# Care Quality Commission

## Inspection Evidence Table

## Dr McManus and Partners (1-552120490)

**Inspection date: 26 February 2020**

**Date of data download: 12 February 2020**

# Overall rating: Good

**At the inspection in July 2019 we rated the practice as Requires Improvement overall with a rating of Requires Improvement for providing a Safe and Effective service. We rated the practice as Inadequate for providing a Well-led service. The population groups were rated as Requires Improvement. As a result, they were served a warning notice for Regulation 17, Good Governance.**

**At this inspection we have rated the practice as Good overall, Safe, Caring, Responsive and Well-led are rated as Good. Effective along with the population groups of long term conditions, families, children and young people, People experiencing poor mental health (including people with dementia) are rated as Requires Improvement because: -**

**The practice has not met the minimum 90% for three of four childhood immunisation uptake indicators.**

**The percentage of women eligible for cervical screening was below the national average of 80%.**

**Exception reporting for patients with long term conditions, mental health and dementia were above the CCG and national averages.**

**We found that the management team had made a number of improvements and had met the requirements of the warning notice. However, there were some areas of governance that needed strengthening.**

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

# Safe Rating: Good

**At this inspection we found that the practice had made improvements to the systems it had in place for patient safety alerts, management of high-risk medicines and medication reviews.**

**Safety systems and processes**

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

| Safeguarding | Y/N/Partial |
|---|---|
| There was a lead member of staff for safeguarding processes and procedures. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |

| Recruitment systems | Y/N/Partial |
|---|---|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Yes[1*] |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Explanation of any answers and additional evidence:<br>1.At the inspection in July 2019 we found that the practice did not maintain full records of the immunisation status of staff to ensure staff received the immunisations that were appropriate their role.<br><br>At this inspection we found that all staff records had been reviewed and an effective system was now in place to ensure immunisation records were completed and kept up to date. They had also added immunisation records to their recruitment process to ensure details were obtained before the staff member commenced their role. | |

| 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: 11 March 2019. The practice only had the testing completed | Yes |

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|---|---|
| every two years. | |
| There was a record of equipment calibration.<br>Date of last calibration: 24 April 2019 | Yes |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks.<br>Date of last check: 20 February 2020 | Yes |
| There was a log of fire drills.<br>Date of last drill: 8 November 2019 | Yes |
| There was a record of fire alarm checks.<br>Date of last check: Weekly – 19 February 2020 | Yes |
| There was a record of emergency lighting checks.<br>Date of last check: Monthly – January 2020 | Yes |
| There was a record of fire training for staff.<br>Date of last training: Various dates throughout 2019 | Yes |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed.<br>Date of completion: 4 December 2018 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| A legionella risk assessment had been completed.<br>Date of Completion: 21 February 2018.<br>A further risk assessment had been carried out on 20 February 2020 and the practice were waiting for the report. | Yes |
| Actions from legionella risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence:<br>The practice was in a purpose-built building which was shared with another GP practice and which also accommodated Kettering General Hospital's Dermatology Department. | |

| Health and safety | Y/N/Partial |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: | No[1*] |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: 20 January 2020 | Yes |
| Explanation of any answers and additional evidence:<br>1. At this inspection we found that the practice had an effective system in place for the management of risk and undertook comprehensive risk assessments. However, they did not have a specific risk assessment for premises and security. | |

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|---|
| 5-year Electrical Installation Safety Certificate (EICR) – took place on 10 March 2019. We were told that the remedial work had been completed but the practice did not have a new certificate on the day of the inspection. |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---|
| There was an infection risk assessment and policy. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: January 2020 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| There was a system to notify Public Health England of suspected notifiable diseases. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| | |

**Risks to patients**

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

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

**Information to deliver safe care and treatment**

## Staff did not always have the information they needed to deliver safe care and treatment.

| | Y/N/Partial |
|---|---|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Partial[1*] |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| 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. | Yes |

Explanation of any answers and additional evidence:

1. At this inspection we saw information that indicated that the practice had a backlog of approximately 1748 records un-summarised patient records which dated back to 2012. There was no oversight of records that needed to be prioritised for summarisation. The practice had not reviewed the backlog of records for the likelihood of risk and was unable to demonstrate a documented action plan to identify how the backlog would be managed. The practice had a notes summary protocol in place which said that all newly registered patients would have their notes summarised in eight weeks.

