Care Quality Commission

Inspection Evidence Table

St Clements Partnership (1-543611756)

Inspection date: 11 February 2020

Date of data download: 07 February 2020

Overall rating: Good

We have rated the practice as Requires Improvement overall because:

- **Care and treatment were not being delivered in a safe manner, particularly in relation to infection prevention and control measures and the monitoring of safety alerts to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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 due to issues relating to ineffective oversight arrangements to ensure completion of actions following risk assessments, the limited dissemination of learning from significant events and processes around the monitoring of valid professional registrations.

At this inspection, we have continued to rate the practice as Requires Improvement for providing safe services because:

- **Infection prevention and control measures had deteriorated since our last inspection, including general cleanliness.**
- **There were gaps in staff compliance with infection prevention and control training.**
- **Legionella testing was limited, and recent tests showed that not all water outlets at the practice were within acceptable temperature ranges.**
- **There was no system to ensure safety alerts received by the practice had been appropriately actioned.**

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

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.	Partial
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's recommended training schedule did not include safeguarding adults training. Its recommended safeguarding children training levels did not appear to have considered the guidance made in the national Intercollegiate Guidance (2019). For example, the practice's safeguarding children level 3 training was listed to be completed by the GP lead for safeguarding children only, while the Intercollegiate Guidance recommends level 3 training for all clinical staff who have contact with children and young adults.

However, on review of the training records provided by the practice during the inspection we found:

- All but five clinical staff had a current record of safeguarding children level 3 training. Two of those staff without a current record were on long-term leave, one was a locum GP and the remaining two had a confirmed external training course booked for late February 2020 and July 2020.
- All but two non-clinical members of staff had a current record of safeguarding children Level 1 training. Of the other two non-clinical staff members, one was on long-term leave and the other had completed safeguarding children training to Level 2.
- All but three non-clinical members of staff had a current record of safeguarding adults Level 1 training.
- All but three clinical staff had a current record of safeguarding adults Level 2 training. These staff members were either on long-term leave from the practice, or a locum GP.

The practice told us three non-clinical staff who acted as chaperones, and been trained to do so, had received an appropriate Disclosure and Barring Service (DBS) check. (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). The practice could not demonstrate that a formalised risk assessment was conducted to support its decision for not completing DBS checks on other non-clinical staff.

The practice told us it did use a risk assessment for staff who had received a DBS check from a previous employment, such as a GP locum. In that risk assessment, staff were asked to confirm if there had been any changes since their last DBS check. The practice confirmed it would amend that form to create a more formal risk assessment for its non-clinical staff moving forward.

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.	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:

On review of five staff personnel files during the inspection, we found the practice had mostly retained evidence of recruitment checks in line with Schedule 3 of the Health and Social Care Act 2008, except for:

- No identification documents for a salaried GP. Nor did we find evidence of the salaried GP's qualification or a current DBS check The practice provided copies of the missing documents in the days following the inspection.
- No evidence of a practice nurse's qualification. The practice provided copies of the missing document in the days following the inspection.

The practice told us records of staff vaccination statuses were requested on induction. On review of the five personnel files, we found vaccination statuses in three files. The practice provided a copy of one more staff member's vaccination status since inspection.

At our last inspection, we found the practice had no system in place to ensure staff professional registrations were maintained. This was highlighted by the practice themselves due to one staff member's registration having lapsed and the practice had been told the day before the inspection. At this inspection, we found all clinical staff had valid registrations and the practice had a system in place to monitor the registrations of its nursing staff.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: April 2018.	Yes
There was a record of equipment calibration. Date of last calibration: 5 November 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: June 2019	Yes
There was a log of fire drills. Date of last drill: 29 October 2019	Yes
There was a record of fire alarm checks. Date of last check: 24 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: 30 November 2018	Yes
Actions from fire risk assessment were identified and completed.	Yes

Explanation of any answers and additional evidence:

At our last inspection, we found the practice had not fully addressed all appropriate actions following its previous fire risk assessment. The practice confirmed its fire risk assessment was valid for three years. It was last reviewed by the practice on 31 January 2020 with no further actions to be completed.

