Care Quality Commission

Inspection Evidence Table

Dr Christopher Cole and Partners (1-550899237)

Inspection date: 28 January 2020

Date of data download: 23 January 2020

Overall rating: Good

At our last inspection, we rated the practice as requires improvement overall. This was due to ineffective governance arrangements to support appropriate oversight within the Safe and Well-Led domains.

At this inspection, in January 2020, we have rated the practice as good overall but requires improvement in Safe. This was due to new areas of concern having been identified that related to the provision of safe services.

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

Safe Rating: Requires Improvement

At our last inspection, we rated the practice as requires improvement for providing safe services. This was due to infection prevention and control measures not being fully embedded, the prescribing competence of staff employed in advanced roles had not been adequately monitored and medicines management processes were not appropriate.

At this inspection, in January 2020, we continued to rate the practice as requires improvement for providing safe services. This was due to:

- **Prescription stationery monitoring and tracking had not taken account of blank scripts when in use.**
- **Staff recruitment checks had not taken account of changes in staff members' names.**
- **The practice could not demonstrate that risk assessments relating to staff awaiting confirmation of Disclosure and Barring Service checks had been undertaken.**

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, staff name changes had not been appropriately verified and staff had not been risk assessed prior to receipt of a completed Disclosure and Barring Service check.

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

Safeguarding	Y/N/Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: The practice had employed a designated Training Officer to arrange and provide its expected training modules to staff. We were told clinical staff received appropriate Level 3 safeguarding training from the local clinical commissioning group, and this was next booked for 1 May 2020, having previously been completed in September 2017. For non-clinical staff, the practice's training officer had devised a training powerpoint presentation that was presented to staff face to face or shared via an email that staff were instructed to read and confirm that they had read the presentation. It was not clear to what level of safeguarding training staff had been trained to, to be in line with the national Intercollegiate Document guidance (2019). Following the inspection, the practice's training officer confirmed they were working towards all non-clinical staff being trained to level 2 for safeguarding children. When we spoke with staff during the inspection, we found no evidence of gaps in knowledge relating to safeguarding processes within the practice. We found staff were able to identify appropriate areas of concern that would require reporting on and the steps they would take if concerns arose. On review of the practice's training log, we found two members of non-clinical staff were overdue their safeguarding children training, and four non-clinical staff were overdue their safeguarding adult training. The practice's training officer confirmed all indicated staff had been chased with emails and they had escalated the non-compliance of those staff members to managers. Through our review of personnel files, we found evidence to demonstrate that Disclosure and Barring Service (DBS) checks had been applied for, for three members of staff who had joined the practice since our last inspection. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Two of the three confirmations of applications had a date documented, July 2019 and November 2019 respectively. The practice could not demonstrate that it had received confirmation of these DBS checks having been completed, nor a risk assessment for the staff members to work with patients while the DBS checks were carried out. Following our last inspection, the practice had revised its position on non-clinical staff being able to provide chaperone duties, following incidents where non-clinical staff had asked to be chaperones. The practice had offered appropriate training to those willing to facilitate the role of a chaperone for patients and clinicians alike. Staff we spoke to who were recognised chaperones demonstrated appropriate knowledge about their responsibilities for that role.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
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:

We reviewed three personnel files of staff members recruited since our last inspection in December 2018. We found the practice had mostly obtained appropriate recruitment documentation in line with the Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, except for:

- One clinical staff member's file did not contain evidence of their qualification.
- A non-clinical staff member's proof of identity was found to be in a different name to the one they had used to apply for the post. The practice could not demonstrate they had sought confirmation of a change of name.

The practice told us it requested evidence of vaccination status from staff at point of employment. A record was kept, and new staff were added accordingly. The practice confirmed it was aware some staff were waiting for some vaccinations but due to a national shortage these had not yet been done. The practice confirmed it had no formal risk assessment in place, but it said it had reminded those staff of their responsibilities to keep themselves safe.

Following our last inspection, the practice told us it had decided to commence monthly checks of the General Medical Council (GMC) pin numbers for all its GPs. The practice checked Nursing and Midwifery Council (NMC) pin numbers monthly. This task was completed by an administrator who maintained a spreadsheet of NMC pin numbers which was checked at the beginning of each month to see if any registrations were due for renewal or revalidation that month. If a renewal or revalidation was due, the administrator reminded the relevant nurse via email and was notified by return email that the renewal or revalidation had been confirmed. The administrator also checked the NMC register itself to ensure the renewal had been confirmed. The spreadsheet was then updated with the new dates accordingly.