Since the inspection the practice had done a review of the information and they found that a large number of patients had already had their notes summarised by their previous practice. Some records had been summarised but had not had a code added to their record. Patients who had joined the practice within the last six months and their previous records had still not been received. This left 0.09% of records which required summarisation.

**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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA) | 0.84 | 0.95 | 0.87 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and | 6.8% | 7.8% | 8.5% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA) | | | | |
| 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 (01/04/2019 to 30/09/2019) (NHSBSA) | 5.70 | 6.04 | 5.60 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA) | 2.23 | 2.11 | 2.08 | No statistical variation |

| Medicines management | Y/N/Partial |
|---|---|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Yes |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Yes |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |

| Medicines management | Y/N/Partial |
|---|---|
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |

Explanation of any answers and additional evidence:

At the inspection in July 2019 we found the practice did not have an effective system in place for medicines reviews. We found concerns around patients who received medicines had not been reviewed in a timely manner and received regular monitoring in accordance with national guidance. We also found that the practice did not have a clear system for the recall of patients with long term conditions, to ensure they were reviewed in a timely manner.

- At this inspection we found that the systems in place for medication reviews had been reviewed and improved. Since the last inspection the practice had used a medication review template. A prescribing team was now in place and searches of patient records was carried out fortnightly to ensure patient safety. In April 2020 the practice would commence the use of the birthday month for the medication reviews and this would be closely monitored.

At the inspection in July 2019 we found that the 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 was not effective. We found concerns with patients on Renin Angiotensin System blocking medicines and those patients who used a home testing kit to check their international normalized ratio (INR). The practice were prescribing the medicines without any knowledge of the blood results from the home testing kits.

- At this inspection we found the management team had reviewed and improved the system in place for patients on high risk medicines. We found that the practice conducted regular searches and alerts were placed on the patient record system and records which were reviewed before patients were given repeat prescriptions to ensure that the required blood monitoring or review had taken place.

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

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

| Significant events | Y/N/Partial |
|---|---|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |

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|---|---|
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Partial[1*] |
| Number of events recorded from July 2019 until February 2020 | 31 |
| Number of events that required action: | 31 |

Explanation of any answers and additional evidence:

1.At the July 2019 inspection we looked at minutes of meetings held by the practice. We could see that significant events were a standard agenda item. Whilst we saw evidence of the meetings that had taken place, minutes of the meetings did not reflect the discussion that had taken place, what actions and learning had been shared and who was responsible for actions and a timeframe.

At this inspection we were told that the practice had put a new form in place to capture significant events. We reviewed four significant events and found that not all the forms were fully completed. We did not find any improvement in the meeting minutes as actions and learning were not documented. However, practice staff we spoke with were able to describe actions taken. We spoke with a GP partner who told us the new process was still 'work in progress' to ensure the forms were fully completed and signed off.

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

| Event | Specific action taken |
|---|---|
| Patient attended with shortness of breath. Observations normal but GP asked for further tests. | Positive event – Experience of GP asking for more tests despite observations being normal, found problem with lungs – admission to hospital for treatment. |
| Prescription generated for incorrect amount of medicines (56 times correct amount) | Practice now do a monthly search on abnormal quantities of medicines prescribed to ensure patient safety. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Yes |
| Staff understood how to deal with alerts. | Yes |

Explanation of any answers and additional evidence:

At the inspection in July 2019 we found the systems for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were actioned appropriately was not embedded or effective within the practice.

At this inspection we found the management team had reviewed and improved the system for MHRA and patient safety alerts. A GP partner oversaw the process and a practice administrator kept a spreadsheet of all alerts received, searches carried out and actions taken. We saw that the alerts were discussed regularly at clinical meetings.