Out of 52 staff, all but three staff members had completed a current fire safety training module. The remaining three staff were all on long-term absence from the practice.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: March 2019	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 September 2019	Yes

Explanation of any answers and additional evidence:

At our last inspection in January 2019, we found the practice had limited evidence of undertaking formal risk assessments or acting upon the findings of previous risk assessments in a timely manner to ensure the safety of its patients and staff. At this inspection in February 2020, the practice showed us a range of health and safety risk assessments which it had commissioned an external contractor to complete. We saw these risk assessments included Display Screen Equipment (DSE) workstations and the use of a ResQmat. (ResQmat is evacuation and rescue aid, a padded mat for the rapid removal of disabled and mobility impaired people from emergency situations).

The practice provided a copy of a building inspection that it had been completed in March 2019, in place of a formal risk assessment. We were told these had been intended to be monthly, but the practice told us these had not occurred as planned and were instead being carried out quarterly. We asked if a more recent building inspection had been completed and the practice agreed more had been done. We asked for copies of further inspection reports be provided following our inspection, but these were not been supplied.

On review of the building inspection report from March 2019, 18 actions were identified. We saw eight had been recorded as actioned. The practice could not demonstrate it had risk assessed the actions left outstanding, so we were not able to establish how urgent the actions were. Such actions included carpets that needed cleaning in three areas, two such areas were patient accessible. Actions for aesthetic reasons, such as painting waiting room walls, had been documented to be allocated to the practice's handy-man, but had not yet been recorded as completed; while other actions, such as a 'bad crack in wall' in two public locations had been marked as requiring 'no action'. We could not be assured that the practice was doing all it could to mitigate the risk of cross infection within the practice in its current state.

During our inspection, we saw a hole in the ceiling above the reception desk area that had not featured in the March 2019 inspection report, nor could we establish how long the hole had been there for.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met and had deteriorated 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. Date of last infection prevention and control audit: 7 February 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
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:

According to the practice's training requirements, only nursing staff were expected to complete annual infection prevention and control (IP&C) training, while its IP&C policy stated annual hand-washing and ongoing IP&C training was required for all staff. On review of the practice's training log regarding IP&C, we found three GPs and four non-clinical staff members, one of whom was on long-term absence from the practice, had no record of completing IP&C training. We saw no information relating to hand-washing training or a hand-washing audit being completed to ensure standard hand-hygiene practices.

The practice told us that its online training provider had been undergoing maintenance prior to the inspection so some staff had not been able to complete their training as required.

The practice's most recent IP&C audit, completed on 7 February 2020 by its local clinical commissioning group's IP&C team, showed the practice's overall IP&C compliance was 75%. This had been broken down into the following areas:

- Environment Compliance Score: 82%.
- Hand Hygiene & Personal Protective Equipment (PPE) Score: 87%.
- Domestic Cleaning Cupboard Compliance Score: 20%.
- Clinical Compliance Score: 79%.
- Sharps Compliance Score: 83%
- Vaccines Compliance Score: 78%

A 45-point action plan had been created following the IP&C audit but due to its recent completion, minimal action to address the identified areas of non-compliance had been completed by the time of the inspection on 11 February 2020.

The overall cleanliness of the practice was not adequate. We saw a medicine fridge that was visibly dirty on its external glass door, and the practice could not tell us when the medicine fridges had been last cleaned. In clinical rooms, we saw cleaning schedules of what needed to be cleaned each day, but no records to show the cleaning had been done. We saw a paper diary was kept in the cleaning cupboard which listed the rooms which had been cleaned each day, and we saw every room was recorded to have been cleaned once a week. In one treatment room, we found dust on top of curtain

rails, plug sockets, door frames, and dirt inside window frames. The practice told us it had previously decided to change its cleaning company, but its progress had been stalled due to staff changes at the practice which the practice had felt needed to be addressed as a priority.

