Care Quality Commission

Inspection Evidence Table

Tooting South Medical Centre (1-566547629)

Inspection date: 5 December 2019

Date of data download: 21 November 2019

Overall rating: Requires improvement

We have rated the practice as requires improvement overall because some systems designed to keep people safe were not operately effectively and because the practice had not acted effectively to address and monitor some areas of below average patient satisfaction.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Requires improvement

We have rated the practice as requires improvement for Safe, because systems and processes to keep people safe had not been effectively implemented, including acting and monitoring on risk assessments.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but they had not been effectively implemented.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial[1]
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial[2]
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care	Y

Safeguarding	Y/N/Partial
professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	

Explanation of any answers and additional evidence:

1. We checked a sample of 5 training records during the inspection. None of the clinical staff whose records we checked (one nurse and two GPs) had completed level three training in safeguarding vulnerable adults. The guidance on training was updated in 2018, with an expectation that staff would complete the increased training at the time of their next update. All three clinical staff members had received adult safeguarding training in 2019 but not to level three. One GP had completed level one training in December 2019.
2. The practice had not completed a DBS check for a practice nurse who had been working at the practice since 2008. We saw evidence that it had been requested.

   The practice had started to carry out Disclosure and Barring Service (DBS) checks on non-clinical staff in July 2019. The process had not been completed at the time of the inspection.

   In response to the draft report the practice sent us evidence of DBS checks for nursing staff. We noted that all but one of these were completed by a different organisation. The practice told us that staff would act in line with guidance and risk assess whether to complete a DBS check or accept one from a previous employer. The practice told us that the details of what staff should consider were not documented in a policy, and that individual risk assessments had not been documented.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N[1]
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N[2]
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N[3]

Explanation of any answers and additional evidence:

1. We checked the recruitment records of 5 members of staff. One (clinical staff member) had no proof of identity and no references. Another had no employment history. Issues with Disclosure and Barring Service (DBS) checks are noted under Safeguarding (above).
2. Records of non-clinical staff immunity were incomplete.
3. Clinical staff registration was checked upon recruitment but was not regularly monitored.

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:	Y September 2019

There was a record of equipment calibration. Date of last calibration:	Y 17/05/2019
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. Date of last check:	Y September 2019
There was a log of fire drills. Date of last drill:	Y 20/06/2019
There was a record of fire alarm checks. Date of last check:	Y 04/12/2019
There was a record of fire training for staff. Date of last training:	Y 25/03/2019
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y 28/05/2019 (External 21/05/2018)
Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence: An external fire risk assessment carried out on 21/05/2018 identified that the practice needed to assess explosive substances and ensure risk assessments were in place for the oxygen cylinder. A handwritten note had been added to the risk assessment which said 'not applicable', signed and dated by a staff member on 21/01/2019. We saw a risk assessment for the oxygen cylinder which said that the door of the room where it was stored should be kept closed and the fire brigade informed. There was no discussion in the risk assessment of signage requirements. There was no signage on the door of the room where the oxygen was stored. Practice staff showed us a sign which had been affixed to the wall immediately above the oxygen, but could not explain the rationale for having it there. Shortly after the inspection the practice sent us evidence of signage on the door of the room where the oxygen was stored.	

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment:	Y See below
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y See below
Explanation of any answers and additional evidence:	

Electrical wiring was checked on 18/11/2019 and was assessed as satisfactory.

Emergency lighting was serviced 06/06/2019.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were generally met, but the practice had not acted effectively on risk assessments that had been carried out, to ensure that actions were completed and resolved the issues as intended.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	28 October 2019
The practice had acted on any issues identified in infection prevention and control audits.	Partial[1]
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Partial[2]

Explanation of any answers and additional evidence:

1. NHS England carried out an inspection prevention and control audit on 28 October 2019. They identified several issues including that mops were stored in a way that meant that they did not dry and were touching (meaning germs could be transferred between mops used to clean different areas of the practice). Practice staff told us that racks had been fitted in the cleaning cupboard to improve mop storage. We noted that the mops were in racks, but we observed that the wet mop heads were touching.