# Effective Rating: Requires Improvement

**At the inspection in July 2019 we rated the practice as Requires Improvement for providing Effective services because we found: -Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. Quality improvement had been carried out but we saw limited evidence that audits were driving improvements to patient outcomes.**

**At this inspection we found that the practice had made improvements to the systems how it assessed patient needs, delivery of care and treatment and quality improvement processes was now in place.**

**However , we have rated the practice as Requires Improvement for providing an Effective service because the population groups of people with long term conditions, families, children and young people, working age people (including those recently retired and students) and people experiencing poor mental health (including people with dementia) were rated as Requires Improvement because :-**

**The practice had not met the minimum 90% for three of four childhood immunisation uptake indicators.**

**The percentage of women eligible for cervical screening was below the national average of 80%.**

**Exception reporting for patients with long term conditions, mental health and dementia were above the CCG and national averages.**

**Effective needs assessment, care and treatment**

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

| | Y/N/Partial |
|---|---|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were | Yes |

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|---|---|
| addressed. | |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Yes |

| Prescribing | Practice performance | CCG average | England average | England comparison |
|---|---|---|---|---|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA) | 0.61 | 0.73 | 0.74 | No statistical variation |

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool called Nelie 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.
- There was a dedicated Care Coordinator in place and they were the first point of contact for care homes and a number of patients identified as at risk.
- There was a dedicated GP for the collaborative care team one session a week who liaised with external agencies or members of the practice team. Care plans were regularly reviewed
- 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.
- 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 most relevant patients in this age group.

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- At the inspection in July 2019 we found that patients in this group were not having their healthcare needs met in a manner that ensured as far as practical their treatment was safe. The practice did not have an effective recall system in place for patients who had long term conditions. The system in place for medication and long term conditions reviews was not effective. Repeat prescribing in the absence of blood monitoring for patients who were prescribed some high risk medicines was not effective.

- At this inspection we found significant improvements had been made. The practice were able to demonstrate the new systems in place for the recall of patients, the monitoring of high risk medicines and how medication reviews were carried out. The practice had rectified this at this inspection with updated searches in place and in records we looked at we found that patients

that required monitoring were being invited for the appropriate appointment. However, exception reporting in a number of long-term conditions was above CCG and national averages.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring
- We saw there was a self-blood pressure monitor available in the health zone in reception.
- There were iPad's in the reception area where patients could log onto to the practice website and complete administration task or ask the practice a question.

| 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) | 86.1% | 82.6% | 79.3% | No statistical variation |
| Exception rate (number of exceptions). | 24.9% (262) | 17.5% | 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) | 82.0% | 79.5% | 78.1% | No statistical variation |
| Exception rate (number of exceptions). | 16.6% (175) | 11.2% | 9.4% | 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 (01/04/2018 to 31/03/2019) (QOF) | 83.2% | 82.2% | 81.3% | No statistical variation |
| Exception rate (number of exceptions). | 23.1% (244) | 14.6% | 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) | 78.4% | 77.1% | 75.9% | No statistical variation |
| Exception rate (number of exceptions). | 34.4% (466) | 9.9% | 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) | 92.2% | 92.4% | 89.6% | No statistical variation |
| Exception rate (number of exceptions). | 35.4% (113) | 14.9% | 11.2% | 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 (01/04/2018 to 31/03/2019) (QOF) | 80.2% | 84.6% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.1% (49) | 4.4% | 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) | 93.1% | 93.4% | 91.1% | No statistical variation |
| Exception rate (number of exceptions). | 6.4% (19) | 4.4% | 5.9% | N/A |

**Any additional evidence or comments**

At the inspection in July 2019 and at this inspection we discussed the higher than expected exception reporting for asthma, chronic obstructive airways disease, diabetes, mental health, dementia and cardiovascular disease primary prevention. (Exception reporting is the removal of patients from the calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

The management team were aware that the exception reporting figures were higher than CCG and national average. Patients were reminded to attend once by letter and a further twice by mJog (automated appointment system reminder). Since the inspection in July 2019 the practice had reviewed this process and sent a further two letters before exception reporting took place. The letter discussed a reduction in medication until the patient had attended for a medication review and the final letter discussed the practice concerns about the continuation of prescribed medicines without the patient being seen. They told us that they had rarely exception reported since this new process and were not able to explain the high exception reporting detailed in this evidence table. Patient records we looked at confirmed patients had been seen. Exception reporting remained high and the provider still had further work to do to make improvements.

