection (year 2016-2017). However, the practice had reviewed the possible cause of high exception reporting and provided an explanation of some of the associated challenges that were contributing factors. This included high levels of deprivation, repeated non-attendance and poor compliance. Some of the actions taken by the practice to reduce exception reporting rates included revisiting the exception reporting policy to ensure consistency and accuracy. A new GP was responsible for exception reporting to ensure ongoing monitoring of the process. A new practice lead was also appointed to increase the number of reviews and follow up for patients who did not attend (DNA). We reviewed unverified QOF data submitted by the practice following the inspection (May 2019) the data showed there were a total of 672 patients on the diabetes register. For the indicator, 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, 456 patients (76%) were within the target range. Of these 84 patients were exception reported (12.6%), for example, 28 patients were on maximum tolerated treatment. For the indicator, 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, 469 patients (76%) were within the target range, of these 64 patients were exception reported (9.6%) for example, 26 patients were exception reported for being unsuitable for treatment. For the indicator, 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. There were 453 patients (78%) within the target range, of these 91 patients were exception reported (13.6%) for example 33 patients were registered within nine months of the end of

the QOF payment period. The data showed that the level of exception reporting was now similar to local and national averages however, there had been a decrease in the achievement from the year 2017-2018 to the current year. For example, for the indicator, 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 was currently 76% compared with 87% in the previous year.

The number of asthma reviews had slightly increased since our last inspection from 68% to 69.5%. The appointment of an additional practice nurse since the previous inspection had increased the number of asthma reviews completed. We reviewed recent unverified data on the day of the inspection from the last 12 months (2018-2019) which showed 437 out of 564 patients had been reviewed (79%) which was similar to the local and national average. The practice anticipated this would further improve with the recent appointment of third nurse.

The practice was tending towards a negative variation for the indicator, 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) with a rate of 76%. Recent unverified data reviewed on the day of the inspection from the last 12 months (2018-2019) showed the data remained unchanged, there were a total of 1350 patients who met the criteria of those 1030 (76%) had the target blood pressure recorded. The practice was providing opportunity for two administrative staff to undertake the role of a health care assistant, we saw that training was ongoing. The aim was to increase clinical capacity and ensure more health reviews were completed.

A coronary obstructive pulmonary disease (COPD) specialist nurse undertook a clinic once every two weeks at the practice to review patients with suspected COPD as well as newly diagnosed patients providing support and care planning.

## Families, children and young people

## Population group rating: Requires Improvement

### Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.
- 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.
- 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.
- Young people could access services for sexual health and contraception, this included referral to local services for support and advice.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target |
|---|---|---|---|---|
| The percentage of children aged 1 who have completed a primary course of | 156 | 175 | 89.1% | Below 90% minimum (variation |

| | | | | |
|---|---|---|---|---|
| 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) | | | | negative) |
| 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) | 104 | 125 | 83.2% | Below 90% minimum (variation negative) |
| 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) | 103 | 125 | 82.4% | Below 90% minimum (variation negative) |
| 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) | 103 | 125 | 82.4% | Below 90% minimum (variation negative) |

## Any additional evidence or comments

At the last inspection, childhood immunisation uptake rates were 89% which was slightly below the target percentage of 90%. During this inspection data showed uptake for some of the immunisation had decreased to as low as 82%. The practice was aware and continued to take action to improve uptake, the practice explained the challenges such as a transient population who had often changed address before the child's immunisation was due. There was also a high number of parents who declined uptake due to cultural reasons. The practice had devised a letter to send to parents/guardians who had declined to ensure the information could be recorded and sent to Child Health services which generates appointments for childhood immunisations. We saw evidence that children who did not attend for immunisation appointments were followed up by the practice by telephone and letter, this included referral to the health visitor if three appointments were missed. Since the last inspection the practice had increased nursing capacity by recruiting a second nurse, a further nurse had been recently appointed which would take the total number of nurses to three. A large notice board was displayed within the practice with information on the importance of childhood immunisation. A new text reminder service had been implemented to reduce the number of missed appointments. However, at the time of the inspection significant improvements had not been made.