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: July 2019	Yes
There was a record of equipment calibration. Date of last calibration: July 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: November 2019	Yes

There was a log of fire drills. Date of last drill at Waterside Health Centre site: 8 January 2020 Date of last drill at Blackfield Health Centre site: 22 February 2019	Yes
There was a record of fire alarm checks. Date of last check: 8 January 2020	Yes
There was a record of fire training for staff. Date of last training: Ongoing	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 12 December 2019	Yes
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence: At our last inspection, we found the practice had not completed fire alarm testing in line with its own protocol. At this inspection, the practice told us an oversight of a typographical error in the protocol had led to the discrepancy. Since then, the practice had revised its protocol to state monthly fire alarm checks were to take place. We saw fire alarm checks had been documented as taking place on a monthly basis. The practice told us its most recent fire risk assessment had not identified any actions that needed addressing.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 10 December 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10 December 2019	Yes
Explanation of any answers and additional evidence: We saw a Legionella risk assessment had been completed on 10 December 2019. The practice had identified itself as at high risk of legionella infection but had implemented appropriate actions to lower the risk accordingly. This included monthly water temperature checks, daily cleaning to prevent the build-up of limescale and biofilm and weekly flushes of underused water outlets to prevent the growth of bacteria in stagnant pipework. (Biofilm is the term used to describe one or more micro-organisms that can grow on many different surfaces).	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met and had improved since our last inspection.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Yes

Date of last infection prevention and control audit: November 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

The practice had recently updated its infection prevention and control (IP&C) policy to include new information in line with Public Health England guidance about the coronavirus outbreak. We saw staff were notified of the new information and a copy of the revised policy dated 27 January 2020 was sent to all staff.

The practice's training log provided to us following the inspection did not contain details regarding staff IP&C training. We raised this with the practice and were told the practice's IP&C lead, completed full IP&C training with all new staff during induction and this was recorded on the staff's personnel induction record sheet. Each year, at point of appraisal all staff received an induction refresher and the practice training officer confirmed annual IP&C training was offered to all staff, except GPs, at that point. We saw that completion of '12-month refresher training' module was recorded in the practice training log to eligible staff. The induction refresher training relating to IP&C covered topics including needlestick injuries, handling of clinical specimens, hand-washing techniques, management of spillages.

We asked how the practice was assured that GPs had completed IP&C training as stipulated in its IP&C policy for all staff and were told the GPs worked closely with the IP&C lead and followed their guidance. We saw IP&C was discussed as a standing agenda item at the practice's monthly GP/Nurse meetings.

The practice's IP&C lead confirmed hand hygiene training was covered during staff induction and at annual refreshers. However, no formal hand-washing audit had been completed in order for the practice to be assured staff were fully aware of correct procedures.

During our last inspection, we raised concerns around the cleanliness of both sites, the changing of privacy curtains and the monitoring of sharps bins used by the practice. At this inspection, we were told:

- The practice had raised the cleanliness concerns identified at our last inspection with its external cleaning company. We saw completed cleaning schedules and the practice told us concerns were raised with the cleaning company via email as and when they occurred with photographic evidence.
- The practice confirmed privacy curtains were changed once a year unless soiled when the affected curtains would be changed sooner. During this inspection, we found privacy curtains in the rooms we visited to be in date and visibly clean.
- A review had been completed of the sharps bins used by the practice. Changes implemented included changing the sharps bins used in the GP consultation rooms to smaller bins to be more cost effective as GPs were not routinely needing larger sharps bins. On review of the minutes of the practice's monthly GP and nurses' clinical meetings, we saw prompts to encourage staff to be vigilant of the sharps bins in the rooms they used, and to monitor those nearing their maximum capacity or three-month use by date.

During this inspection of both sites, we noted the ceiling-mounted extractor fans in staff-only toilets had a noticeable build-up of dust over the fan grids. These toilets did not appear to be in a patient-accessible area. Otherwise, we found the cleanliness of both sites to be appropriate and in good condition. We also found the cleaning cupboards at the both sites to be appropriately organised and clean.