   A legionella risk assessment was carried out on 15 March 2019. The report said that the plumbing required remedial works, the water system should be descaled quarterly, and water temperatures should be taken and recorded. At the time of the inspection in December 2019, some (but not all) of the remedial works had been carried out, but the practice had not completed any of the other actions.

   The practice received a quote for a thermometer and log book on 25 November 2019.

   Staff told us that a plumber had advised that the other recommended remedial works were not required, but staff were not clear as to why this was the case and did not have this advice in writing. Shortly after the inspection the practice sent us an email from the plumber used by the practice which said that no further work was necessary on the water system and that quarterly descaling was not necessary. The plumber gave no rationale for their opinion. It was not clear why there was a difference in opinion between the legionella risk assessment and the plumber and the practice sent no risk assessment justifying the decision to consider the second opinion the correct one.

   In response to the draft report the practice sent us a further email from the plumber detailing why

further works were not necessary, referencing NHS Estates Health Guidance.

2. The practice had appropriate arrangements for managing clinical and specimens waste, but arrangements for disposing of waste generated by patients were unclear. There were no sanitary waste bins in the toilets, but there were bins marked as for clinical waste. These did not have clinical waste bags in them and staff told us that these were for nappies and sanitary waste, not clinical waste.

   In response to the draft report the practice sent us evidence that one of the bins in each patient toilet was now marked as for sanitary waste and contained a clinical waste disposal bag.

Risks to patients

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

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

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	Y

deliver safe care and treatment.	
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence:	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, but they were not all effectively implemented.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.67	0.68	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	7.3%	10.5%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	5.47	5.62	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	0.80	1.20	2.08	Variation (positive)

Medicines management	Y/N/Partial

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).	Partial[1]
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.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

1. We looked a sample of Patient Specific Directions. All of those we looked at for one Health Care Assistant had been authorised by the GP after the vaccinations had been administered. Those we looked at for the second Health Care Assistant had been correctly authorised.

   We looked at sample of Patient Group Directions. All of those we looked at had had clinicians added after the authoriser's signature.

Medicines management	Y/N/Partial

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:	Evidence not collected
Number of events that required action:	Evidence not collected
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
Vaccine fridge was turned off	Staff were alerted on Monday morning by the alarm in the fridge. The practice segregated the affected vaccines and followed advice from the manufacturer as to their safety. Staff added a sign to the plug to reduce the risk of the event being repeated. The practice reported the event via the National Reporting and Learning System.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: There was a log of safety alerts and the actions taken, but this was incomplete. We spoke to staff about actions taken and further evidence of action taken was sent shortly after the inspection. No further evidence was sent as to a consistent system of recording safety alerts and the actions taken.	

Effective Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.26	0.72	0.75	Variation (positive)

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. • The practice carried out structured annual medication reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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 shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- 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.
- Patients with asthma were offered an asthma management plan.

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 (01/04/2018 to 31/03/2019) (QOF)	69.3%	75.3%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.8% (16)	8.6%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	73.0%	73.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	3.6% (21)	7.6%	9.4%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	82.1%	78.6%	81.3%	No statistical variation
Exception rate (number of exceptions).	4.7% (27)	8.3%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	80.4%	75.4%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.7% (6)	2.4%	7.4%	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 (01/04/2018 to 31/03/2019) (QOF)	81.2%	91.5%	89.6%	No statistical variation
Exception rate (number of exceptions).	1.4% (1)	7.6%	11.2%	N/A
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	75.9%	80.7%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.4% (11)	2.9%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	93.8%	88.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.0% (1)	6.1%	5.9%	N/A

Any additional evidence or comments

The practice performance in indicators of care for patients of long-term conditions was generally in line with average.

Two indicators were tending towards negative variation (related to care of hypertension and HbA1c management) but the trend was upwards for both of these, as it wasfor all diabetes indicators from the previous year (2016/17).

