Care Quality Commission

Inspection Evidence Table

Lanark Medical Centre Ground Floor (1-6989677395)

Inspection date: 30 January 2020

Date of data download: 29 January 2020

Overall rating: Requires Improvement

The practice was rated as requires improvement for providing effective and well-led services because:

- **Childhood immunisations and cervical screening uptake were below national averages.**
- **The provider had not ensured that effective systems and processes were in place to ensure good governance in accordance with the fundamental standards of care. In particular, governance systems had failed to identify gaps in relation to safety-netting of urgent two-week wait referrals and cervical cytology, quality improvement, induction and skill competency processes and policies and procedures.**

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

Safe Rating: Good

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.	Partial[1]
Policies and procedures were monitored, reviewed and updated.	Partial[2]
Partners and staff were trained to appropriate levels for their role.	Yes[3]
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[4]

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	Yes[5]
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

Explanation of any answers and additional evidence:

1. We found that safeguarding children and adult policies lacked detail and did not reflect the practice's procedures. For example, the safeguarding children policy did not reference female genital mutilation (FGM) or include the mandatory reporting duty for healthcare professionals. The safeguarding adult policy did not reference the Prevent (anti-radicalisation) strategy or training, human trafficking, modern day slavery, or the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policies did not reference the latest Intercollegiate Safeguarding training guidance for children or adults.
2. We saw that the safeguarding children policy had been reviewed in October 2019. On review we found that the policy contained out-of-date and incorrect information. For example, the policy included a member of staff as deputy safeguarding lead who had left the practice, referenced the Primary Care Trust (PCT) throughout and included read code alerts for a clinical system not used by the practice.
3. We saw that the GPs, the practice nurse and healthcare assistant were trained to safeguarding children level 3. The practice told us they were reviewing the level of training for all staff in line with the latest guidance. For example, for non-clinical staff to be trained to safeguarding children level 2. We saw all staff had received Prevent training.
4. We saw evidence that all staff had undertaken a Disclosure and Barring Service (DBS) check. However, we saw that the practice had accepted a standard DBS check at the point of recruitment for a member of staff whose role and responsibilities and the level of contact with patients, potentially children and vulnerable adults, required an enhanced DBS check. After the inspection the practice provided an enhanced DBS check that the member of staff had undertaken for another employment. The practice told us they had now applied for a practice-specific enhanced DBS check.
5. The practice had a chaperone policy in place, but this did not reference any requirement for staff acting in the role of chaperone to have undertaken a DBS check. However, all staff had undertaken a DBS check.

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:

1. We saw that the provider maintained an overview of clinical and non-clinical staff immunisation status, but the record was incomplete and not in line with current guidance outlined in the 'Green Book' Immunisation Against Infectious Diseases (Chapter 12) for staff in direct and non-direct patient contact. After the inspection the provided sent evidence that it had updated its records and demonstrated evidence of immunisation status for all staff in line with guidance.

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: 20 February 2019	Yes
There was a record of equipment calibration. Date of last calibration: 5 December 2019	Yes
There were risk assessments for any storage of hazardous substances for example, storage of chemicals.	Yes[1]
There was a fire procedure.	Yes
There was a record of fire alarm maintenance checks. Date of last check: 3 June 2019	Yes
There was a record of fire extinguisher checks. Date of last check: 11 October 2019	Yes
There was a log of fire drills. Date of last drill: April 2019	Yes
There was a record of fire alarm checks. Date of last check: 21 January 2020 (undertaken weekly and logged)	Yes
There was a record of fire training for staff. Date of last training: Variable dates (on-line). Undertaken annually.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 25 July 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: 1. The provider had undertaken a Control of Substances Hazardous to Health (COSHH) risk assessment and had data safety sheets available, but this was limited to the cleaning products. The practice had not considered or determined any additional risks to health from any other hazardous substances used or created by the practice's activities. After the inspection the practice sent an updated COSHH risk assessment which included liquid-based cytology pots and bodily fluid spill kits.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 20 January 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 20 January 2020	Yes
Explanation of any answers and additional evidence: • We saw evidence of a valid gas safety certificate (2 December 2019) and an electrical installation condition report (3 March 2016), which was valid for five years. • We saw documentation that a lift examination report had been undertaken on 21 February 2019. • We reviewed the legionella risk assessment and saw that hot and cold-water temperatures were checked and recorded on a monthly basis.	