We found the practice's external clinical waste bins to be locked and secured to an external wall of the premises. We discussed the possible addition of a covered structure around the external clinical waste bins, to provide an enhanced level of security. The practice confirmed it would investigate the options available.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: Basic life support training was given to staff on an annual basis by the local hospital's resuscitation team. The practice had arranged the next BLS face to face training to take place on 24 February 2020.	

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
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. This did not include monitoring the use of prescription stationery or consistent implementation of the practice's stock control arrangements.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.84	0.80	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)	11.0%	11.1%	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)	5.86	5.95	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.45	2.08	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial

Explanation of any answers and additional evidence:

During this inspection, we found the practice was recording serial numbers of blank prescription stationery when re-stocking printers in consultation and treatment rooms at both sites. However, the quantity of prescription stationery used each time was not recorded and there were not appropriate security measures in place at the end of the day. For example, the printers were not emptied, and any unused blank prescriptions were not recorded. The consultation and treatment rooms were locked at both sites when not in use, but printers were not, and the practice had not risk assessed access by unsupervised members of staff and external contractors who had access to these rooms.

At our last inspection, the practice was not appropriately monitoring the prescribing competency of its non-medical prescribing (NMP) practitioners, such as its advanced nurse practitioners. There was also limited clinical supervision to support those nurses working in advanced roles, making independent clinical decisions on diagnosis.

At this inspection, we found the practice continued to include the NMP practitioners in its medicines management prescribing audits, which identified individual prescribing practices. It had also implemented a monthly individual supervision and tutorial session with a named GP for all of its NMP practitioners, as well as two-monthly teaching sessions with other NMP practitioners and an allocated GP where prescribing practices could be discussed. We spoke to two NMP practitioners during this inspection who confirmed they felt well supported, were aware of their own competency for prescribing, and the level of supervision at the practice was appropriate to their needs. The NMP practitioners generally worked within the GP-led Urgent Care Clinic service so we were told they all had access to a

Medicines management	Y/N/Partial
duty GP as required and they were always given the opportunity to discuss any issues. NMP practitioners also attended the quarterly GP/Nurse clinical meeting where new guidance, learning from significant events and complaints and updates on clinical learning was regularly shared. At our last inspection, we found the practice had not been monitoring its stock of Controlled Drugs appropriately. (Controlled Drugs are types of medicines whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law). At this inspection, the practice told us it had revised its need to stock CDs and confirmed it had decided to no longer keep CDs on site. As a result, the practice had removed its previous stock at both sites in line with national guidance. Out of 10 fridges used by the practice for the storage of vaccines, we reviewed three at the main location, and two at the branch site during the inspection. We saw records of fridge temperatures being recorded and appropriate action being taken to investigate any breaches of minimum or maximum temperature ranges. In one fridge at the main location, we found two unopened delivery boxes of vaccines. On review of the boxes, we found they had been delivered to the practice on 23 December 2019 and 16 January 2020 respectively. The practice confirmed the cold chain, to protect the safety and efficacy of the vaccines, had not been interrupted. We raised this with the practice who were unable to say why the vaccines had not been unpacked, to check the integrity of the stock, and then stored in line with its stock control measures.	

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:	80
Number of events that required action:	80

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

Event	Specific action taken
Text message reminders, from the practice and the local hospital, had been sent to the wrong patient.	Practice investigated. It found the mobile number of one patient had been added to another patient's record, meaning referral letters also contained the wrong mobile number. Both patients were asked to confirm their mobile numbers. Practice apologised to both patients.
Three out of date vaccines found in vaccine fridge at branch site.	Vaccines found to be leftover stock following locality's school nurse takeover of the Teen Booster programme. Expiration dates noted to be from January 2019, identified in June 2019. Practice issued reminder to all staff to rotate stock when new vaccine stock added to fridges.

Request for an urgent repeat prescription missed as allocated to a member of staff not in practice rather than added to the urgent request list.	Practice investigated and identified that policy and procedure had not been followed. Staff were reminded of appropriate procedures and the process was monitored for six months. No repeat episodes were identified after six months. Patient was apologised to in line with the practice's complaints procedure.