Families, children and young people Population group rating: Good

Findings

- The practice was below 90% for uptake of two childhood immunisations. Both showed an upwards trend from the previous year. Practice staff explained to us the reason some recalls were not completed in good time in 2019 and the steps taken to address the issue. We saw evidence that immunisation rates had improved. The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	128	142	90.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	115	131	87.8%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	116	131	88.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	118	131	90.1%	Met 90% minimum

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

Population group rating: Good

Working age people (including those recently retired and students)

Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	64.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	62.4%	63.6%	72.1%	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)	41.6%	47.6%	57.3%	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)	77.8%	75.9%	69.3%	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)	38.5%	48.2%	51.9%	No statistical variation

Any additional evidence or comments

Practice staff explained to us the reason some recalls were not completed in good time in 2019 and the steps taken to address the issue. We saw evidence that cervical sampling rates had improved.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental

Population group rating: Good

health (including people with dementia)

Findings
• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • Same day and longer appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • Patients with poor mental health, including dementia, were referred to appropriate services.

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 (01/04/2018 to 31/03/2019) (QOF)	84.5%	91.3%	89.4%	No statistical variation
Exception rate (number of exceptions).	0.9% (1)	7.3%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	85.6%	92.8%	90.2%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.1%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	71.8%	83.5%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	4.3%	6.7%	N/A

Monitoring care and treatment

The practice had a 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)	527.4	No Data	539.2
Overall QOF score (as a percentage of maximum)	94.3%	No Data	96.4%
Overall QOF exception reporting (all domains)	2.7%	No Data	No Data

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

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

The practice audited the HBA1c blood test results of patients with diabetes. In 6 months the percentage of patients with blood results in the intended range improved from 77% to 83%.

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.	N
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.	Y
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: Staff told us that online training courses are completed in staff members' own time.	

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 (01/04/2018 to 31/03/2019) (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.	Y
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
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 (01/04/2018 to 31/03/2019) (QOF)	94.2%	94.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (6)	0.6%	0.8%	N/A

Consent to care and treatment

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

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

Caring Rating: Requires improvement

The latest National GP Patient Survey results were published in July 2019. The practice was statistically significantly below average for patient satisfaction with interactions with healthcare professionals. The practice had not taken effective steps to investigate the cause of the low satisfaction or to monitor whether the changes made to date had improved patients' views of their care.

Kindness, respect and compassion

Feedback from patients was mixed about the way staff treated people, with below average survey results and some negative comments.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards 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.	21
Number of CQC comments received which were positive about the service.	17
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment cards	There were some complimentary comments about staff in the practice. There were also comments that reception staff could be rude as they seemed stressed, and that doctors seemed rushed, were not always careful and did not always listen to patients.
NHS Choices	Of the 33 comments, 20 were solely positive. The majority of negative comments related to access, but some referred to what patients felt were poor interactions with reception staff and with healthcare professionals. The practice had responded to all comments.
Friends and Family Test	The practice used the Friends and Family Test to assess patient satisfaction. Documents in the practice showed that staff reviewed the individual comments but there was no comparison of satisfaction rates between months. Our analysis showed that rates of patients who were likely (or extremely likely) to recommend the practice ranged from 68% in February 2019 to 91% in June 2019.

	The average over the seven months of data the practice had was 79%. In every month there were at least 3 patients who said that they would be extremely unlikely to recommend the practice to friends and family. Most of the negative comments related to access but there were some which related to staff attitudes – of both non-clinical and clinical staff. The practice had arranged customer service training for new non-clinical staff.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10538.0	473.0	96.0	20.3%	0.91%

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 (01/01/2019 to 31/03/2019)	70.4%	89.9%	88.9%	Significant 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 (01/01/2019 to 31/03/2019)	76.1%	88.1%	87.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	83.5%	96.2%	95.5%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	70.9%	87.4%	82.9%	No statistical variation

Any additional evidence or comments

Following the inspection of 5 April 2016 we rated the practice as requires improvement for providing Caring services. GP Patient survey data was below average and the practice had not taken action.

The practice was rated as good following the announced desk-based follow up inspection in 2017. The practice had discussed the matter with the practice participation group and survey results had improved in 2017, although they were still low compared to local and national averages. For example:

- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%. The practice scored 70% for this indicator in 2016.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%. Previously the practice scored 70%.