## 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.
- The uptake for cervical and bowel cancer screening was below the national average.

| 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) (01/04/2017 to 31/03/2018) (Public Health England) | 62.6% | 65.8% | 71.7% | Tending towards variation (negative) |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 68.0% | 64.2% | 70.0% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE) | 46.9% | 42.1% | 54.5% | 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. (01/04/2017 to 31/03/2018) (PHE) | 67.9% | 65.8% | 70.2% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE) | 54.1% | 50.0% | 51.9% | No statistical variation |

### Any additional evidence or comments

At the last inspection, the practice screening rates (2.5year coverage) for bowel cancer in people between the ages of 60-69, was 46% which was similar to the local average however, below the national average of 55%. The uptake for this indicator was now 47%, we saw that the practice proactively followed up patients who did not attend screening. The records of patients who did not respond for screening were coded and referred to the practice manager to initiate follow up, a new text messaging system had been implemented and patients were sent text reminders for appointments. The practice had devised a letter to send to patients who failed to attend screening providing information on signs and symptoms and encouraging uptake. Information was displayed in the patient waiting area promoting the service and

encouraging uptake.

The practice's uptake for cervical screening was 64% at the last inspection, which was comparable with local of 66% but below the national average of 72% and below the 80% coverage target for the national screening programme. Current data showed the uptake had reduced to 63%, which remained similar to the local average but below the national average and the national screening programme target. We saw evidence that the practice was encouraging uptake, this included information in the patient waiting area, telephone calls, text message reminders and follow up for women who did not attend. The practice had an appointed an additional nurse since the last inspection with a further nurse appointment in progress, this would increase the number of nurses to three, with the appointment of additional nurses there were plans to provide opportunistic screening. However, at the time of the inspection significant improvements had not been made.

## People whose circumstances make them vulnerable

**Population group rating: Good**

**Findings**

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

**Population group rating: 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.
- 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.
- A number of staff had received dementia training in the last 12 months.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 95.4% | 91.6% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 17.7% (14) | 13.5% | 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) | 95.6% | 93.1% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 13.9% (11) | 10.9% | 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) | 75.0% | 83.6% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 9.7% (3) | 6.8% | 6.6% | 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) | 537.4 | 538.1 | 537.5 |
| Overall QOF exception reporting (all domains) | 8.4% | 6.2% | 5.8% |

| | 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 |

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

Since the inspection in September 2018, the practice had completed the following three audits:

- Antibiotic prescribing audit (November 2018 to 31 January 2019). The purpose of the audit was to review the prescribing rates amongst GPs within the practice to identify areas for improvement and ensure adherence to best practice guidelines. The findings of the audit showed variability of antibiotic prescribing rates and the highest and lowest prescribers were consistent. As a result of the audit, the practice identified scope to reduce unnecessary antibacterial prescription for example, issuing delayed prescriptions for urine infections where it had been assessed as appropriate and following the relevant pathway. A re audit was scheduled to take place between May and June 2019.
- Audit to assess the safety, efficacy and governance around the Minor Surgery Joint injection service offered (February 2019). A total of 40 patients were assessed using a set of five criteria such as adverse reactions. The findings of the audit demonstrated that the joint injection service offered was effective. All patients who underwent the procedure were properly consented. In addition, all patients reported that the procedure was well tolerated. 95% of the patients reported some benefit to varying degrees of the joint injection. No patients reported any adverse effects after their injection and 92.5% of the patients would have the procedure again.

**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, nurses, paramedics, pharmacists and physician associates. | N/A |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| Explanation of any answers and additional evidence:<br>A system was in place to monitor and review staff training.<br>The practice had provided two administrative staff the opportunity to train as Health Care Assistants, the training was ongoing and due to be completed in October 2019.<br>Administrative staff were due to attend training to develop their computer skills as part of the practices development plan to improve the service.<br>The nurses employed in the practice were not undertaking extended roles, a pharmacist was employed on a sessional basis to undertake medication reviews. | |

**Coordinating care and treatment**

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

| 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 that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Y |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | N/A |
| Explanation of any answers and additional evidence:<br>The practice worked closely with various services and organisations to support patients and ensure care was delivered in a coordinated way. For example, community mental health services, the palliative care teams and the community midwife and health visitor. There were regular multi-disciplinary team meetings to share information. | |