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

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.21	0.63	0.74	Significant Variation (positive)

Older people Population group rating: Good

Findings
• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • The practice carried out structured annual medication reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.   - Staff who were responsible for reviews of patients with long-term conditions had received specific training.   - GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.   - The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.   - The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.   - Adults with newly diagnosed cardio-vascular disease were offered statins.   - Patients with suspected hypertension were offered ambulatory blood pressure monitoring.   - Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.   - Patients with 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)	83.7%	79.0%	79.3%	No statistical variation
Exception rate (number of exceptions).	16.9% (238)	14.2%	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)	78.3%	78.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	14.5% (204)	11.3%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	84.5%	82.7%	81.3%	No statistical variation
Exception rate (number of exceptions).	17.2% (242)	14.9%	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)	73.5%	76.4%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.8% (28)	11.2%	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)	90.2%	91.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	13.2% (79)	14.8%	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)	85.9%	82.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.0% (165)	4.4%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	90.7%	91.2%	91.1%	No statistical variation
Exception rate (number of exceptions).	7.1% (41)	5.9%	5.9%	N/A

Families, children and young people   Population group rating: Good

Findings

- The practice has met the WHO based national uptake target of 95% (the recommended standard for achieving herd immunity) for one childhood immunisation indicator. The practice has met the minimum 90% uptake target for the remaining three childhood immunisation 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)	198	205	96.6%	Met 95% WHO based target
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)	220	233	94.4%	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)	219	233	94.0%	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)	218	233	93.6%	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.

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)	72.3%	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)	76.0%	76.9%	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)	65.9%	65.1%	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)	80.8%	75.1%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	51.4%	57.1%	53.8%	No statistical variation

Any additional evidence or comments
On the day of inspection, the practice showed us data from its clinical records system which showed an improvement it cervical screening uptake performance data. According to this data, which has not been externally verified the practice had achieved: • 97% uptake for eligible female patients aged 25-49years who were screened within the last 3.5years. • 95% uptake for eligible female patients aged 50-64years who were screened within the last 5.5years.

The practice showed us that up to the day of inspection, 217 patients had declined a cervical screen, the equivalent of 1% of the practice's eligible population.

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. The practice showed us evidence to demonstrate it had invited 72% of its 112 patients who were on its learning disability register and who were eligible for an annual health check. As of the day of inspection, it had completed a health check for 46% of those invited, while a further 11% had been recorded as declined. • 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. • 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. • All staff had received dementia training in the last 12 months. • 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)	90.0%	92.1%	89.4%	No statistical variation
Exception rate (number of exceptions).	5.9% (10)	13.7%	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)	96.9%	90.9%	90.2%	No statistical variation
Exception rate (number of exceptions).	5.9% (10)	12.1%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	85.3%	84.5%	83.6%	No statistical variation
Exception rate (number of exceptions).	15.1% (34)	6.5%	6.7%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	550.5	539.2
Overall QOF score (as a percentage of maximum)	100.0%	98.5%	96.7%
Overall QOF exception reporting (all domains)	8.7%	5.3%	5.9%

Any additional evidence or comments
Following our last inspection, the practice was noted to be an outlier for its overall Quality and Outcome Framework (QOF) exception reporting data. (Exception reporting is the exclusion of eligible patients from reported indicators). The practice told us it had revised its annual recall and exception reporting process for the financial year 2018/2019. The practice's dedicated administrative team told us it ran daily searches based on birth months for patients to identify those eligible for an annual review. Identified patients were called on their registered telephone number. Two telephone calls were attempted, if no response then a letter was sent to patients inviting them for an annual review. If no contact achieved, the patient's GP was notified to call or to text patients specifically to offer further individualised contact opportunities. As a result of these measures, the practice had seen a reduction in its overall exception reporting from 18.20% to 11.02%. This meant that more patients were more consistently receiving treatment that was appropriate to their chronic diseases and conditions.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes

The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- Due to the changes in the practice's recall system to improve the monitoring of patients and their treatment, the practice had identified a significant improvement in its recalling for full blood count (FBC)/Prostate-Specific Antigen (PSA) test for those patients taking synthetic testosterone medicines. For example, in the first year the practice reported a 50% uptake for testing, which had then improved to an 80% uptake.
- Through audits monitoring the renal (kidney) function in new anticoagulant (blood-thinning) medicines the practice had reduced the number of patients with no creatinine clearance in the previous 12 months from 224 patients, equivalent to 45.5%, to 67 patients, equivalent to 11.7%.