The survey questions and methodology changed in 2018, so it is not possible to compare the results from 2016 and 2017 with those from 2018 and 2019.

The practice was somewhat below average for several indicators in 2018, but not statistically significantly below average for indicators used to assess caring.

In 2019, the practice remained statistically significantly below average for patients who felt their needs were met. All measures of satisfaction with healthcare professionals fell in 2019, including how well patients felt they were involved in decisions (see below).

We asked the practice what they had done to address these areas of below average patient satisfaction in the national GP patient survey. Staff told us that:

- New reception staff had been recruited and received customer service training.
- Reception duties had been rearranged to reduce the pressures on reception staff.
- The practice had recruited a new salaried GP and was now using fewer locums, from September 2019.

Other actions had recently been agreed, but had not yet been implemented, for example sending all non-clinical staff on communication skill training (not just those recently recruited) and providing RCGP consultation model training for GPs.

The last survey by the practice was in 2018. The practice had not carried out any formal monitoring exercise since the last national survey, to allow assessment of whether the changes made had resulted in improvement in patient satisfaction. The practice had not carried out any survey to assess if it was all clinical staff or just particular GPs or nurses that patients felt needed more support with consultation skills. There was no active monitoring of how caring patients perceived staff to be, other than review of ad hoc comments on the Friends and Family Test.

We gave feedback at the end of the inspection about weaknesses in the practice response to the survey results and monitoring arrangements. Shortly after the inspection, the practice sent us an email which said that staff had been actively monitoring and taking actions. As evidence we were sent a letter summarising the improvements made to appointment access and an audit of access to appointments. No evidence was sent of actions or monitoring of patient satisfaction with how caring the practice staff were.

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

Involvement in decisions about care and treatment

There were mechanisms to support patients to be involved in their care, but the practice was below average in the National GP Patient survey for how well patients felt they were involved in decisions.

	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
Interviews with patients.	Patients in the practice participation group (PPG) told us that in their experience staff were caring and attentive to the needs of patients. PPG members told us that newly recruited reception staff were better able than their predecessors to help patients.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	79.1%	94.1%	93.4%	Variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: There were no easy read materials. In response to the draft report the practice sent us a range of leaflets now available in easy read format.	

Carers	Narrative
Percentage and number of carers identified.	44 carers identified (0.42%)
How the practice supported carers (including young carers).	There was a lead staff member for carers. The practice offered carers annual reviews and flu immunisations. The practice had not identified any young carers.
How the practice supported recently bereaved patients.	The practice had a leaflet with information for bereaved patients. GPs referred patients for counselling if required.

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:	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	N/A
The practice ensured patients were informed how their records were stored and managed.	N/A
Patients were made aware of the information sharing protocol before online services were delivered.	N/A
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	N/A
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	
Explanation of any answers and additional evidence:	

Responsive Rating: Requires improvement

The practice had received negative feedback from patients about access and having their needs met. The practice was below average on the 2019 National GP Patient Survey for questions about access, and statistically significantly below average for patient satisfaction having their needs were met and getting through by telephone.

The practice had taken action to improve appointment access and had audited to assess the improvement. Action had been taken to address issues with getting through by telephone, but had not audited or other monitoring put in place to check for improvement. There was no audit or other monitoring to assess if actions the practice felt should improve patients' views of their needs being met were effective. We noted that patients continued to give negative feedback to the practice after actions had been implemented the practice hoped would resolve the issues. These issues will impact on all population groups so they have all been rated as requires improvement.

Responding to and meeting people's needs

The practice had taken some steps to deliver services to meet patients' needs, but in both the 2018 and 2019 National GP Patient Surveys patients at the practice were statistically significantly less happy than those at other practices with how well their needs were met. The practice told us that they had taken some action but there was no monitoring to check patients found improvement.