**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 | Y |

| | |
|---|---|
| developing a long-term condition and carers. | |
| 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) | 97.1% | 95.7% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.8% (16) | 0.7% | 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:<br>Discussion with clinical staff showed that verbal consent was always obtained before care and treatment and where relevant written consent for example, for minor surgical procedures. Staff had received training in areas such as the Mental Capacity Act and Deprivation of Liberties Safeguards (DoLS). Staff spoken with were aware of the importance of consent and showed understanding of areas such as best interest and Gillick competency.<br><br>A consent audit was completed for minor surgery (January 2019) as part of ongoing monitoring of the standards for written consent. | |

# Caring Rating: Good

**Kindness, respect and compassion**

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

| | Y/N/Partial |
|---|---|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Y |
| 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. | 20 |
| Number of comments cards received which were mixed about the service. | Seven |
| Number of CQC comments received which were negative about the service. | Zero |

| Source | Feedback |
|---|---|
| CQC comment cards | There were 27 comment cards which included positive comments about the staff who were polite, helpful and caring.<br><br>There were seven cards with mixed feedback, these included positive comments about staff, the areas for improvement did not relate to negative experiences with staff. |
| Patient interviews | We spoke with five patients. Positive comments included staff being respectful and caring. |
| NHS Choices comments | There were five new reviews since the last inspection in September 2018, and the comments were all positive |

**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 |
|---|---|---|---|---|
| 9190 | 319 | 87 | 27.3% | 0.95% |

| 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) | 73.8% | 83.4% | 89.0% | 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 (01/01/2018 to 31/03/2018) | 81.7% | 81.3% | 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) | 87.5% | 93.0% | 95.6% | Variation (negative) |
| 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) | 70.7% | 75.5% | 83.8% | No statistical variation |

| Any additional evidence or comments |
|---|
| The GP national survey had not been updated since the inspection in September 2018 and therefore the results were the same, the practice was below the local and national averages in for patients experience of healthcare professionals listening and below the national average for confidence and trust and overall experience of the GP practice. At the time of the last inspection the practice was aware of the results although had not reviewed it in detail. The practice had completed an in-house survey although this focused predominantly on access to appointments.<br><br>At this inspection, the practice had not completed a further in-house patient survey however, they had reviewed the results of the national GP survey and analysed recent patient feedback from the Friends and |

| |
|---|
| Family Test completed between January 2019 and April 2019. This included comments collated using the new text messaging system. The response rate was higher than that of the national GP survey, the results showed of the 166 responses 78 were extremely likely to recommend, 26 likely, 9 unlikely and 11 stated they did not know (42 respondents did not want their response to be published). Feedback from patients demonstrated that patients were overall satisfied with the service and staff and this was aligned with feedback that we received from patients. However, there were some negative comments from patients who were unlikely to recommend such as feeling rushed and the health care professional not listening, these had not been explored further, the practice had also not developed an action plan to review areas of low satisfaction identified in the national GP survey. |

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

**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 |
| Explanation of any answers and additional evidence: | |

| Source | Feedback |
|---|---|
| CQC comment cards | There were 27 comment cards which included positive comments about staff who took time to listen to patients needs and involve them in decisions about their care and treatment. |
| Patient interviews | We spoke with five patients, the feedback was positive, patients described staff as understanding and took time to listen to their needs and involve them in decisions about their care and treatment. |

**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 | 86.1% | 89.4% | 93.5% | Tending towards variation (negative) |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 31/03/2018) | | | | |

| Any additional evidence or comments |
|---|
| The GP national survey had not been updated since the inspection in September 2018 and therefore the results were the same. The practice was tending towards a negative variation for patients experience of involvement in decisions about their care and treatment. The practice had not completed a recent in-house patient survey however, they had reviewed the results of the national GP survey and analysed recent patient feedback from the Friends and Family Test. The results demonstrated that patients were overall satisfied with staff and no negative comments were related to involvement in decisions. This was aligned with feedback that we received from patients. However, the practice had not developed an action plan to review areas of low satisfaction identified in the national GP survey. |