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[1]
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: March 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes[2]
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[3]

Explanation of any answers and additional evidence:

1. We saw that staff had received infection prevention and control (IPC) training relevant to their role, which was updated on an annual basis. A newly recruited practice nurse had been nominated the IPC lead but had not undertaken any training for the lead role. For example, specific IPC knowledge in line with the Hygiene Code which identified specific primary care IPC responsibilities for this role such as how to mitigate the risk of healthcare acquired infection. The practice told us that they would source some suitable training.
2. A formal IPC audit had been undertaken by the CCG IPC team in March 2019. We saw that the practice had been given a timeframe for the completion of six action points. For example, clinical hand washing facilities not complaint with current recommended guidance. The practice told us they were addressing the outcomes of the audit in line with the specified completion timeframes.
3. On the day of the inspection we found some clinical waste bins had not been signed and dated when assembled, in line with guidance. After the inspection the practice sent evidence that they had rectified this.

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[1]
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

Explanation of any answers and additional evidence:

1. On the day of the inspection the practice did not have a paediatric pulse oximeter as part of its medical emergency equipment. After the inspection the practice sent evidence that one had been obtained.

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
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[1]
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes[2]
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. The practice maintained a spreadsheet of all patients referred via the urgent two-week wait pathway. We saw that the practice logged when the patient had received an appointment but did not have a failsafe system to demonstrate that the patient had attended the appointment and that an outcome letter had been received by the practice. After the inspection the practice sent evidence that it had reviewed and updated its spreadsheet to include that an outcome letter had been received for each patient referred. The practice confirmed that this would be the policy and procedure going forward.
2. On the day of the inspection the practice could not demonstrate a failsafe system to ensure a cervical screening result was received for each cervical smear sample sent to the laboratory. After the inspection the practice sent a spreadsheet which recorded the date a sample was taken and by whom, the result and any follow-up. The practice told us they used the spreadsheet to also monitor patients referred for colposcopy.

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	0.84	0.52	0.87	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)				
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)	10.0%	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)	6.02	5.72	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)	8.64	1.23	2.08	Significant Variation (negative)

Any additional evidence or comments
The practice was aware that the prescribing of NSAIDs was higher than the CCG and national averages. The lead GP told us that the practice was focussing on the care and treatment of patients prescribed NSAIDs by promoting healthy living, physical activity and physiotherapy to potentially alleviate symptoms. We saw from historical prescribing performance data that there had been a reduction in prescribing. For example, data for the period ending 31 March 2018 was 11.08 and for the period ending 31 March 2019 was 9.54. At the time of our inspection the practice prescribing performance was 8.64.

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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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

Medicines management	Y/N/Partial
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
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[1]
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes[2]
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: 1. The practice engaged with the Clinical Commissioning Group (CCG) medicine optimisation team and participated in the local prescribing incentive scheme. The practice was aware of their prescribing outcomes. 2. On the day of the inspection we found that the practice had not undertaken a risk assessment to demonstrate their rationale to not stock some emergency medicines, for example, to treat a child presenting with croup. After the inspection the practice sent evidence that it had reviewed their emergency medicine policy and had decided to stock the emergency medicines highlighted at the inspection. We saw that the emergency medicine expiry check list had been updated to reflect this.	

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
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.	Yes
Number of events recorded in last 12 months:	3
Number of events that required action:	3

Explanation of any answers and additional evidence:

- There was an incident policy and form, which was accessible to staff.
- The practice had reported three significant events in the past 12 months in relation to a flood, an aggressive patient and fraud. There had been no clinical-related incidents recorded. We reviewed the incident policy which outlined some examples of significant incidents, but this was brief, and the policy did not reference the National Reporting and Learning System (NRLS).
- We saw that significant events were a standing agenda item at practice meetings. We reviewed minutes of meetings and saw outcomes and learning points from incidents were discussed. Staff we spoke with were able to give an example of learning from a recent significant event.

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Fake Statement of Fitness for Work (previously 'sick note').	• Identified that document was fake, and patient not known to practice. • Reported incident externally - CCG, Police. • Discussed as incident internally. • Reviewed security of documentation and practice stamp.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes[1]
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

1. We saw that the practice had a system in place to receive and review patient safety alerts which was overseen by the lead GP. The practice maintained a spreadsheet of actions taken, for example, patient searches and patient follow-up. We saw that some recent alerts had been received and actioned, for example an alert on coronavirus. However, on the day of the inspection the practice could not demonstrate that they had received and actioned some alerts relevant to general practice issued prior to September 2019. Immediately after the inspection the practice sent an updated spreadsheet which included all alerts received and actioned from January 2019.