Effective staffing

The practice was able demonstrate that staff had the skills, knowledge and experience to carry out their roles, but evidence of practice assurances of such knowledge was limited.

	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.	Partial
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	

The practice had a dedicated training officer to support staff to stay up to date with the practice's expected training modules. For modules such as basic life support or safeguarding training for clinical staff, the training officer had arranged for training sessions with external providers, such as the local hospital's resuscitation team or the safeguarding team from the local clinical commissioning group. For other modules, identified as mandatory by the practice such as Information Governance, Mental Capacity Act and Dementia Awareness, the training officer completed the indicated online module and then devised a training power-point presentation that was presented to staff or shared via email. During the inspection, we asked how such methods of delivery assured the practice that staff had the appropriate knowledge, as there was no assessment of staff knowledge was undertaken. Where staff were employed by external providers, such as the care navigators that the practice had access to, the practice told us that evidence of training was requested, provided by the staff member and then stored. We saw training was recorded in the practice's training log for care navigators, locum GPs and GP registrars in line with practice expectations.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
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,	Yes

for example, stop smoking campaigns, tackling obesity.	

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)	90.7%	93.9%	95.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.1% (70)	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.	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
Policies for any online services offered were in line with national guidance.	Yes

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-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.	24
Number of CQC comments received which were positive about the service from both sites.	19
Number of comments cards received which were mixed about the service from both sites.	4
Number of CQC comments received which were negative about the service from both sites.	0

Any additional evidence
One comment card collected during the inspection contained a mobile number. We tried several times to contact the number provided in case the person wished to speak to the inspection team directly, but no answer was received.

Source	Feedback
CQC Comment Cards	Positive comments provided by patients via the CQC comment cards stated staff were caring and kind. Patients reported they felt well-looked after and staff did all they could to support patients in accessing the care and treatment they needed. Mixed comments provided by patients contained no negative comments relating to how patients were treated by staff at the practice.
Patient interviews	We spoke to two patients during our inspection. One confirmed they had been treated with respect by staff, while one stated they had previously had cause to complain about the reception staff at the practice.
NHS UK website	The practice had received eight reviews via the NHS UK website since our last inspection. There were five 5-star reviews, one 4-star review and two 1-star reviews recorded. Positive comments included staff being reported to be kind and professional towards patients, putting patients at ease, and supporting them as much as possible to receive the care they needed. The practice had responded to the

	reviews appropriately.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
23,403	249.0	116.0	46.6%	0.50%

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)	87.5%	91.0%	88.9%	No statistical variation
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)	91.1%	90.2%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	96.7%	96.8%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	81.6%	86.9%	82.9%	No statistical variation

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

Any additional evidence
At our last inspection, we recommended the practice continue to use patient feedback to drive improvement. At this inspection, in January 2020, we saw a practice survey was undertaken following the results of the national GP Patient Survey, completed over seven weeks from 2 December 2019. The purpose of the survey was to further understand below average levels of satisfaction in the practice as well as identify areas for improvement to the services offered. The practice's survey was sent to 250 patients, 197 responded, the equivalent to an approximate 79% response rate. The practice's survey showed that:

- 99% of respondents were very or fairly satisfied with overall the clinical care provided at the practice.
- 90% of respondents felt continuity of care was very or fairly important.
- 65% of respondents confirmed they got to see the same GP most of the time.

As a result of its own survey, areas of improvement had been identified. Due to the recent completion of the survey, areas of improvement were currently aspirational at the time of inspection. For example:

- The practice was looking at ways to improve continuity of care, such as personal lists, and the practice confirmed a review of its in-house tiering programme for the equal workload balance for its' GPs was planned for 2020.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Comment cards	Positive comments provided by patients via the CQC comment cards stated patients felt involved with their care and treatment. Patients stated they received excellent care, and reminders about health checks, blood tests were helpful. Mixed comments provided by patients contained no negative comments relating to how patients were involved in their care and treatment.
Interviews with patients.	We spoke to two patients during our inspection. Both confirmed they felt informed with their care and treatment and were proactive in requesting time to discuss any issues they had.