## Families, children and young people

## Population group rating: Requires Improvement

**Findings**

- The practice has not met the minimum 90% for three of four childhood immunisation uptake

indicators. We discussed with the management team the information CQC held as some of the childhood immunisation uptake rates were just below the World Health Organisation (WHO) targets of 90%.The evidence they provided demonstrated that they had achieved the 90% target for all four targets but it was clear that the practice received uptake rates from a different information source to the Care Quality Commission.

- The practice contacted the parents or guardians of children due to have childhood immunisations. Clinics were available both morning and afternoon.
- Minor illness appointments were available after school hours.
- 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 now had arrangements in place to identify and review the treatment of newly pregnant women on all long-term medicines, for example, Carbimazole. These patients were now provided with advice and post-natal support in accordance with best practice guidance.
- The practice website had a section dedicated to Teen Health where young people could access information on services for sexual health and contraception.
- The practice had a dedicated mother and baby area on first floor of the building. This could be used for mothers to breastfeed or to sit after their child had received immunisations.
- 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) | 217 | 237 | 91.6% | 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) | 234 | 265 | 88.3% | 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) | 236 | 265 | 89.1% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, | 233 | 265 | 87.9% | Below 90% minimum |

| | | | | |
|---|---|---|---|---|
| mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | | | | |

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

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

## Population group rating: Requires Improvement

**Findings**

- The practice cervical cancer screening figures was below the 80% uptake rate and the practice still had actions to take to improve these outcomes.
- 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.
- On-line consultations were available through the practice website (non-urgent) or via Engage Consult for on the day problems.
- Video consultations were also available during the week and also on Sundays.

| 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). (01/07/2019 to 30/09/2019) (Public Health England) | 73.0% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE) | 74.6% | 75.1% | 71.6% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE) | 54.1% | 57.0% | 58.0% | N/A |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE) | 52.6% | 68.1% | 68.1% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE) | 52.9% | 54.1% | 53.8% | No statistical variation |

| Any additional evidence or comments |
| --- |
| We spoke with the assistant practice manager about their cervical screening process. The practice had a system in place to call patients who required a cervical smear.<br><br>The practice was aware of the low results but felt they were doing all they could to encourage patients eligible to attend for cervical screening. They had a dedicated administrator who did the recall process. Three recall letters were sent out to a patient. The practice also received a list of those patients who had not responded.<br><br>The practice had a failsafe system in place to ensure that cervical screening samples sent from the practice received a documented result or had taken up the opportunity for further tests |

## People whose circumstances make them vulnerable

## Population group rating: Good

| Findings |
| --- |
| • Same day appointments and longer appointments were offered when required. Patients were added to the special access register in order for them to be tracked by the care coordinator.<br>• Patients who presented at the reception desk who were on the special access register were seen by the on-call doctor on arrival.<br>• All patients with a learning disability were offered an annual health check.<br>• End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.<br>• The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.<br>• 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: Requires Improvement.

| Findings |
| --- |
| • Exception reporting for people experiencing mental health and dementia was above CCG and national averages.<br>• The practice had employed a mental health practitioner who 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.<br>• Same day and longer appointments were offered when required.<br>• 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Sky tiles were in place in the reception area to reduce anxiety and promote mental wellbeing

| 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) | 93.8% | 93.6% | 89.4% | No statistical variation |
| Exception rate (number of exceptions). | 56.2% (82) | 17.2% | 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) | 92.5% | 94.0% | 90.2% | No statistical variation |
| Exception rate (number of exceptions). | 26.7% (39) | 13.5% | 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) | 78.5% | 84.6% | 83.6% | No statistical variation |
| Exception rate (number of exceptions). | 10.2% (18) | 9.0% | 6.7% | N/A |

