Care Quality Commission

Inspection Evidence Table

The Waterfield Practice (1-549446468)

Inspection date: 4 March 2020

Date of data download: 19 February 2020

Overall rating: Good

We undertook a comprehensive inspection of The Waterfield Practice on 4 March 2020 to follow up on concerns we found at our previous inspection in February 2019 when we rated the provider as Requires Improvement overall. During the March 2020 inspection, we found systems and processes had improved for Safe and Well led services, although we found some new areas of concern for Safe services. The practice is now rated as Good overall and Requires improvement for Safe.

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

Safe Rating: Requires Improvement

During our previous inspection (February 2019) we rated the practice as Requires Improvement for providing safe services. There were risks that had not been identified, such as control of substances hazardous to health (COSHH) or assessing emergency medicine provision and storage. In addition, identifying and learning from significant events was inconsistent and a newly introduced process was not yet embedded.

Following this inspection (March 2020) we have rated the practice as Requires Improvement for providing safe services.

The practice had made improvements in several areas of concern found at the last inspection. The provider had reviewed their risk assessments and taken action to improve the emergency medicine provision and storage and control of substances hazardous to health. The new system and process for identifying and learning from significant events was now established and embedded into the practice.

However, the provider could not demonstrate clinical supervision of non-medical prescribers in line with their own policy and had not included them in record keeping audits. There was no system for tracking blank prescription stationery through the practice and some personnel files had not been collated using the information required under schedule three.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. Some areas required a review, such as recruitment checks and risk assessments for background checks.

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

Explanation of any answers and additional evidence:

(a) We viewed staff training records and found clinical staff had been trained to level three for child safeguarding and non-clinical staff trained to level two. Staff we spoke with were aware of their role and understood how to identify and raise a safeguarding incident.

(b) During the last inspection (February 2019) we found the practice had undertaken basic risk assessments for non-clinical staff who did not require a DBS check. The assessments did not consider those staff undertaking chaperoning duties.

During this inspection we saw DBS risk assessments had been carried out for all non-clinical staff including those who undertook chaperoning duties. The risk assessments outlined what role the non-clinical member of staff was employed to undertake, for example receptionist/chaperone.

The assessments identified if there was a high, medium or low level of risk in the role and this was recorded, dated and signed for each non-clinical staff member. However, there was no indication on the risk assessments of what risks were being measured against, such as if the person would be left alone with patients or asked to look after a child whilst a parent is being seen.

(c) During the last inspection (February 2019) we found chaperone training had been offered to some staff, but the practice was unable to show us who had received the training.

During this inspection we viewed training records and found all staff who acted as a chaperone had received appropriate training.

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

Explanation of any answers and additional evidence:

(d) During the last inspection (February 2019) we found recruitment files had not been completed or maintained in line with schedule three of the Health and Social Care Act (2008).

During this inspection we viewed four recruitment files for staff employed since the last inspection. We found background checks had been appropriately requested and reviewed. Two non-clinical staff had been asked to supply a third reference as only one had been returned and the second had not responded. This was clearly documented in the records. The practice told us these staff members had been able to join the practice very quickly after their successful interview, so the requisite for the “pre-employment” checks had been informally assessed to enable the recruitment checks to carry over into the beginning of their employment.

(e) The file for one clinical member of staff did not contain interview notes, evidence of a check of their professional qualifications or registration status with the appropriate governing body. The staff member had only recently been employed and the practice sent us the qualification documents and registration check after the inspection. We were told the interview and recruitment processes for this member of staff had been carried out by another member of clinical staff and there had been no oversight of the process by the practice management team to ensure compliance with schedule three of the Health and Social Care Act (2008).

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: April 2019	Y
There was a record of equipment calibration. Date of last calibration: April 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y (f)
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: April 2019	Y
There was a log of fire drills. Date of last drill: January 2020 (main site) No drill undertaken for branch site.	Y
There was a record of fire alarm checks. Date of last check: February 2020	Y
There was a record of fire training for staff. Date of last training: various dates for staff	Y
There were fire marshals.	Partial (g)
A fire risk assessment had been completed. Date of completion: January 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

(f) At the last inspection (February 2019) the practice had not carried out any control of substances hazardous to health (COSHH) risk assessments.