Effective Rating: Requires Improvement

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

- **Childhood immunisations and cervical screening uptake were below national averages.**

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current	No[1,2]

evidence-based practice.	
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 addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Explanation of any answers and additional evidence:

1. On review of a selection of clinical records we found that patient care and treatment was delivered in line with current evidence based-guidance. However, on the day of the inspection the lead GP could not demonstrate a formal system to receive or share updated guidance with clinical staff, for example through clinical meetings. We were unable to speak with any of the salaried GPs on the day of the inspection to explore this further. After the inspection the practice sent a protocol which had been reviewed in October 2019 which detailed the procedure for the receipt and review of new National Institute for Health and Care Excellence (NICE) guidelines and indicated that the lead GP and practice manager were registered to receive updates which would then be discussed within two weeks of receipt at a meeting. This process was not demonstrated on the day of the inspection.
2. We reviewed some clinical protocols available for the practice nurse and found some were out of date, incomplete and referred to the previous lead GP although the review date was October 2019. After the inspection the practice told us that they had reviewed and updated the identified protocols.

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)	2.08	0.88	0.74	Variation (negative)

Any additional evidence or comments

The practice was aware that the prescribing of hypnotics was higher than the CCG and national averages. The lead GP had undertaken a hypnotic audit and was reviewing individual patients. We saw from historical prescribing data that there had been a reduction in prescribing. For example, data for the period ending 31 March 2018 was 3.2 and for the period ending 31 March 2019 was 2.42. At the time of our inspection the practice prescribing performance for hypnotics was 2.08.

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.
- 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.
- 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.
- 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)	77.9%	79.6%	79.3%	No statistical variation
Exception rate (number of exceptions).	2.6% (7)	9.3%	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)	81.2%	77.8%	78.1%	No statistical variation
Exception rate (number of exceptions).	3.3% (9)	8.7%	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)	78.9%	79.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	4.8% (13)	10.1%	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. (01/04/2018 to 31/03/2019) (QOF)	77.6%	75.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.7% (4)	7.6%	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)	85.2%	88.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	13.7%	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)	79.1%	79.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.8% (13)	3.8%	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)	92.6%	86.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	6.9% (2)	5.3%	5.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the four childhood immunisation uptake indicators. The practice was aware of this and proactively monitored their achievement and contacted parents or guardians of children due to have childhood immunisations and those who failed to attend.
- 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)	45	50	90.0%	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)	26	34	76.5%	Below 80% uptake
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)	28	34	82.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	27	34	79.4%	Below 80% uptake

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

Any additional evidence or comments

- The practice was aware that childhood immunisation uptake rates were below with the World Health Organisation (WHO) target of 95% for one and two-year-olds. The practice had a reminder and recall system and contacted parents or guardians of children who had failed to attend. The practice proactively facilitated access to appointments at local GP hubs which had late evening and weekend appointments.
- We saw that there had been some improvement in uptake for two-year-olds when compared to March 2018 data. We found:
  - The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) was 64.1% (2018) and 76.5% (2019)
  - 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) was 76.9% (2018) and 82.4% (2019).
  - The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) was 74.4% (2018) and 79.4% (2019).

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice achievement for cervical screening was 49% and significantly below the England average of 70% and the national target of 80%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)	49.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	51.2%	54.1%	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)	32.0%	38.1%	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)	43.5%	58.6%	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)	42.9%	53.4%	53.8%	No statistical variation

Any additional evidence or comments

- The practice was aware that the achievement for cervical screening was 49% and considerably below the England average of 80%. We saw that the practice had systems in place to monitor their uptake and demonstrated a recall and reminder system. We saw that non-clinical staff had been booked on a cervical screening workshop training designed to help staff explore ways to improve the number of women booking appointments and the practice had invited Jo's Cervical Cancer Trust to come to the practice to deliver a presentation. We saw that patients were encouraged to access cervical screening appointments at a local GP hub practice in the evenings and at weekends. After the inspection additional verified outcome data was published which showed for

the period 1 July 2019 to 30 September 2019 the practice had achieved 50.2%. However, this was still considerably below the target.