**Any additional evidence or comments**

We discussed the higher than expected exception reporting for mental health and dementia. (Exception reporting is the removal of patients from the calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
The management team were aware that exception reporting figures were higher than CCG and national averages.
The practice employed a mental health practitioner who saw patients daily in the practice. In patient records we looked at we found care plans were in place but assessments carried out by the external mental health team had not been correctly coded. The practice told us they would review the patient records to ensure all records were accurate and up to date.

**Monitoring care and treatment**

## The practice now 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) | 559.0 | 550.4 | 539.2 |
| Overall QOF score (as a percentage of maximum) | 100.0% | 98.5% | 96.7% |
| Overall QOF exception reporting (all domains) | 10.2% | 6.9% | 5.9% |

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

At the inspection in July 2019 we found the practice did not have a programme of continuous audits to monitor quality and to make improvements. They had limited evidence to demonstrate continuous improvements to patient outcomes or any action plans put in place to monitor implementation of any recommendations. We were not shown any clinical audits that were full cycle. We found that the quality improvement audits we looked at would benefit from more structure and detailed analysis together with action plans to monitor implementation of any recommendations.

At this inspection we found an audit plan in place. We saw a large amount of quality improvement which included: -

- Five audit cycles had been completed since the last inspection on prescribed medicines where blood monitoring was required. The aim was that 100% of prescribed medicines had received the appropriate blood monitoring. Fortnightly searches were carried out by the pharmacy technicians, three letters were sent out to patients and if they did not respond medication was reviewed and reduced to a one week supply until the patient had attended for monitoring. The number of patients who had outstanding blood monitoring had significantly reduced by the fifth cycle and the practice planned to repeat the audit again in six months to ensure the improvements had been sustained.

We also saw examples of other improvement activity, for example,

- Clinical Consultation Audit to check that consultations met the agreed standards. A random sample of five patient records were reviewed for each clinician. Inconsistency was found in some records, for example, recording of blood pressure and temperature, no records of pallor, blood pressure or abdominal examination for consultations for anaemia or menstrual bleeding. The audit recommended that all clinicians used the Arden's templates to record their consultations

and a re-audit would take place in May 2020.

- After death audit for the last 20 patients who had died at the practice. The findings were that 11 deaths had cause unknown, six patients had died unexpectantly, relatives of 12 patients had been contacted since the bereavement had taken place and 15 were on one the practice support registers The results were discussed at a GP partner meeting and it was agreed that a palliative care template would be used by all clinicians to ensure consistency, all unexpected deaths would be raised as significant events and discussed at a clinical meeting and a re-audit would take place in 12 months' time.

**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. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Yes |
| 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. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |

**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) | Yes |
| 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 | Yes |

| | |
|---|---|
| treatment. | |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Yes |

**Helping patients to live healthier lives**

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

| | Y/N/Partial |
|---|---|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Patients had access to appropriate health assessments and checks. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Yes |

| 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) | 92.2% | 94.8% | 95.0% | No statistical variation |
| Exception rate (number of exceptions). | 0.3% (11) | 0.8% | 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. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and | Yes |

| | |
|---|---|
| recorded a patient's mental capacity to make a decision. | |
| The practice monitored the process for seeking consent appropriately. | Yes |
| Policies for any online services offered were in line with national guidance. | Yes |

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

| CQC comments cards | |
|---|---|
| Total comments cards received. | 24 |
| Number of CQC comments received which were positive about the service. | 12 |
| Number of comments cards received which were mixed about the service. | 10 |
| Number of CQC comments received which were negative about the service. | 2 |

| Source | Feedback |
|---|---|
| Comments Cards | Comments cards were positive about the care and treatment received at Weavers Medical. Comments included treatment first class, treated with respect, staff were caring and helpful, listened to my concerns.<br>10 mixed comments were in regard to the time they had to wait to get through by phone and lack of appointments.<br>Two negative comments were in regard to wait to get through by phone and lack of appointments along with lack of communication between secondary care and the GP practice. |
| Family and Friends Testing (FFT) | The practice monitored FFT on a monthly basis. From October 2019 to February 2020 over 84% would recommend the practice to family and friends. |