During this inspection we found COSHH risk assessments had been completed at both practice sites (main site and branch site). The assessments included data sheets and how to respond to spills and splashes.

(g) The practice had two fire marshals who had received specific training. The two members of staff worked mostly at the main site. We were told cover arrangements at the branch site was undertaken by the receptionist on duty, although none of the reception staff had received fire marshal training. There had been no fire drill carried out at the branch site which had been identified in the fire risk assessment in January 2019. The practice had noted this on their own risk management log.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2020	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

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

Explanation of any answers and additional evidence:

(h) At our last inspection the practice was unable to demonstrate that all staff had received infection prevention and control (IPC) training as there were gaps in the training records.

During this inspection we found staff training records had been transferred to a new computer system that enabled a live record to be updated for all staff. We checked several staff training records and saw evidence they had all received appropriate IPC training since the last inspection.

(i) During our last inspection we found some areas of risk identified during an IPC audit had not been actioned. For example, the risks associated with having non-wipeable fabric chairs throughout the practice and branch site and no cleaning schedule for these.

During this inspection, we found a practice risk assessment of the fabric chairs which stated they should be cleaned at four monthly intervals. The practice showed us steam cleaning records of the fabric chairs at five to six-monthly intervals and had spoken with the clinical commissioning group to understand any further actions that were required.

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

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

(j) The practice had been undertaking NHS records assessments and audits regularly since February 2019 following an incident that had required a review of clinical records and record keeping documentation.

We were told the records audits were only carried out for the GPs notes and the practice had not considered including the non-medical prescribers that also worked for the practice. (Non-medical prescribers are qualified clinical staff such as nurses, pharmacists or paramedics that have undertaken an accredited training programme to enable them to prescribe medicines and treatments to patients).

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. There were some areas that required a review such as the monitoring and tracking of blank prescription stationery, risk assessments of emergency medicines stocks and oversight and supervision of non-medical prescribers.

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)	0.79	0.81	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). (01/10/2018 to 30/09/2019) (NHSBSA)	6.1%	9.5%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	5.70	5.70	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)	1.94	1.75	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.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial (k)
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N (l)
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
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y (m)
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:

(k) The practice had a system to log blank prescription stationery when it was received by the practice and when a batch of these were distributed into individual printers in clinical rooms. The practice noted the first and last number of each batch of blank prescriptions but had not recorded the quantity of prescriptions that were in each batch. They were also not counting or logging how many remained in the printer at the end of each day. There had been no formal review of the risk. The practice told us the clinical rooms were locked when not in use.

(l) The lead GP told us non-medical prescribers (NMPs) were offered clinical supervision and support to undertake their role and ensure prescribing competency. There were two NMPs at the practice. One was qualified to prescribe and the other was undertaking their prescribing course, which had commenced in January 2020. The NMPs had a designated GP mentor and access to any GP for

Medicines management	Y/N/Partial
support and guidance each day (such as the duty doctor). The practice's clinical supervision policy stated that clinical supervision sessions should take place regularly and the supervisor should keep a record of supervision sessions. The practice was unable to demonstrate formal clinical supervision or peer review was taking place and could not supply any records to evidence this, or any auditing of their prescribing or consultation activity. (m) During the previous inspection, we found some of the emergency equipment was out of date and there had been no risk assessment of emergency medicines to determine what was required to be stocked at the practice sites. At this inspection, we found the emergency equipment stock to be in date at both sites. There were regular checks and a checking log was completed. We found a risk assessment had been undertaken in relation to an antibiotic used for sepsis. The practice had identified the stock was not available from suppliers and had reviewed and sourced an alternative in line with guidance. The practice had not undertaken a risk assessment, to identify why they had made the decision to not stock opioids (high strength pain relieving medicines) or furosemide (a medication used to treat heart failure), both of which are recommended first line emergency medicines. The practice told us they had not stocked opioids for many years and did not feel they needed to risk assess this. They sent us a risk assessment of furosemide following the inspection, which had been identified as a low risk item, and therefore did not require a stock in the practice.	