The practice's current IP&C lead took over the role in September 2019 and told us they had not received any protected time to do the role until January 2020. Since that time, they had reintroduced legionella water testing to minimise the risk of infection, which we were told had not been done since January 2019. An initial check of the practice's water temperatures on 31 January 2020 identified two hot water outlets were below the recommended 50 degrees Celsius. The IP&C lead told us the practice's boiler temperature was increased but when the water was re-tested on 4 February 2020, one outlet was still below the recommended temperature. (Legionella is a water-based bacterium that exists in water temperatures between 20-50 degrees Celsius).

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: The practice's most recent basic life support, a face to face training session with an external provider, took place on 16 January 2020. Out of 52 staff, 27 attended. The practice told us a further session for those staff who did not attend the session on 16 January was booked for 26 March 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	Yes

summarising of new patient notes.	
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.

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)	0.72	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)	11.9%	11.1%	8.5%	Tending towards variation (negative)
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)	5.44	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)	1.65	2.08	2.08	No statistical variation

Medicines management	Y/N/Partial

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
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
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:

On review of the practice's monitoring system for patients receiving high-risk medicines, we found a random sample of four patients had received up to date blood tests and medication reviews. The practice's own search conducted during the inspection showed, out of 81 patients receiving high risk medicines, 38 were found not to have had blood tests within three months. On further review, these 38 had also included patients who had blood tested via secondary care, but we were unable to establish how many of these patients with a blood tests had been included in the practice's search.

The practice told us it was in the process of implementing a new recall system to support the monitoring of patients receiving high risk medicines.

During our inspection, we found one fridge used for the storage of flu vaccines specifically was overstocked. This meant the practice had not ensured appropriate air flow could circulate around the vaccines to maintain appropriate cold chain measures in line with national guidance. Two other fridges

Medicines management	Y/N/Partial
used in the practice for storing medicines, were found to be appropriately stocked with medicines well-spaced and stored in line with national guidance. We raised this with the lead nurse during the inspection who told us an alternative fridge was needed for 'flu season' to ensure vaccines could be appropriately stored but we were unable to establish when that measure would come into effect. On review of the practice's fridge temperature logs, we found, in its most recent week of documented temperature checks, a whole day had not been documented. We discussed this with the practice's lead nurse who admitted the fridge temperatures had been forgotten that day due to human error and a lack of time to do so. Temperatures recorded on other days remained in the appropriate range to ensure efficacy and safety. We saw a copy of a significant event report that was raised following this incident and learning points were identified to prevent this from happening again.	

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:	69
Number of events that required action:	63

Explanation of any answers and additional evidence:

The practice told us it had seen a change in culture in relation to staff reporting incidents and raising incidents on its reporting system, Datix. (Datix is web-based incident reporting system). The practice showed us that its overall reporting figures, as confirmed by the local clinical commissioning group, had increased from 13 incidents in 2018, to 59 incidents in 2019. In 2020, by the time of inspection on 11 February 2020, the practice had reported 10 incidents.

At our last inspection, we found the practice demonstrated limited dissemination of learning from significant events. At this inspection, the practice told us it had introduced regular significant event review meetings. These were being minuted and information relating to any learning was recorded in the minutes. These minutes were shared directly with all GPs and clinical staff, and if non-clinically significant events arose the learning from these was shared with the non-clinical team accordingly. The practice told us the minutes from significant event review meetings were also available on the practice's intranet system for any staff member to access. Staff we spoke with during the inspection told us they were aware of relevant learning following significant events and they knew where to find the minutes from the meetings if they wished to access them.

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

Event	Specific action taken

Needle found in the practice's downstairs patient toilet (located near front door).	Practice acted to remove the needle. No further needles were found. Practice made the decision to lock the toilet and receptionists keep the key. Patients informed to ask for the key when use of the toilet was required.
Delayed coding following patient death.	Email reminder sent to all GP personal assistants regarding the importance of timely coding of patient deaths.