| | 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. | N |
| Information about support groups was available on the practice website. | Y |
| Explanation of any answers and additional evidence:<br>Information leaflets in other languages and in easy read format were not readily available in the practice but could be ordered on request. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | There were 97 carers on the register (1% of the practice population). |
| How the practice supported carers. | The practice had a register for carers to ensure all carers were easily identified and could be offered an annual health assessment, the flu vaccination and support and advice. A notice board was displayed in the patient waiting area with information and advice for carers and encouraging carers to identify themselves, so support could be offered. A carers event was planned for June 2019, with representatives from support groups to attend. The carers event was promoted on the practices social media page. |
| How the practice supported recently bereaved patients. | Patients receiving end of life care were discussed at multi-disciplinary team meetings so that information was shared in a timely manner and families could be contacted and offered support. The practice also referred patients to support services and bereavement counselling. Bereavement support information was displayed in the patient waiting area. |

**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:<br>A notice was displayed informing patients that a private room was available should they wish to speak in confidence away from the waiting room. | |

# Responsive Rating: Good

We inspected the practice in September 2018 and rated the practice requires improvement for providing responsive services as patients were not always able to access the service in a timely manner and the complaints system was not robust. During this inspection we rated the practice as good overall and across all population groups. A number of positive changes were made to improve access including increasing staffing levels. Patient feedback on access was mostly positive.

**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. | Partial |
| 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:<br>The practice did not have an induction loop system and had not considered the potential impact for patients with a hearing impairment. | |

| Practice Opening Times | | |
|---|---|---|
| **Day** | **Time** | |
| Opening times: | Norvic Family Practice | Norman Road |
| Monday | 8am to 6.30pm | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm | 8am to 5pm<br>*5pm to 6.30pm cover from Norvic |
| Thursday | 8am to 6.30pm | 8am to 6.30pm |
| Friday | 8am to 6.30pm | 8am to 6.30pm |
| | | |
| Appointments available: | | |
| Monday | 8am to 6.30pm | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm | 8am to 5pm |

| | |
|---|---|
| Thursday | 8am to 5pm 8am to 6.30pm<br>*5pm to 6.30pm cover from Norman Road |
| Friday | 8am to 6.30pm 8am to 6.30pm |
| Extended Hours opening | Monday to Friday 6.30pm to 8pm (available at Norvic Family Practice)<br><br>Saturday and Sunday 9am to 11.30 (available at Norvic Family Practice) |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 9190 | 319 | 87 | 27.3% | 0.95% |

| 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) | 94.5% | 92.4% | 94.8% | No statistical variation |

## Older people Population group rating: Good

**Findings**

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The nurse and health care assistant undertook home visits for blood tests and to administer vaccinations for those who had difficulties getting to the practice

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

**Findings**

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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.
- 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**

- Appointments were available until 8pm Monday to Friday and 9am to 1130am on weekends for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

**Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pmm on a Monday to Friday. Appointments were available Saturday and Sunday 10am until 1pm.
- The practice had increased the number of pre-bookable and online which would benefit working age patients

## People whose circumstances make them vulnerable — Population group rating: Good

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Where necessary, home visits were undertaken to complete annual health checks.

## People experiencing poor mental health (including people with dementia) — Population group rating: Good

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs

and those patients living with dementia.

- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients with mental health needs were offered health reviews to assess their overall health.

**Timely access to the service**

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

National GP Survey results

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

| 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) | 59.2% | 58% | 70.3% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018) | 56.6% | 58.3% | 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) | 60.0% | 62.0% | 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) | 73.9% | 65.8% | 74.4% | No statistical variation |

**Any additional evidence or comments**

The GP national survey had not been updated since the inspection in September 2018 and therefore the results were the same, the practice was below the national average for patients experience of getting through to the practice by phone and overall experience of making an appointment. At the time of the last inspection the practice was aware of the results although had not reviewed it in detail. The practice had also completed an in-house survey focused on access to appointments and identified areas for improvement such as increasing the availability of pre-bookable appointments.