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)	92.0%	95.6%	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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 417 patients that were also carers. This represented approximately 1.7% of the practice patient's population and was an increase in numbers compared to our last inspection.
How the practice supported carers (including young carers).	The practice supported carers with an NHS health check, extended appointments at flexible times, and a seasonal flu vaccine. The health checks included information on maintaining good health for carers as well as local and national support groups. We saw information relating to support for carers in the practice waiting rooms and in the practice's brochure.
How the practice supported recently bereaved patients.	The practice sent a condolence letter to all recently bereaved patients, offering support or a follow up appointment if required.

Any additional evidence
The practice, in association with its patient participation group, had developed and facilitated a 'Living After Loss' bereavement support group.

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

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes

Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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
Explanation of any answers and additional evidence: We saw photographs of staff members added to the doors of consultation and treatment rooms as well as the name of the staff member. This was intended to support patients in knowing who they were seeing for their appointment.	

Practice Opening Times	
Day	**Time**
Waterside Health Centre opening times:	
Monday	7.30am-8.00pm
Tuesday	7.30am-8.00pm
Wednesday	7.30am-1.00pm, 2.00pm-8.00pm
Thursday	7.30am-8.00pm
Friday	7.30am-6.30pm
Blackfield Health Centre opening times:	
Monday	8.00am-1.00pm, 2.00pm-6.30pm
Tuesday	8.00am-8.00pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-8.00pm
Friday	8.00am-6.30pm

Any additional evidence or comments
We asked the practice about its appointment availability, and on the day of inspection, 28 January 2020, at approximately 3.10pm, we were told: • The next 'on the day' appointment with a GP was at 8.40am on 29 January 2020. This appointment could also be used as a routine appointment if a patient needed it. • The next 'treatment room' appointment with a practice nurse was at 4.50pm on the day of

inspection.
- The next appointment for an asthma review with a practice nurse was at 10am on 19 February 2020.
- The next cervical screening appointment with a practice nurse was at 2.50pm on 12 February 2020.
- The next appointment for phlebotomy (blood-taking) was 30 January 2020 at 3.15pm.
- The Urgent Care Clinic (UCC) service, based at the Waterside Health Centre site, still had appointments available, the next one at 3.20pm, and we were told patients could walk in and access such an appointment if they needed it.

We were told appointments were also available at the branch site, and patients were given the option of going to the branch site if they wanted to.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
23,403	249.0	116.0	46.6%	0.50%

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)	92.6%	95.7%	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, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

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's annual recall administrative team maintained a 'waiting list' of patients in case of cancellations. Patients on the waiting list for an annual review would then be offered an appointment sooner if appropriate to their needs.

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

Findings

- Additional nurse appointments were available until 8.00pm Monday to Friday across both sites so school age children could attend an appointment outside of school hours.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open from 7.30am to 8.00pm on Monday to Thursday, and 7.30am to 6.30pm on a Friday at the Waterside Health Centre site. The practice's branch site, based at Blackfield Health Centre was open from 8.00am to 8.00pm on a Tuesday and Thursday, and 8.00am to 6.30pm Mondays, Wednesdays and Fridays.

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

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. The practice's on the day Urgent Care Clinic (UCC) service allowed those patients from a transient background or of no fixed abode to access primary care services quickly and as required.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. The practice had employed two care navigators and a social prescriber to support patients identified as vulnerable to promote good health and continuing independence.
- 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. • In association with a local voluntary service and following a donation to the practice, the practice had developed an outside space to the rear of the premises into a 'Healthy Haven', a garden space. Patients were encouraged to visit the garden, to enjoy the surroundings or to participate in the gardening tasks to promote improved well-being. The practice provided anecdotal evidence of some patients verbally reporting an improvement in their overall health and well-being as result of visiting and getting involved with the garden.

Timely access to the service

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

	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: Receptionists at the practice had been provided with clinically approved 'symptom prompts' to support them when taking telephone calls from patients. The prompts enabled them to identify the most urgent symptoms and which appointment was the most suitable for the patient to be offered. Alongside these prompts, the receptionists also had access to lists of staff and types of conditions, illnesses, appointments that were most appropriate for them to see, such as the advanced nurse practitioner in the Urgent Care Centre, a GP, the member of the practice nursing team or a healthcare assistant. This allowed receptionists to book a patient with the most appropriate clinician dependent on the presenting needs of the patient.	