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 (n)
There was a system for recording and acting on significant events.	Y (o)
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	16
Number of events that required action:	16
Explanation of any answers and additional evidence: (n) During the last inspection, we found not all incidents and events had been identified or escalated using the significant events pathway, which resulted in potential learning opportunities being missed. At this inspection we found the practice had undertaken staff training and had a marked increase in reported incidents and events since the last inspection. The practice told us all events and incidents raised went through a pre-significant event screening to understand if it was appropriate to be reviewed using the significant event pathway. Those deemed appropriate were then reviewed accordingly. (o) During the last inspection the practice had identified a new process for reporting and responding to significant events (SEs), but it had not been fully established or embedded.	

At this inspection the practice demonstrated the process which had been escalated to all staff and included reviews, discussion and sharing of learning across all staff groups. The clinical commissioning group had reviewed the SE system in place and had told the practice they would like to share this with other practices locally as an example of good practice.

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

Event	Specific action taken
Sample sent for testing did not receive a result back	All patients were instructed to contact the surgery one week after procedure/sample to request results. GPs were reminded to send a note to themselves if they thought a patient would not contact the practice, so no-one would be missed.
Patient contacted practice to advise of outcome of recent health issue and to offer feedback about experience.	GPs to discuss full possibilities and risks with patients when they attend with specific symptoms. Possible outcomes also to be discussed during the consultation. GPs were reminded to ensure they fully listen to patient concerns when undertaking consultations by telephone.

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

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

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)	0.80	0.64	0.74	No statistical variation

Older people — Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- 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 available 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.
- The practice told us 97% of patients on four or more medicines and 71% of patients on one or more medicines had received a medicine review in the last 12 months.
- 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 COPD were offered rescue packs, where necessary.
- 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)	84.8%	78.7%	79.3%	No statistical variation
Exception rate (number of exceptions).	12.6% (76)	12.4%	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)	84.7%	81.7%	78.1%	No statistical variation
Exception rate (number of exceptions).	8.8% (53)	7.2%	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)	78.1%	81.5%	81.3%	No statistical variation
Exception rate (number of exceptions).	9.6% (58)	10.3%	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)	73.8%	77.3%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.1% (17)	4.2%	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)	92.3%	92.8%	89.6%	No statistical variation
Exception rate (number of exceptions).	13.9% (21)	9.1%	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)	81.8%	82.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.4% (57)	2.8%	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)	86.3%	91.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.9% (8)	5.1%	5.9%	N/A

Families, children and young people — Population group rating: Good

Findings

- The practice had met the minimum 90% for four childhood immunisation uptake indicators.
- 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)	133	141	94.3%	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)	132	143	92.3%	Met 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)	132	143	92.3%	Met 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)	132	143	92.3%	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

Working age people (including those recently retired and students)

Population group rating: Good

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.
- A surgery pod was accessible to patients within the practice to undertake blood pressure measurements, weight measurements and alcohol screening. Results could be entered directly into the practice computer system for a GP or nurse to review.

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)	78.4%	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)**	79.7%	70.4%	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)**	59.4%	52.0%	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)**	61.0%	75.3%	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)	45.3%	49.0%	53.8%	No statistical variation

Any additional evidence or comments
Cervical screening rates had improved since the last inspection (from 76.7% in March 2018 to 78.4% in September 2019). The practice showed us unvalidated data from National General Practice Profiles which showed the practice had achieved 81% for cervical screening in 2018/19 for eligible patients aged between 25 to 64 (combined). The nursing team contacted patients who had not attended for their screening to discuss any concerns or to answer any questions. There were a number of appointments available at different times of the day, including extended hours.