At this inspection, the practice had not completed a further in-house patient survey however, they had reviewed the results of the national GP survey and findings of the previous in-house survey. As a result, a number of actions were taken to improve access and patients overall experience. This included the following:

- More pre-bookable appointments, online appointments and telephone consultations.
- Ongoing monitoring of the missed appointment rates for pre-bookable appointments to ensure the service is effective management of resources.
- The commencement of a text message reminder service for appointment to reduce non-attendance rates.
- Extra appointments were added to the weekend surgery
- The main practice and branch no longer closed for a half a day each week (open until 5pm) offering more appointments with GPs and nurses.
- Appointments across both sites were promoted and encouraged to reduce wastage and increase capacity as the practice had identified not all appointments were being utilised across the two sites.
- Increased clinical capacity by the recruitment of two additional nurses, a GP partner and the training of two reception staff to undertake the role of a health care assistant.
- Utilising specialist skills of a pharmacist and COPD nurse to support with patient review.
- The practice planned to introduce one practice number to be utilised across both the main and branch practice and offer a call option system. The aim is to ensure a single point of access for patients, provide patients a choice of options to get through to the most appropriate staff member and ensure patients can get through to one practice if the other is busy.

The practice had also analysed feedback from the Friends and Family Test (FTT) completed between January 2019 and April 2019. This included comments collated using the new text messages system. Results demonstrated that patients were overall satisfied with the service and this was aligned with feedback that we received from patients. However, there were some areas for ongoing improvement which related to access, actions taken by the practice included.

- Promoting the extended opening hours, particularly the weekend for working patients and their families.
- Offering advance appointments where possible.
- Ensuring all walk-in patients were aware of the ‘potential’ wait if offered emergency appointment.

- Encouraging all staff and clinicians to explain to patients why they are kept waiting beyond their appointment time.
- Offering appointments at main or branch surgery according to need and availability.
- Promoting the extended opening hours on the practice website.
- Responding to NHS Choices and patient comments with information relevant to ensuring they are aware of opportunities for 'emergency' and weekend appointments.
- Sharing feedback with all practice staff and encouraging a greater awareness of the importance of information sharing between staff and patients to 'improve patient experience' and build on the improvements that have recently been introduced to patient access.

| Source | Feedback |
|---|---|
| CQC comment cards | There were 27 comment cards of these four comments related to difficulty accessing appointments and one related to difficulty getting through to the practice by phone. |
| Patient interviews | We spoke with five patients. One patient told us that it was sometime difficult to obtain an appointment however, two patients commented that access to appointments had improved recently. Three patients commented that it was difficult to get through to the practice by phone. |
| NHS choices | There were five new reviews since the last inspection in September 2018, and the comments were all 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. | Seven (since last inspection) |
| Number of complaints we examined. | Three |
| Number of complaints we examined that were satisfactorily handled in a timely way. | Three |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | Zero |

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

Explanation of any answers and additional evidence:

We saw a poster displayed in the patient waiting area informing patients of the complaint's procedure however, there was no contact details and patients would have to request a complaints leaflet form reception staff.

The system for handling complaints had been improved since the last inspection to ensure all complaints were recorded and responded to in a timely manner.

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Patient unhappy with telephone call from practice | Discussed with staff member concerned and learning shared with all staff in team meeting |
| Patient unhappy that medication not issued | Discussed in governance meetings, staff to ensure reason for not issuing is documented and patient is contacted to explain. |

# Well-led Rating: Good

We inspected the practice in September 2018 and rated the practice requires improvement for providing well led services as There was a lack of effective leadership oversight to ensure good governance. Systems and processes were not always embedded to ensure risks were assessed and managed and improvements sustained. During this inspection we rated the practice as good as significant improvements were made across all areas of the service with systems of accountability to support good governance and effective oversight. The practice had invested and committed to quality and safety with a formal development plan in place to modernise the service and ensure sustainability.

**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 GP partners and manager understood the challenges they faced and were proactively trying to address them. They demonstrated a willingness to learn and improve and responded positively to feedback from the previous inspection. A number of areas for improvement identified at the last inspection were addressed and positive changes had been implemented. For example, the practice had appointed a new GP partner to ensure succession planning. A practice development manager was employed on a fixed term basis to support the practice manager and develop a formal practice development plan for 2019/2020.The plan included reviewing staff roles and responsibilities and providing training and development opportunities to ensure long term sustainability. The practice was in the early stages of appointing a business manager to oversees the long-term service delivery and as part of the practices wider re-structuring of the service.