- The uptake for patients who participated in the national cancer screening programmes for bowel and breast cancer was below national targets. For example, we found females, aged 50-70, screened for breast cancer in last 36 months was 51.2% (CCG 54.1%; England 71.6%) and persons, aged 60-69, screened for bowel cancer in last 30 months was 32% (CCG 38.1%; England 58%). The practice was aware of this and told us they would discuss opportunistically with a patient during a consultation and had posters around the surgery.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

People experiencing poor mental 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.
- A mental health nurse clinic was held at the practice fortnightly.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Clinical staff had received dementia training.
- 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	100.0%	88.9%	89.4%	Variation (positive)

31/03/2019) (QOF)				
Exception rate (number of exceptions).	14.3% (4)	10.3%	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)	88.0%	91.4%	90.2%	No statistical variation
Exception rate (number of exceptions).	10.7% (3)	7.3%	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)	88.9%	85.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.8%	6.7%	N/A

Monitoring care and treatment

There was some evidence of quality improvement activity.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	491.7	520.8	539.2
Overall QOF score (as a percentage of maximum)	89.4%	93.7%	96.7%
Overall QOF exception reporting (all domains)	3.7%	6.8%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes[1]
The practice had a programme of quality improvement and used information about care and treatment to make improvements.	Partial[2]
Quality improvement activity was targeted at the areas where there were concerns.	Partial[2,3]
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

1. The practice facilitated educational meetings for GPs and practice nurses from local practices. Topics had included asthma and diabetes.
2. The lead GP had taken over the practice in January 2019 and had undertaken a single-cycle audit on the use of clopidogrel (a blood thinning medicine to prevent blood clots) as part of their appraisal personal development plan (PDP) in November 2019 and a minor surgical audit undertaken in December 2019 as part of the lead GP's service delivery of minor surgery for the practice's patients and that of local practices under an enhanced service. The practice told us they planned to repeat both audits in six months' time. However, the practice had not identified or established a programme of clinical audits to drive quality improvement.
3. The practice did not have a formal system to review the consultations and prescribing of salaried GPs at the practice. The lead GP told us they did review clinical notes but there was no formal documented system in place for this.

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.	Partial[1,2]
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.	Partial[2]
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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.	Partial[3]
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

1. The practice had identified core mandatory training for staff which included basic life support, infection prevention and control, fire safety, safeguarding children and adults, mental capacity act, equality and diversity, prevent, chaperone, sepsis, information governance and health and safety.
2. A practice nurse had been recruited two weeks prior to our inspection. The practice could not demonstrate that a skills competency and training needs assessment had been undertaken at the point of commencement and during the initial induction. After the inspection the practice sent evidence that this had been undertaken a skills competency and training needs assessment with the practice nurse and had identified areas of additional training required and arranged mentorship.
3. The practice was able to demonstrate that non-clinical staff had undertaken an annual appraisal. The practice maintained a record of the NHS GP appraisal date for their salaried GPs but had not at the time of the inspection undertaken any formal internal appraisal process with their GPs. After the inspection the practice told us they planned to commence these immediately and sent an example of the appraisal document.

Coordinating care and treatment

Staff worked 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	Yes

and organisations, were involved in assessing, planning and delivering care and 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
Explanation of any answers and additional evidence: • The practice hosted a weekly smoking cessation clinic.	

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)	98.2%	95.5%	95.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.7% (11)	1.2%	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 recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes

Explanation of any answers and additional evidence:

- Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Clinicians had a good understanding of the Mental Capacity Act (MCA) and had received training.
- We saw evidence of signed consent forms for minor surgical procedures. The practice did not scan the consent forms into the clinical system but told us after the inspection that they had now scanned the historical consent forms into patient records and would now make this their standard policy and procedure.

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-judgemental 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.	29
Number of CQC comments received which were positive about the service.	25
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment Cards	We found that 25 comment cards received contained positive feedback and patients said that the practice was excellent and gave a very good service. Patients said staff were caring, kind, helpful, showed empathy and that they were treated with dignity and respect. There were four mixed comments, of which three were about getting an appointment.