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

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 8pm
Tuesday	8am - 8pm
Wednesday	8am – 8pm
Thursday	8am – 8pm
Friday	8am – 8pm
Saturday	9am – 1pm
Appointments available:	

Monday	8am – 8pm
Tuesday	8am – 8pm
Wednesday	8am – 8pm
Thursday	8am – 8pm
Friday	8am – 8pm
Saturday	9am – 1pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10538.0	473.0	96.0	20.3%	0.91%

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 (01/01/2019 to 31/03/2019)	85.7%	94.7%	94.5%	Variation (negative)

Any additional evidence or comments

The practice was somewhat below average for several indicators in 2018, and statistically significantly below average for patients who felt their needs were met at their last appointment: 83.9% compared to the national average of 94.8%. The practice remained statistically significantly below average for this indicator in the 2019 survey.

We asked the practice what they had done to address this area of below average patient satisfaction in the national GP patient survey. Staff told us that:

- New reception staff had been recruited and received customer service training.
- Reception duties had been rearranged to reduce the pressures on reception staff.
- The practice had recruited a new salaried GP and was now using fewer locums, from September 2019.

Other actions had recently been agreed, but had not yet been implemented, for example sending all non-clinical staff on communication skill training (not just those recently recruited) and providing RCGP consultation model training for GPs.

The last survey by the practice was in 2018. The practice had not carried out any formal monitoring exercise since the last national survey, to allow assessment of whether the changes made had resulted in improvement in patient satisfaction. The practice had not carried out any survey to assess patients felt that particular GPs or nurses needed more support with consultation skills. There was no active monitoring of how caring patients perceived staff to be, other than review of ad hoc comments on the Friends and Family Test.

We gave feedback at the end of the inspection about weaknesses in the practice response to the survey

results and monitoring arrangements. Shortly after the inspection, the practice sent us an email which said that staff had been actively monitoring and taking actions. As evidence we were sent a letter summarising the improvements made to appointment access and an audit of access to appointments. No evidence was sent of actions or monitoring of patient satisfaction with whether their needs were met.

Older people

Population group rating: Requires improvement

Findings

- Patients gave negative feedback through various methods about difficulties with access and having their needs met. The practice had taken some action, but had not but in place monitoring to ensure that all of the issues were resolved. These issues will impact on all population groups so they have all been rated as requires improvement.

- 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 practice provided effective care coordination to enable older patients to access appropriate services.
- We now have a dedicated telephone number for elderly patients (75 years plus) only, between 09:00-11:00, so that elderly people don't have to wait long. These elderly patients have been informed about this service by sending letters out to them.

People with long-term conditions

Population group rating: Requires improvement

Findings

- Patients gave negative feedback through various methods about difficulties with access and having their needs met. The practice had taken some action, but had not but in place monitoring to ensure that all of the issues were resolved. These issues will impact on all population groups so they have all been rated as requires improvement.

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- 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: Requires improvement

Findings

- Patients gave negative feedback through various methods about difficulties with access and having their needs met. The practice had taken some action, but had not but in place monitoring to ensure that all of the issues were resolved. These issues will impact on all population groups so they have all been rated as requires improvement.

- Additional nurse appointments were available outside of school hours so that children did not need to miss school.
- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Patients gave negative feedback through various methods about difficulties with access and having their needs met. The practice had taken some action, but had not but in place monitoring to ensure that all of the issues were resolved. These issues will impact on all population groups so they have all been rated as requires improvement.

- 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 8pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- Patients gave negative feedback through various methods about difficulties with access and having their needs met. The practice had taken some action, but had not but in place monitoring to ensure that all of the issues were resolved. These issues will impact on all population groups so they have all been rated as requires improvement.

- 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 such as homeless people and Travellers.

- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- Patients gave negative feedback through various methods about difficulties with access and having their needs met. The practice had taken some action, but had not but in place monitoring to ensure that all of the issues were resolved. These issues will impact on all population groups so they have all been rated as requires improvement.
- 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.

Timely access to the service

Feedback from patients was that they were not always able to access care and treatment in a timely way.