**Vision and strategy**

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

| | Y/N/Partial |
|---|---|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | 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:<br>Discussions with staff reflected the practices vision and values. Staff told us that they took pride in ensuring patients received a caring compassionate service. The aim was to deliver high quality care and promote good outcomes for patients. Feedback from patients suggested that this was generally patients experience of the service. A formal practice development plan was in place which reflected the practices vision. |

**Culture**

## The practice had a culture which drove high quality sustainable care.

| | Y/N/Partial |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Y |
| Explanation of any answers and additional evidence:<br>Staff told us they felt supported by management and felt confident to raise any issues or concerns and were confident they would be listened to. Openness, honesty and transparency was encouraged and there was evidence to support this in practice.<br><br>We saw evidence that staff had received appraisals and were supported with their personal and professional development, this included training to undertake new roles and responsibilities. There were examples of development opportunities that were prompted by learning identified during the appraisal process. We saw that some of the staff had received training in areas such as equality and diversity training, and whistleblowing. | |

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

| Source | Feedback |
|---|---|
| Staff Members | Staff commented that they were provided with training and development opportunities that reflected their career aspirations. Staff told us the practice manager and the GP partners were approachable and open to suggestions to improve. |

**Governance arrangements**

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

| | Y/N/Partial |
|---|---|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence:<br><br>A number of actions had been taken since the previous inspection to strengthen the governance arrangements in place. This included increasing clinical capacity to improve access, more collaborative working across both sites and management reconfiguration and modernising of the service. Regular governance meetings took place to ensure monitoring and oversight. Standing agenda items included health and safety, significant events and complaints. Regular staff meetings took place to share information with staff. | |

**Managing risks, issues and performance**

## There were clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|---|
| There were comprehensive assurance systems which were regularly reviewed and improved. | 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. | Partial |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Partial |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence:<br><br>The majority of risks were effectively assessed and managed however, the practice had not completed a risk assessment for blind cords in use.<br><br>There was a business continuity plan in place which was accessible to all staff. Staff had not received formal training in preparation for a major incident although our discussion with staff showed they were aware of what to do in the event of a major incident.<br><br>The practice had proactively acted on risks identified during previous inspections. For example, infection prevention and control, health and safety, complaints and the governance arrangements. | |

**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. | Partial |
| Performance information was used to hold staff and management to account. | Y |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |
| Explanation of any answers and additional evidence:<br><br>Data showed areas for improvement in the delivery of effective care to population groups such as patients with long term conditions. | |

**Engagement with patients, the public, staff and external partners**

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

| | Y/N/Partial |
|---|---|
| Patient views were acted on to improve services and culture. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| Explanation of any answers and additional evidence:<br><br>Plans were in place to work conjunction with Primary Care Networks to improve service delivery for patients. The practice had responded to some of the feedback from the national GP survey and friends and family test. However, further analysis and action was required to ensure all areas were responded to. There was a patient participation group (PPG) and we saw meetings had taken place and membership encouraged by the practice. However, there was a lack of interest in the group and insufficient members to enable the group to make an impact. The practice had set up a social media page to improve patient engagement and promote services offered. The practice manager had developed a newsletter to provide staff with information and updates and promote staff involvement and engagement. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| The practice had a patient participation group (PPG). We spoke with two members who provided some positive feedback. However, they explained that whilst meetings took place and there was good relationship with the practice there was insufficient members and poor attendance in meetings. There were attempts to promote and encourage membership however, there had been a poor response and a general lack of interest. This had impacted on the PPG's ability to work collaboratively with the practice to improve patients experience of the service. |

### Continuous improvement and innovation

## There were evidence of systems and processes for learning, continuous improvement and innovation.

| | 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: | |

| Examples of continuous learning and improvement |
|---|
| Learning and improvement was encouraged through staff appraisals and meetings. The practice made use of internal and external reviews of incidents and patient safety alerts and learning was shared and used to make improvements. Clinical and non-clinical audits were completed and provided the opportunity to learn and improve for example, in the areas of antibiotic prescribing. The practice had employed a practice development manager to help improve 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 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.
- 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.

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.