**National GP Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to | 87.7% | 87.6% | 88.9% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 31/03/2019) | | | | |
| 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) | 92.6% | 86.5% | 87.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019) | 96.7% | 94.8% | 95.5% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019) | 82.4% | 81.8% | 82.9% | No statistical variation |

| Question | Y/N |
|---|---|
| The practice carries out its own patient survey/patient feedback exercises. | Yes |
| At this inspection we found they had carried out a patient survey from 22 August 2019 to 22 September 2019. 61 patients had responded. 100% of patients who responded said they were treated with respect. 91% of patient who responded said they rated the care they received as good to excellent | |

**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. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

**National GP Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as | 89.4% | 92.8% | 93.4% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019) | | | | |

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

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 531 patients = 2.74% of patients registered at the practice. |
| How the practice supported carers (including young carers). | The practice had two young carers registered at the practice. A noticeboard was available in the waiting area to advise patients on the services available. |
| How the practice supported recently bereaved patients. | The practice had produced a sympathy card for bereaved relatives which was sent out from all the staff. It included a list of organisation which could support them.<br>The practice website also had information to support bereaved relatives. |

**Privacy and dignity**

## The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|---|---|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Yes |
| Consultation and treatment room doors were closed during consultations. | Yes |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |

# Responsive Rating: Good

**At this inspection we have rated the practice as for providing a responsive service.**

**Responding to and meeting people's needs**

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

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

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| Opening times: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 1pm and 2pm to 6.30pm |
| | |
| Appointments available: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| | 7.30am to 7.30pm |
| Extended Hours | Friday – 6.30pm to .307pm by appointment only |
| | |
| **Patients who were registered with a GP in Kettering could access:-**<br><br>**GP Extended Access Hub – Kettering :-** Weavers Medical – Prospect House, Lower Street Kettering .NN16 8DN<br><br>Additional same day and booked appointments were provided by GPs, Nurse Prescribers, Clinical Pharmacists, Practice Nurses and other clinicians outside of core General Practice hours. | |

Available:
4pm to 8pm Monday to Friday
8.30am to 12.30 - Saturday
1pm to 5pm – Sunday - Video Consultations
8.30am to 12.30 Bank Holidays

**National GP Survey results**

| 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) | 94.4% | 94.3% | 94.5% | 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 practice provided effective care coordination to enable older patients to access appropriate services.

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

**Findings**

- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The management team told us they in the future they planned to have 'group consultations' which would allow the practice team to support people to take control and actively manage their health which in turn would reduce GP and nurse clinical workload. They planned to start a group of patients with Type 2 diabetes in the coming months.
- 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**

- 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.
- Appointments outside of school hours and on Saturday mornings were available.
- The practice website contained information on Child and Teen Health, for example, in relation to immunisations and vaccinations and young minds.

## 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 had a health zone on the ground floor of the building. A self blood pressure monitoring machine along with weighing scales were also available for patients to use.
- 25% of appointments were available online and were made available up to six weeks in advance.
- The practice was open until 7.30pm on a Friday. Appointments were available Saturday and Sunday 8.30am until 12.30 with the GP extended access hub.

## People whose circumstances make them vulnerable

**Population group rating: Good**

**Findings**

- The practice had adjusted the delivery of its services to meet the needs of patients who were military veterans.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- 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.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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

**Population group rating: Good**

**Findings**

- Priority appointments were allocated 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 website had links for groups such as changing minds, substance to solution, Samaritans and MIND.