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. Out of 46 patients on the practice learning disability register, 42 health checks had been undertaken. The practice told us they were following up on the remaining four. • 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. • The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • Same day and longer appointments were offered when required. • An external stakeholder was facilitated by the practice to provide emotional support for patients with a mental health diagnosis. • 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)	93.8%	93.3%	89.4%	No statistical variation
Exception rate (number of exceptions).	2.4% (2)	8.3%	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)	91.1%	93.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	3.7% (3)	5.7%	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)	71.4%	83.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	3.9% (2)	4.6%	6.7%	N/A

Any additional evidence or comments
Since the last inspection, the practice had improved their achievement and exceptions for mental health indicators: • Patients on the serious mental illness register (SMI) with a comprehensive care plan had improved from 84.4% in 2017/28 to 93.8% in 2018/19 with exceptions reducing from 5.9% to 2.4%. • Patients with SMI whose alcohol consumption was recorded had improved from 84.6% in 2017/18 to 91.1% in 2018/19 with exceptions remaining the same (3.7%). We noted the practice achievement for patients on the dementia register receiving a face to face review had reduced from 82.2% to 71.4%. The exceptions had also reduced from 11.8% to 3.9%. The practice had a GP dementia lead and a dementia champion who were overseeing recalls for assessment, care and treatment.

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)	557.5	550.1	539.2
Overall QOF score (as a percentage of maximum)	99.7%	98.4%	96.7%
Overall QOF exception reporting (all domains)	4.7%	5.6%	5.9%

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

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

Audit of NSAIDs prescribing

An audit of non-steroidal anti-inflammatory drugs (NSAIDs) was undertaken in May 2019 which identified:

- 19 patients over the age of 65 years, had not been offered another medicine to protect the stomach lining, called a proton pump inhibitor.
- Five patients who had been identified as having previously had a stomach ulcer had been prescribed an antiplatelet medicine without a proton pump inhibitor co-prescribed.
- Eight patients on warfarin (a blood thinning medication) or other anti-coagulants had not been prescribed a proton pump inhibitor.
- 17 patients being prescribed aspirin and another anti-platelet had not been prescribed a proton pump inhibitor.

A second cycle of the audit was undertaken in December 2019 which showed reductions across all the groups:

- Seven patients over the age of 65 years, had not been offered another medicine to protect the stomach lining, called a proton pump inhibitor. (A reduction of 12 patients)
- Two patients who had been identified as having previously had a stomach ulcer had been prescribed an antiplatelet medicine without a proton pump inhibitor co-prescribed. (A reduction of three patients)
- Five patients on warfarin (a well-known blood thinner medication) or other anti-coagulants had not been prescribed a proton pump inhibitor. (A reduction of three patients).
- 10 patients being prescribed aspirin and another anti-platelet had not been prescribed a proton pump inhibitor. (A reduction of seven patients).

Learning and recommendations included reminding prescribing clinicians to co-prescribe gastro-protection (such as a proton pump inhibitor) for patients at risk and to add electronic alerts to remind prescribers to review the need for gastro-protection in these patients.
The practice decided to re-audit every three months to identify any new patients and discuss their care needs at practice meetings.

Review of high-dose opioid prescribing

An audit of patients taking opioids was undertaken in November 2019 which identified nine patients who were required to be recalled and reviewed with regard to their prescription of opioids. (Opioids are a class of medicine, such as morphine, which require regular review and oversight of prescribing to minimize the risk of overuse, abuse or overdose).

The audit was reviewed in February 2020 to check the actions that had been carried out following the audit in November 2019. The findings were: eight of the nine patients had been reviewed and six of these had had their dosage of opioids reduced in line with guidance.

The practice planned to re-run the audit in two months and had added alerts to all patients who were being prescribed high-dose opioids.

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 (p)
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N (q)
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:

(p) At the last inspection we saw a training log that had not been regularly reviewed and updated to identify training requirements for staff. The practice could not demonstrate chaperone training had been undertaken as there were no records or certificates of training. Some staff were not included on training log.