	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.	Partial

Explanation of any answers and additional evidence:

On arrival in the practice, we saw a board in reception which had a list of all the GPs, with times against their names. The shortest time was 10 minutes. One GP was noted as 30 minutes and one as 45 minutes. We asked staff about the board and was told that this was the average time, calculated by reception staff over a period of several weeks, that patients will wait to see the GP, after their appointment time. We were told that some GPs were particularly popular with certain patients, who tended to need more time.

We received some negative comments on the CQC comments cards about regularly having to wait more than 45 minutes after appointment time. There were several similar comments on the NHS

Choices website and on the Friends and Family test responses.

The practice participation group told us that GPs did not run to time, but that was because the GPs did not restrict patients to one issue per appointment. Members of the group told us that delays varied, with some GPs only usually running behind by 5 – 10 minutes.

We asked staff what steps had been taken to manage waiting times. Staff told us that reception staff would advise patients on arrival if GPs were running late. This was confirmed by the practice participation group.

We gave feedback to the practice about weaknesses in their response to patient feedback on waiting times, as there was no evidence of improvement activity. Shortly after the inspection the practice sent us an audit of one week's consultations in early November 2019. The practice highlighted that in the audit only one clinician ran beyond 30 minutes on one day. In their response the practice told us that they intended to keep monitoring waiting times and would act upon it, if an ongoing issue with waiting times were to be identified.

We looked at the audit. We noted that the same GP ran over time on every session, 32.3 minutes on one day and 18.6 minutes on another. The average delay for this GP was 13 minutes. A second GP was delayed by 22.5 minutes on one day and 18 minutes on another, with an average delay of 15.3 minutes.

The practice did not send us any analysis of the reason for the delays that did occur during the audit period or plans for improvement. The practice did not explain why, if the audit demonstrated that there was not an ongoing issue with waiting times, there was a consistent theme of negative patient feedback. We were not sent details of any other audit of this issue.

The practice told us (in the email shortly after the inspection) that the waiting times board had since been removed as it was inaccurate. The practice did not explain how the information on the board in reception had been calculated that made it inaccurate.

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 (01/01/2019 to 31/03/2019)	42.7%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	52.7%	73.8%	67.4%	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 (01/01/2019 to 31/03/2019)	58.1%	71.8%	64.7%	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 (01/01/2019 to 31/03/2019)	59.3%	76.4%	73.6%	No statistical variation

Any additional evidence or comments
The practice was below average for patient satisfaction with access in the 2019 National GP Patient Survey, and statistically significantly for getting through to the practice by phone. We asked the practice what they had done to address this area. The practice told us: • A new salaried GP was appointed. • An extra reception staff member had been recruited with three staff answering calls at peak times, rather than two, and a separate staff member dealing with face-to-face enquiries at the reception desk. • A dedicated telephone line had been created to allow patients over 75 priority access. • Some sameday appointments had been converted to routine appointments. Early and late appointments changed from same day to routine. • Next day appointments introduced. • Five extra telephone consultations created per day (in addition to the previous 11) • Appointments available to book up to 4 weeks in advance, rather than 2 weeks. Staff told us that reception staffing changes were implemented from March 2019 and changes to appointment slots by May 2019. We noted that there continued to be negative comments about both getting through by phone and appointment access on NHS Choices and Friends and Family Test responses after this date (up to September, the last evidence available). Minutes of a patient participation group meeting in September 2019 showed discussion of an ongoing issue with telephone access, with a note that the issue was not caused by an increase in incoming call rates. There were further plans to upgrade the telephone system. The practice had audited appointment access for two weeks in September 2019, in response to the National GP Patient Survey. The audit showed that in this period 4 patients were unable to access a routine appointment and 11 patients were unable to book a same day appointment. The practice planned to increase the appointments available on a Monday (when there was peak demand) and re-audit again mid- January 2020. There was no audit of telephone access or other monitoring to check if the improvements had improved patient experience or patient satisfaction with getting through by phone. The practice was not using the telephone system information dashboard to monitor call waiting times.

Source	Feedback
CQC comments cards	There were negative comments on CQC comments cards about getting through by phone, making an appointment and delays after appointment time.
NHS Choices	Of the 33 comments, 20 were solely positive. The majority of negative comments related to access – getting through by phone and making an appointment.
Friends and Family Test	We looked at data in the practice, from January to September 2019. Most of the negative comments related to access.