National GP Survey results

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)	71.1%	N/A	68.3%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)	61.9%	72.5%	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)	62.7%	66.8%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	64.6%	76.7%	73.6%	No statistical variation

Any additional evidence or comments
The practice's own patient survey, completed over seven weeks from 2 December 2019, showed that, out of 197 respondents: • 88% of respondents found the practice's opening hours to be excellent or good. • 88% of respondents found it to be very or fairly easy to get through to the practice on the telephone. • 84% of respondents were very satisfied with the administrative and reception teams at the practice. As a result of its own survey, the practice told us it felt the results challenged the results of the national GP Patient survey and areas of improvement had been identified. However, due to the recent completion of the survey, these areas of improvement were currently aspirational at the time of inspection. For example: • The practice planned to discuss the options for weekend opening with its Primary Care Network partner practices. • The practice planned to improve its telephone process, to slimline its messages and streamline the process, to make a smoother pathway for patients to access the practice by telephone.

Source	Feedback
Comment cards	Positive comments provided by patients via the CQC comment cards stated the appointment system was easy to use, appointments were easy to access when required and the wait for appointments was short. Mixed comments provided by patients referred to disappointment in a two-week wait for appointments to see specific clinicians, or the delay in diagnostic processes being completed. Another comment referred to the need to raise the volume on the call system within the practice, as patients had found it too quiet and were concerned they may miss their appointment as a result.
Patient interviews	We spoke to two patients during our inspection. One confirmed they felt the practice offered a good service despite the current pressures but confirmed the timing of appointments were not always long enough. The other patient confirmed they would proactively book a double appointment if they felt they needed longer to speak with a doctor.
NHS UK website	The practice had received eight reviews via the NHS UK website since our last inspection. There were five 5-star reviews, one 4-star review and two 1-star

	reviews recorded. Positive comments posted by patients included easy access to appointments and repeat prescriptions. Telephone access was also reported to be easy if patients did not have the ability to go online. Negative comments posted by patients included poor communication channels with the practice and inability to get an appointment as required.

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.	33
Number of complaints we examined.	2
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient had been told by hospital prior to discharge a follow up with specific GP was required a week later. Upon calling to make an appointment, an appointment was not available at the stipulated time. When a second attempt was made, the GP was fully booked within 20minutes of the practice's telephone line being opened.	Practice investigated and found patient's discharge letter did not include details about the specific appointment as requested by the family. Alternative appointments would have been offered for what had been stated in the letter. However, the practice confirmed the GP in question had added an additional slot to their clinic in order to accommodate the patient. Practice sent a letter of apology to the family and the complaint was discussed at a subsequent clinical meeting.
Practice refused to take a patient's sample, forcing patient to take to the local hospital themselves.	Practice investigated and found staff had followed its own procedure regarding the acceptance of patient samples. However, the practice had made arrangements for patients with specific directions for future samples to have access to the appropriate sample containers. Practice sent a letter of apology and the complaint was discussed at a subsequent clinical meeting.
Delay to treatment as letters from private health provider not received by the practice.	Practice investigated and found this to be a one-off situation as there was no other evidence of letters not arriving from same private health provider. Practice obtained copies of the letters from the patient directly. Practice sent a letter of apology and the complaint was discussed at a subsequent clinical meeting.

Well-led Rating: Good

At our last inspection, we rated the practice as requires improvement for providing well-led services. This was due to ineffective governance arrangements to maintain adequate oversight of clinical personnel, infection prevention and control measures relating to cleanliness and adherences to some practice policies and fire risk assessments.

Following this inspection, in January 2020, we have rated the practice as Good for providing well-led services.

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

Vision and strategy

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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes

When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: The practice had identified a Freedom to Speak Up Guardian for staff to access if required. However, the Guardian was only identified as 'a member' of the local clinical commissioning group (CCG). Staff we spoke to were not able to tell us who it was specifically, but they told us if they had concerns they would contact the local CCG and find out who was the best person to speak to. The practice's training log, provided after the inspection, did not contain records of staff completing equality and diversity training. We raised this with the practice's training officer after the inspection, who told us equality and diversity training was not a mandatory module to be individually completed. However, the topic was covered with all staff during their induction, and then included in their 12-month induction refresher. We were told staff led by example and all staff had access to the appropriate protocols and procedures relating to equality and diversity via the practice's Master Document Register.	