During this inspection we were shown a new software system the practice was using to upload staff training certificates. The software enabled a “live” profile of staff training and sent reminders when training was due for an update. We saw individual staff records and searches by training topic, which enabled the practice to have oversight of modules that were required to be completed or updated.

(q) The practice was unable to demonstrate how they assured themselves of the competence of the non-medical practitioners as there were no records of clinical supervision, in line with their policy, or oversight of performance through consultation or prescribing audits.

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

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 (r)
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: (r) The practice had supported several patients to undertake a local healthmakers scheme which offers patients support tools to manage long term conditions. These patients were also trained to support other patients.	

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)	93.8%	95.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.7% (20)	0.7%	0.8%	N/A

Consent to care and treatment

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

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

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
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

CQC comments cards	
Total comments cards received.	28
Number of CQC comments received which were positive about the service.	26
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Of the 26 positive comments we received, patients told us they were happy with the practice and staff were caring and helpful at all levels. Many staff were mentioned by name for their care and attention, with many patients stating they thought the care they received was excellent and they felt supported by the GPs, nurses and paramedic practitioner. The two mixed comments praised staff whilst offering a negative opinion not related to care or treatment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that 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)	81.2%	86.7%	88.9%	Tending towards 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)	74.3%	83.7%	87.4%	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)	87.0%	94.4%	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)	82.3%	79.4%	82.9%	No statistical variation

Any additional evidence or comments
The practice was aware of the outcomes of the GP national survey and were attempting to recruit another paramedic practitioner to improve access to a clinician. The latest Friends and Family test data showed 90% of patients would recommend the practice to others.

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

Any additional evidence
The practice had disbanded their patient participation group (PPG) in June 2018 and had recently commenced a new PPG. A patient survey would be included in the newly formed PPG plans for the future. The last in-house patient survey had been carried out before the last inspection (February 2019).

Involvement in decisions about care and treatment

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

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

Source	Feedback
Comment cards	We received 26 positive comment cards from patients across both practice sites. There were some comments relating to how the patients felt involved in their care and treatment. Specifically, we saw two comments about being offered a full explanation of their care and how the staff often went above and beyond to help them. Patient feedback we received from the CQC comment cards did not suggest any concerns with being involved in their care and treatment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	84.9%	91.3%	93.4%	Tending towards variation (negative)

Any additional evidence or comments
The practice was aware of the outcomes of the GP national survey and had discussed the findings at staff meetings. They had reviewed their recruitment requirements to identify if there were any gaps and were in the process of recruiting another paramedic practitioner.

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

Carers	Narrative
Percentage and number of carers identified.	The practice had 250 patients on their carers register. This equated to approximately 1.8% of their practice list.
How the practice supported carers (including young carers).	The practice signposted carers to an external carers organisation for additional support. Carers were also offered an annual flu vaccination and could access a health check if required.
How the practice supported recently bereaved patients.	Staff were informed of all patient deaths and the named GP would contact the family to offer support and advice.

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

Responsive Rating: Good

Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 7.30pm (6.30pm at branch site)
Tuesday	8am to 7.30pm (6.30pm at branch site)
Wednesday	8am to 6.30pm (both sites)
Thursday	8am to 6.30pm (both sites)
Friday	8am to 6.30pm (both sites)
Appointments available:	
Monday – Friday	AM appointments 8.30am to 11.40am
	PM appointments 2pm to 5.20pm
Appointments were available for GPs, nurses and the paramedic practitioner. Patients could access appointments by calling or visiting the practice or using online services. An online consultation via the website (ask the doctor a question) could be requested anytime and patients were informed this was for non-urgent issues only. In addition to the practice own extended hours, patients could access appointments at the extended hours service provided by the federation of Bracknell and Ascot GP practices. Appointments could be booked directly by the practice Monday to Friday from 6.30pm to 8.30pm, Saturdays from 8am until 2pm and Sundays mornings by request.	

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)	91.0%	93.2%	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.
- Clinical and treatment rooms were located on the ground floor with ease of access for less mobile patients.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- Flexible appointments were available for older patients who needed to coordinate with family members or carers to facilitate attending the practice.