	Although rates of patients saying they would be likely (or extremely likely) to recommend the practice were higher since May 2019 when the improvements had been implemented (average 85%, compared to 75% from January to May) there was still an average of 4 patients per month saying they would be unlikely or extremely unlikely to recommend the practice. We do not have a statistical comparison between practices for the Friends and Family Test, but the national average for July – September is 90% of patients saying that they would recommend their practice. We noted that patients continued to add negative comments about getting through by phone and appointment access after May 2019.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	10 Verbal 6 Written
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
Explanation of any answers and additional evidence: One of the four complaint responses we reviewed did not have details of what the patient could do if still dissatisfied.	

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Information about how to complain was incorrect as it advised that if patients were not satisfied with the practice response they could complain to NHE England. In response to the draft report the practice sent us a copy of an updated complaints leaflet with accurate information.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient queued for so long at reception that they missed their appointment time.	The practice made the self check-in machine more evident to patients.

Well-led Rating: Requires improvement

We have rated the practice as requires improvement because the practice had not put in place systems to ensure that systems and processes were operating as intended and had not established monitoring to ensure that actions taken had resulted in improvement or mitigated the intended risk.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership. The practice had identified challenges and had taken action to address them, but had incomplete monitoring to assess improvement.

	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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: • The practice had identified and acted on challenges. Some of these actions had been successful in addressing the challenges. It was not clear that all of the actions taken had been successful, as the practice had not established comprehensive monitoring arrangements.	

Vision and strategy

The practice had a vision and strategy to provide high quality sustainable care. This was being revised. Monitoring arrangements were incomplete at the time of the inspection.

	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.	Partial
Explanation of any answers and additional evidence: The practice had a vision and strategy to provide high quality sustainable care. This was being revised. Monitoring arrangements were incomplete at the time of the inspection.	

Culture

The practice generally 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
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	N
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

The practice whistleblowing policy says that staff may notify an appropriate outside body, but no details were given and there were no details of a named external person.

In response to the draft report, the practice sent us an updated policy, which had a person named as Freedom to Speak Up Guardian and whistleblowing lead. However, the practice was still not in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy as it listed an internal process and said that staff could notify the appropriate outside body if dissatisfied with the outcome of the investigation, without making clear that staff could also contact the Freedom to Speak Up Guardian or to an external organisation if they felt unable to raise the matter within the practice.

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

Source	Feedback
Staff	Staff told us that they felt happy and well supported.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management, but they were not fully effective.

	Y/N/Partial
There were governance structures and systems 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: • Most policies were complete and had been reviewed. Some policies were incomplete, for example the whistleblowing policy and the clinical governance policy and some did not have evidence of review, for example the information security policy. • The governance arrangements had not allowed the practice to be aware of tasks that had not been completed by a staff member, until after the staff member had left.	

Managing risks, issues and performance

There were processes for managing risks, issues and performance, but the practice had not put in place systems to ensure they were effective.

	YP/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
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.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: • Assurance systems had not ensured that processes such as those for ensuring proper authorisations to administer medicines, were operating as intended. • Arrangements for managing risks had not ensured that risks identified had all been acted upon and that the action taken had effectively mitigated the risk.	

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
Staff whose responsibilities included making statutory notifications understood what this	Y

entails.	
Explanation of any answers and additional evidence:	

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

The practice reviewed feedback, but had not established comprehensive monitoring to assess whether all of the actions taken had led to improvement.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice had acted on patient feedback, but had not put in place monitoring to assess the actions taken had improved all of the issues raised.	

Feedback from Patient Participation Group.

Feedback
• Members of the patient participation group told us that the practice was keen to work with the group to improve care for patients in the practice, and was making improvements.

Continuous improvement and innovation

There was evidence 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

- The practice had improved the care of patients with diabetes.
- The practice was reviewing their governance arrangements and developing a practice-wide improvement plan.

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

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.