**Timely access to the service**

## People were not always 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. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| Appointments, care and treatment were only cancelled or delayed when absolutely necessary. | Yes |
| 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 (01/01/2019 to 31/03/2019) | 28.5% | 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) | 57.9% | 65.9% | 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) | 56.5% | 63.8% | 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) | 74.8% | 74.3% | 73.6% | No statistical variation |

| Any additional evidence or comments |
|---|

At the inspection in July 2019 we asked the practice to continue to monitor and improve patient access in relations to phone access and lack of appointments.

At this inspection we found they had carried out a patient survey from 22 August 2019 to 22 September 2019. 61 patients had responded.

Patients were asked how easy it was to get through by phone. 41% of those who responded felt it was easy to get through to speak to a receptionist whilst 56 % did not find it easy.
80% of patients rang for an appointment between 8am and 10am. Of those 43% waited five to ten minutes to speak to someone whilst 33% waited over ten minutes. 79% of those who responded would recommend the practice to family and friends. The practice did not have in place an action plan which addressed the areas of the national GP patient survey that were below the CCG average.

The management team spoke about the challenges that they had experienced in regard to the installation of a new telephone system. This had been an ongoing process since April 2019 and was finalised the week prior to the inspection. The changes that were planned had not been implemented by the practice but were acknowledged and the impact will be reviewed at the next inspection.

| Source | Feedback |
|---|---|
| For example, NHS Choices | Two positives in regard to care and treatment. Two negatives, one in regard to wait to get through by phone and lack of appointment and one in regard to appointments for travel vaccinations. |

**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 from July 2019 to February 2020 | 21 |
| Number of complaints we examined. | 3 |
| 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 |

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

Examples of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Request for injections not sent through to community services. | Medical secretaries did not follow the practice policy. Apology given to patient and relatives. Discussed at practice meeting. Practice to follow up request with a phone call to ensure |

| | |
|---|---|
| | requests are actioned. |
| Complaint re care and treatment – potential missed diagnosis | Apology sent to patient. Records reviewed to check care and treatment. Symptoms did not suggest that the diagnosis at the appointment was incorrect. Explanation in complaint response re signs and symptoms. Offered to meet with patient to discuss further if required. |

# Well-led Rating: Good

**At the inspection in July 2019 we found that the practice did not provide a Well-led service. They were rated as Requires Improvement overall with a rating of Inadequate for providing a Well-led service. They were served a warning notice for Regulation 17, Good Governance.**

**At this inspection we found that the management team had made a number of improvements and had met the requirements of the warning notice. However, there were some areas of governance that needed strengthening. They were now rated as Good for providing a well-led service.**

**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. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| Explanation of any answers and additional evidence:<br>Since the last inspection in July 2019 the practice had further reviewed its management board which now had a board of four partners and the practice manager. This enabled the management team to have a more responsive process for decision making, rapid evaluation and implementation and review.<br>They had also taken the opportunity to review the whole of the practices systems and processes to ensure that they were in line with the new model of the partnership.<br>The practice had a team approach to deliver personalised, safe and high-quality care. | |

**Vision and strategy**

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

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

**Culture**

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

| | Y/N/Partial |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |

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

| Source | Feedback |
|---|---|
| Staff Survey (similar to family and friends testing). | Out of eight staff who took part in January 2020, six staff would recommend the practice to family and friends.<br>Staff comments included: -<br>Friendly staff, some excellent GPs, very professional and conscientious.<br>Very friendly work environment.<br>Very well organised but not much evidence of staff development for new clinicians in the medical team. |

**Governance arrangements**

## Some governance arrangements required strengthening.

| | Y/N/Partial |
|---|---|
| There were governance structures and systems which were regularly reviewed. | Partial[1*] |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| Explanation of any answers and additional evidence:<br><br>At the inspection in July 2019 we found that although systems and processes were in place, we found that these were not always operated effectively. For example, patient safety alerts, management of high risk medicines, recall of patients with long term conditions and management of medication reviews.<br><br>1.At this inspection we found: - | |

We saw an improved process for the management of MHRA and patient safety alerts.

Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.

We reviewed a sample of patient records to demonstrate that high risk medicines were managed appropriately.