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

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice 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.
- The practice had enlisted some patients, with long term conditions, to undertake a local healthmakers course. (Healthmakers is a programme which aims to help patients self-manage their long term conditions). These patients, upon completion of the course, would become super users for the scheme and help promote and train others in self-management of their conditions. At the time of the inspection there had been four patients successfully completing the course and they were due to start their first drop in session within a few weeks of the inspection day.

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.
- There were no nurse appointments available outside core hours for working parents and school children. The practice could offer appointments at the federation extended hours service, if this was required.

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 offered a “contact the practice” form through the practice website, for patients to ask a question of a GP, nurse or the practice administration team. This was intended for non-urgent requests (such as a sickness certificate) and had reduced the number of incoming calls and requests for appointments.
- The practice was open until 7.30pm on Monday and Tuesday evenings for GP appointments. Pre-bookable appointments were also available to all patients at another location in the local area, via the GP federation of Bracknell and Ascot practices.

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

Findings

- The practice held a register of patients living in vulnerable circumstances, where necessary 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 adjusted the delivery of its services to meet the needs of patients with a learning disability. For example, home visits and 30-minute appointments were offered.
- 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: 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.

Timely access to the service

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

National GP Survey results

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

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)	54.3%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	68.4%	60.4%	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)	60.6%	59.4%	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)	73.4%	69.8%	73.6%	No statistical variation

Any additional evidence or comments
The practice was aware of the outcomes of the GP national survey and had increased the number of telephone lines to support an increase in incoming calls in December 2019. It was too soon to understand if the additional lines had impacted on patient accessibility to the practice. In addition, the practice had reviewed gaps in service provision and had commenced recruitment of a second paramedic practitioner.

Source	Feedback
Comment cards	26 of the 28 comment cards received were positive about how the practice was responsive to their needs. Several of these had offered examples of how staff had helped and supported them with a specific need or issue.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	12
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.	1

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

Explanation of any answers and additional evidence:

(s) The practice complaints policy outlined the timescale from receiving a complaint to acknowledging it, but did not include the timescale expected from acknowledging to offering a response to the patient. The practice told us they would add a suitable timescale to the policy after the inspection and include this in the acknowledgement letters, to offer patients an idea of how long until a response could be expected.

(t) During the last inspection we found complaints that had not been reviewed or discussed.

At this inspection we saw complaints were added to the agenda for weekly meetings and a log was kept to understand if the complaints process had been completed and learning actions identified for sharing.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained about the attitude of a GP during a consultation	GPs were reminded to listen to patient concerns and not to rush patients during consultations. The patient received an apology.
A patient complained they had felt rushed during an appointment and wanted to discuss additional concerns.	GPs were reminded to manage patient expectations at the beginning of their 10 minute consultation. If more than one issue required discussion to ask the patient to book another appointment. The patient received an apology.

Well-led Rating: Good

During our last inspection in February 2019, we found the practice was requires improvement for providing well led services. The governance arrangements had been inconsistently applied and risks and areas of concern had not been identified or effectively managed.

During this inspection, we found the practice had improved their governance arrangements and had ensured staff were aware of the changes made.

Leadership capacity and capability

Leaders had the capacity and skills to deliver good quality sustainable care.

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

Vision and strategy

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

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

Culture

The practice had a culture which drove good 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.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: We were shown an example of a duty of candour response to a patient whose personal information was included in a letter to a third party. The error had occurred during filing of the notes and when printed, included another patients details.	

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

Source	Feedback
Staff interviews	Staff told us they were proud to work at the practice and felt part of a team. Staff felt able to raise concerns and were supported to do so. The staff we spoke with were aware of how to raise a significant event.

Governance arrangements

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

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

Explanation of any answers and additional evidence:

(u) During the last inspection, we found concerns with the governance arrangements for recruitment checks, an inconsistent approach to risk assessments, with some missing or not undertaken, and the monitoring and documentation of staff training.