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	80.2%	85.9%	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)	76.0%	81.5%	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)	92.9%	92.0%	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)	82.2%	78.7%	82.9%	No statistical variation

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

Any additional evidence

- The practice actively sought patient feedback through the NHS Friends and Family Test (FFT). Results for the period July to December 2019, based on 27 responses, showed that 74% of patients would be extremely likely or likely to recommend the service. We saw that the practice had reviewed and discussed written comments provided by patients. Comments included that staff were great, friendly and accommodating. The practice displayed the outcome of the FFT in the patient waiting area.
- The practice sought feedback from patient accessing services such as phlebotomy, wound care and diabetes management delivered as part of an out of hospital services/partnership in practice initiative. Results for the period January to December 2019, based on 19 responses showed that 100% of patients would be extremely likely or likely to recommend the service.
- The practice had carried out their own patient survey for patients attending the practice in October to December 2019. We saw that 60 surveys had been distributed and 52 were completed. We found that patient responses in relation to kindness, respect and compassion showed:
  - 98% of patients said that they strongly agreed/agreed that they were treated with dignity, kindness and respect.
  - 96% of patients said that they strongly agreed/agreed that staff were supportive and compassionate when they needed help.
  - 93% of patients said that they strongly agreed/agreed that staff respected their personal, cultural and social needs.

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,	Yes

treatment and condition, and any advice given.	
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Explanation of any answers and additional evidence:

- Receptionists had undertaken 'signposting' training which enabled staff to access a directory of information about support services and direct patients to the most appropriate source of help or advice, for example voluntary or community services. Patients could also be referred to a Primary Care Navigator for more focused and individual guidance on support services available.
- The practice encouraged patients to engage with the Expert Patient Programme (a free, self-management course that supports people living with, or caring for someone with, one or more long-term health conditions).

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)	93.0%	90.5%	93.4%	No statistical variation

	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

Explanation of any answers and additional evidence:

- The patient appointment arrival system was configured in several languages aligned to the patient demographic.
- Practice staff spoke several languages which included Hindi, Urdu, Bengali and the Arabic language.
- British Sign Language (BSL) interpreters were available and the practice had a hearing loop.
- The practice captured patients' special needs, for example language and mobility at the point of registration through the patient registration form and ongoing through consultations. The practice website, which translated to other languages, contained information to signpost patients to various services.
- The practice had engaged with the LGBT Foundation and were due to commence the Pride in Practice (a quality assurance and social prescribing programme that strengthens and develops Primary Care Services' relationships with their lesbian, gay, bisexual and trans (LGBT) patients) Programme in April 2020.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 61 carers, which was 1.6% of the practice population.

How the practice supported carers (including young carers).	• The practice identified carers at the point of registration and on an on-going basis through clinical consultations. • The practice offered extended appointments, influenza vaccination and health checks for carers. • There was a carers noticeboard in the waiting room and information on the practice website.
How the practice supported recently bereaved patients.	The practice told us that if a family had suffered a bereavement they sent a condolence card and their usual GP would contact them. This would be followed-up with a patient consultation at a flexible time and location to meet the family's needs. The practice told us they would signpost patients to the appropriate support services.

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

Explanation of any answers and additional evidence:

- We observed that computers on the reception desk were positioned so patients could not view the screens.
- Staff we spoke with told us they followed the practice's confidentiality policy when discussing patients' treatments. This was to ensure that confidential information was kept private, for example, patient information was never on view.
- We saw that all staff had undertaken information governance training as part of the mandatory training schedule.

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.	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 8pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

- The practice provided extended opening on Monday from 6.30pm to 8pm where patients could access GP and practice nurse appointments.
- Out of surgery hours patients were directed to call NHS 111.
- Patients could access GP and practice nurse appointments in the evenings and at the weekend at three local GP hubs. Patients could book appointments via the practice team when the surgery was open.

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)	93.1%	91.3%	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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients through community pharmacists.

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.

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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. In particular the practice was open on Monday from 6.30pm to 8pm where patients could access GP and practice nurse appointments. Patients could also access a GP hub within the area in the evenings and at weekends.

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

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, refugees 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.
- 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.

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.	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: • When a request for a home visit was received, reception staff took details of the request and added it to the triage list. The duty doctor would determine whether a visit was necessary. If an urgent request was received the duty doctor was advised straight away of the request.	

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)	85.2%	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)	78.4%	64.7%	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)	72.4%	60.6%	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)	67.7%	63.5%	73.6%	No statistical variation

Source	Feedback
NHS Choices	Since our last inspection in January 2019 the practice had received six reviews on NHS choices, all of which were positive with patients rating the practice five stars.