An effective system was now in place for medicines reviews. Searches and audits took place to ensure patients who received medicines were reviewed in a timely manner and received regular monitoring in accordance with national guidance.

A clear system was in place for the recall of patients with long term conditions to ensure they were reviewed in a timely manner. From April 1st 2020 patients would be recalled under the month of their birthday.

Since the last inspection the practice had carried out quality improvement activity.

Risks were assessed and well managed.

However, not all the systems and processes were operated effectively. For example:-

Exception reporting required further monitoring as the practice was above the CCG and national averages in a number of QOF indicators'.

Further monitoring was required for patients who required a cervical smear to ensure women were offered an appointment.

The practice did not have an overview of patient records that required summarisation. However, since the inspection a review of patient records had taken place.

Patient satisfaction still needed further work to ensure patients had timely access to the service, in particular, the improvement of telephone access and appointments.

Meeting minutes needed further work to ensure actions and learning was documented to allow opportunities for learning to be shared and discussed with all staff, particularly for significant events and complaints.

**Managing risks, issues and performance**

## There were processes in place for managing risks, issues and performance.

| | Y/N/Partial |
|---|---|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Partial[1*] |
| There was a systematic programme of clinical and internal audit. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial[2*] |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |

| | |
|---|---|
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |

Explanation of any answers and additional evidence:

1. Exception reporting required further as the practice was above the CCG and national averages in a number of QOF indicators'.

Further monitoring was required for patients who required a cervical smear to ensure women were offered an appointment.

2.The system the practice had in place for the summarisation of patient's notes was not effective. The practice had a backlog and were unable to demonstrate a plan to address this. The risk to patients had not fully been considered. Since the inspection the practice had done a review of the information and they found that a large number of patients had already had their notes summarised by their previous practice. Some records had been summarised but had not had a code added to their record. Patients who had joined the practice within the last six months and their previous records had still not been received. This left 0.09% of records which required summarisation.

The new and updated process for significant events needed further work to ensure the forms were fully completed and signed off.

At this inspection we found that the practice had an effective system in place for the management of risk and undertook comprehensive risk assessments. However, they did not have a specific risk assessment for premises and security.

**Appropriate and accurate information**

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

| | Y/N/Partial |
|---|---|
| Staff used data to adjust and improve performance. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial[1]* |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Yes |

Explanation of any answers and additional evidence:

1. Some of the systems in place to manage and mitigate risks required further improvement. For example, significant events, notes summarisation, oversight of the premises and security and an action plan in response to the improvement of patient satisfaction.

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

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

| | Y/N/Partial |
|---|---|
| Patient views were acted on to improve services and culture. | Yes |
| The practice had an active Patient Participation Group. | Yes- virtual |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |

Explanation of any answers and additional evidence:

- The practice had completed a "You said- We did" exercise for patients and staff with examples of where specific feedback from patients has been actioned. For example, patients wanted improved phone access. Weavers Medical had increased the number of front line staff to answer the phones and a new phone upgrade had just been approved.
- Patients and staff wanted more routine appointments so Weavers Medical had increased the number of clinical staff with the aim to increase the number of available appointments.

The practice used myPPG which is an on-line discussion forum which gave the practice the ability to discuss a range of topics and get patient feedback and often an immediate response to a question.

We viewed feedback from myPPG saw that discussions had taken place.
For example:-

- Telephone – patients still experienced difficulty in getting through the phone. An upgrade to the phone system had just been approved on the day of the inspection.
- Group consultation – shared links with myPPG and asked members if they would be willing to join a group consultation to see how it worked.
- Rate the experience at Weavers Medical – for example, questions on clinical staff, phone system, building and facilities. Clinicians and building were rated very well, phone system rated as poor.

**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. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |

| Examples of continuous learning and improvement |
| --- |
| Weavers Medical were a training practice and were also involved in teaching medical students from two Universities (Cambridge and Leicester) on a continuous basis. They occasionally taught students from the Imperial College. All doctors involved had named tutors who were responsible for their teaching and assessment. They attended annual updates on teaching methods and new clinical needs which are given at each university |

**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.