At this inspection, we found staff training recording and tracking had improved with all training being moved to a new “live” system and regularly updated by the practice management team.

Recruitment processes included all the relevant background checks and supporting documents. During this inspection we found one file that did not have some pertinent documents as outlined in schedule three. All but one of these documents, the interview summary, were forwarded to us after the inspection day.

(v) During the last inspection in February 2019, a new significant events process was being introduced, but had not yet been embedded and staff were unaware of when to raise a significant event, including incidents with a positive outcome.

At this inspection, we saw evidence of staff training and noted an increase in reported incidents since the last inspection. Significant event discussions were included on the agenda at clinical team meetings, which were held weekly. Learning was identified and shared with relevant staff. The new process had been reviewed by the clinical commissioning group, who were planning to share it with other practices as an example of good practice.

Managing risks, issues and performance

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

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

(w) At the last inspection, we found some systems and processes were inconsistently reviewed for their effectiveness, such as complaints management. The practice did not discuss complaints in a timely way and had not included details of the health ombudsman in complaint response letters.
During this inspection we reviewed complaints and found the health ombudsman had been included in all acknowledgement and response letters, to enable patients to understand further escalation processes if they felt their complaint had not been appropriately handled by the practice.
We also saw meeting minutes where complaints were discussed and learning was shared.

(x) During the last inspection there had been no control of substances hazardous to health (COSHH) or emergency medicines risk assessments undertaken. In addition, DBS risk assessments were limited and had not been carried out on an individual basis.
During this inspection, we found COSHH risk assessments had been established at both practice sites and an emergency medicine risk assessment had been carried out. The risk assessment was for one emergency medicine and there were two other emergency medicines that had not been risk assessed. These were received after the inspection.
All non-clinical staff had received an individual disclosure and barring service (DBS) risk assessment in replacement of undertaking a DBS check. The DBS risk assessments outlined the role of the staff member, including if they were a chaperone, but did not include details of the risks being measured against. (When undertaking a risk assessment, all the potential risks should be considered and recorded to ensure an audit trail of the decisions made and final outcome of the risk assessment).

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 (y)
There were effective arrangements for identifying, managing and mitigating risks.	Y (z)
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: (y) At the last inspection, the practice did not maintain accurate oversight of staff training. During this inspection, the practice had transferred all the staff training records to a "live" system which was updated regularly and monitored by the practice management team. Any training that was due to be undertaken or updated was sent to the individual as a reminder. (z) During the last inspection, the practice had not identified or considered several risks which required action, including some in the infection control audit. At this inspection, we saw a practice risk log, which noted all the areas requiring review, or had actions completed that needed re-assessing. The infection control audit had been repeated in May 2019 and had not carried over any risks since the last inspection.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y (aa)
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: (aa) The patient participation group was newly formed, having been previously disbanded in July 2018. They had met twice and were still working out the best way forward for the group to work with the practice.	

Feedback from Patient Participation Group (PPG).

Feedback
The practice had supported some patients to to undertake a peer support course called “healthmakers”. The practice vision was to gain a number of patients to support other patients through long term conditions and these patients would form a new PPG. They already had four patients who had completed the course and were meeting with them regularly to understand how they could work with the practice to improve care. We received feedback from two members of the PPG who told us they had been supported by the practice to undertake the healthmakers course and were due to commence a series of “pop up” cafes to support patients with their long term conditions. As the PPG was so newly formed, they had only held two meetings and apart from the healthmakers initiative, had not had an opportunity to explore further work with the practice. At the time of the inspection, PPG meetings were also on hold in response to a pandemic which priortised clinical work.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y (bb)
Learning was shared effectively and used to make improvements.	Y (cc)
Explanation of any answers and additional evidence: (bb) The practice had made changes to their governance processes since the last inspection, to ensure learning was identified and actions taken in response to events, incidents and complaints. (cc) We saw evidence of meetings where significant events and complaints were discussed regularly and learning was shared with other members of the team.	

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.