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

Source	Feedback
Staff interviews	When we spoke to staff during the inspection, we were told they felt proud to work at the practice. Staff said they felt supported by the GPs, managers and colleagues. Staff told us they had been supported by the practice to complete additional training in order to progress their careers. Staff told us they felt if they had concerns to raise, these would be promptly addressed. Staff said they felt well-informed by managers and practice leaders.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: During this inspection, we saw evidence to demonstrate that the practice had improved following our previous inspection. For example, changes had been made to how staff employed in advanced clinical roles received clinical supervision and how the practice was assured regarding their prescribing competence. The practice had also revised its decision around stocking and storing controlled drugs on the premises.	

The practice's dedicated training officer confirmed if evidence of non-compliance was found, appropriate emails were sent to identified staff to chase them and relevant managers were informed.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance but there were limited assurances around staff knowledge via its training arrangements.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	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: During the inspection, we raised concerns about the practice's level of assurance relating to staff knowledge from its training package arrangements. We saw no evidence of a lack of knowledge or unsafe practices with the staff we spoke with on the day and the practice was able to provide evidence that training was taking place. However, the practice could not demonstrate assurance that staff had understood information given to them. For example, its training package did not include an assessment of staff knowledge that was commonly seen when staff completed online training packages, nor was there evidence of a hand-washing audit to formally demonstrate that staff were following safe hand hygiene practices. During the inspection, we also raised concerns about how the practice was monitoring and tracking its blank prescription stationery. We found a semi-structured approach to its prescription stationery security that had not included oversight of prescription stationery and the risk associated to that when blank scripts were in use. Prior to this inspection, the practice told us it had experienced a breakdown of its Docman system in December 2019. (Docman is a cloud-based clinical platform for managing incoming correspondence to health care providers). Attempts to restore the system had failed, and as of 16 January 2020, the practice had implemented its business continuity plan and reverted back to a paper-based system for reviewing patient information received by the practice. The practice had a plan in place as to how it would ensure all correspondence was uploaded to patient records once its Docman system had been restored.	

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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	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 showed us evidence of a recent patient survey to gather patient views on how to improve the services the practice offers. The practice had worked alongside its patient participation group and local volunteers to plan and facilitate additional support resources for patients. For example, following a donation to the practice, a Healthy Haven garden had been created to the rear of the practice premises and a 'Living After Loss' bereavement support group had been set up and run from the practice. We were told this group had grown considerably from its inception that the practice were now looking for alternative sites to run the group out of as the practice could no longer comfortably accommodate the size of the group.	

Feedback from Patient Participation Group.

Feedback
We received feedback from one member of the practice's patient participation group (PPG) following a steering group meeting who responded on behalf of the whole PPG. In response to our questions, the PPG confirmed it met either via steering groups with the practice manager and a GP representative or with the practice manager alone, to clarify strategies and operational procedures on which the PPG could contribute. The PPG maintained its own website, which was also accessible from the practice's website. It contained current information relating to health promotion information, practice information such as the services

available and the Primary Care Network (PCN) including the benefits to patients of this PCN. The PPG confirmed the practice invited patient feedback in a variety of ways and the practice manager had full oversight of such feedback.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: The practice told us it was making progress in its plan to become a student nurse training site. For example, an educational environment audit was completed in November 2019 by one of the local universities. The practice was now in the process of evaluating its nursing staff had the appropriate mentoring qualification in order to support student nurses on placement at the practice.	

Examples of continuous learning and improvement
• The practice had signed up to the MyCOPD app to support its patients with Chronic Obstructive Pulmonary Disease to take ownership of their condition. The practice intended to roll-out lifelong licences to eligible patients to access the service in the months following the inspection. • The practice was the pilot site for Referral Support Service which has been successfully rolled out for the rest of the local clinical commissioning group area. • Text messaging services AccuRx and MJOG utilised by practice to contact patients with appointment reminders and health promotion links.

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.