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.	2
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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

Explanation of any answers and additional evidence:

- There was a complaint policy, which was accessible to staff, written in line with recognised guidance.
- Information about how to complain was available for patients, for example, a complaint leaflet.
- The practice recorded verbal complaints to ensure all opportunities to learn from feedback was captured.
- Complaints were discussed in clinical and practice meetings as a standing agenda item and we saw evidence of minutes of meetings.
- We reviewed one complaint and noted that the written patient response did not include details of how a patient could complain to The Parliamentary and Health Service Ombudsman (PHSO) should they be unsatisfied with the outcome of a complaint or how the practice had responded to a complaint. After the inspection the practice sent evidence of a complaint response template which included details of the PHSO which would be used for any future complaint responses They told us they had contacted the two patients who had received a complaint response in the last year and sent details of the PHSO.

Well-led Rating: Requires Improvement

The practice is rated as requires improvement for providing well-led services because:

- **The provider had not ensured that effective systems and processes were in place to ensure good governance in accordance with the fundamental standards of care. In particular, governance systems had failed to identify gaps in relation to safety-netting of urgent two-week wait referrals and cervical cytology, quality improvement, induction and skill competency processes and policies and procedures.**

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: • The lead GP had taken over the practice in January 2019, from being a salaried GP, following the retirement of the previous single-handed lead GP. • The lead GP and practice manager had been responsive to the inspection feedback and had addressed some of our findings immediately after the inspection.	

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
Explanation of any answers and additional evidence: • The practice told us that their mission statement was 'To deliver the highest level of medical care to our local populations; deliver health care in a flexible and innovative way to meet patient choice and reflect the changing political and economic circumstances. To ensure patients are always at the 'heart' of everything we do: ensuring patients are treated with dignity, respect, empathy and sympathy.'	

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 an 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
Explanation of any answers and additional evidence: • The practice had duty of candour and whistleblowing policies in place, which were accessible to staff.	

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

Source	Feedback
Staff Interviews	Staff we spoke with told us the GPs and management were very approachable and the practice worked as a team. Staff were proud and happy to work at the practice.

Governance arrangements

Although there were roles and systems of accountability to support good governance, we found gaps in its management and oversight.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes

Explanation of any answers and additional evidence:

- The lead GP was the clinical governance lead. There was a clinical governance policy in place which outlined the practice's approach to clinical governance which included patient involvement and experience; health and safety and risk control; clinical audit; evidence-based medical treatment; information and its use; staff and staff management; education, training and continuing professional development; strategy. However, we found gaps in management oversight and some systems and processes were not sufficiently embedded to ensure good governance. For example, there were gaps in quality improvement, which included the absence of a programme of clinical audit, no formal system to review and document clinical notes and prescribing of clinical staff and no clear system to receive, disseminate and discuss new and updated evidence-based guidance. In addition, we found gaps in relation to safety-netting of urgent two-week wait referrals and monitoring cervical cytology and the practice's induction processes had failed to appropriately assess the skills competency and training needs of a newly recruited practice nurse.
- We saw there were practice-specific policies including, child and adult safeguarding, infection and prevention control and significant events. Although the practice policies had been reviewed in the last 12 months we found that some contained out-of-date and insufficient information. For example, the Infection Prevention and Control (IPC) Policy referenced the Primary Care Trust (PCT) and the Health Protection Agency (HPA) both of which were no longer functioning bodies.
- The practice held monthly practice meetings and multidisciplinary team meetings (MDT), which were minuted. Minutes were available for staff.
- The practice had nominated staff into designated lead roles, for example safeguarding, infection prevention and control and complaints. Staff we spoke with knew who the leads were.

Managing risks, issues and performance

Although there were processes in place for managing risks, issues and performance we found gaps in its management.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
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: • We were not assured that the practice's systems in place to effectively manage risk and performance were sufficiently embedded as we found some gaps in processes and management oversight.	

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

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
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 an active Patient Participation Group (PPG) who met quarterly. The practice had met with Healthwatch (an independent national champion for people who use health and social care services) in January 2020 for guidance on how to improve its patient engagement activity.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement
• The practice engaged with the CCG and neighbouring practices in local current and future initiatives which included the Primary Care Network (an approach to strengthening and redesigning primary care to focus on local population needs and provide care closer to patients' homes) and the out of hospital services (OOHS) initiative designed to bring services closer to the patient in the primary care setting. In addition, the practice delivered minor surgical services to patients from its own practice and neighbouring practices under an enhanced service contract. • The practice had engaged in the Productive General Practice (PGP) Quick Start quality improvement programme to review processes and systems and develop internal efficiencies. • The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

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.