Safety alerts	**Y/N/Partial**
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We saw examples of recent alerts having been received by the practice that were then sent on to relevant staff to action. However, there was no system in place to record what actions were then taken in response.	

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)	1.36	0.63	0.74	No statistical variation

Older people Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were 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)	63.5%	79.0%	79.3%	Variation (negative)
Exception rate (number of exceptions).	20.8% (147)	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)	72.8%	78.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	14.0% (99)	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)	76.3%	82.7%	81.3%	No statistical variation
Exception rate (number of exceptions).	16.3% (115)	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)	70.6%	76.4%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.1% (11)	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)	90.9%	91.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	12.0% (30)	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)	81.7%	82.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.1% (128)	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)	88.6%	91.2%	91.1%	No statistical variation
Exception rate (number of exceptions).	5.3% (20)	5.9%	5.9%	N/A

Any additional evidence or comments

We spoke with the practice about its Quality and Outcome Framework (QOF) performance. In relation to its QOF achievement of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months, the practice confirmed it was aware of the decrease in its results and the following information was provided:

- Departure of key nursing staff, including a practice nurse with special interest in diabetes, had limited the practice's ability to offer diabetic review appointments. This had led the practice to introduce more GP-led clinics to supplement its diabetic care.
- Recruitment of new nursing staff with diabetes experience had not been successful and the practice was now training existing practice nurses with diabetes care.
- The practice was part of the local WISDOM project (WISDOM stands for West Hampshire Improving Shared Diabetes Outcome Measures – a local clinical commissioning group programme designed to support practices to target those patients that required treatment escalation).

The QOF indicators changed on the 1st April 2019. The practice showed us their unverified data for the current QOF year for diabetes which showed its performance was demonstrating a broadly improving picture. For example, as of 11 February 2020:

- 83% of patients newly diagnosed with diabetes had been referred to a structured education programme. The target for this new indicator, to be achieved by 31 March 2020, was 90%
- 63% of patients with diabetes and no moderate or severe frailty had a blood pressure measurement of 140/80mmHg or less. The target for this new indicator, to be achieved by 31 March 2020, was 78%.
- 75% of patients with diabetes and recognised frailty in whom the last IFCC-HbA1c result was 58mmol/mol or less. The target for this new indicator, to be achieved by 31 March 2020, was 92%.

Families, children and young people Population group rating: Good

Findings

- The practice had not met the minimum 90% target for all four childhood immunisation uptake indicators.

- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	101	113	89.4%	Below 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)	104	119	87.4%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	105	119	88.2%	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)	104	119	87.4%	Below 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

Any additional evidence or comments

The practice confirmed it was aware of the decrease in its childhood immunisation uptake performance and the following information was provided:

- Departure of key nursing staff had limited the practice's ability to offer flexible immunisation appointments.
- Recruitment of new nursing staff had not been wholly successful and the practice was now training up existing practice nurses in the childhood immunisation programme.

During the inspection, the practice provided unvalidated data demonstrating its childhood immunisation uptake rate had increased across all four indicators. For example, as of 7 February 2020, the practice's uptake was:

- 94% 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).
- 96% of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster).
- 93% 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)
- 93% of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR).

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (01/07/2019 to 30/09/2019) (Public Health England)	69.1%	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)	72.0%	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)	56.9%	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)	81.4%	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	53.4%	57.1%	53.8%	No statistical variation

31/03/2019) (PHE)				

Any additional evidence or comments
The practice confirmed it was aware of its cervical screening uptake performance and the following information was provided: • Departure of key nursing staff had limited the practice's ability to offer flexible cervical screening appointments. • Recruitment of new nursing staff had not been wholly successful and the practice was now training up existing practice nurses in the cervical screening programme. • Appointments for cervical screening were being offered to patients via the local extended access hubs. During the inspection, the practice provided unvalidated data to demonstrate its cervical screening uptake had increased. For example, as of 7 February 2020: • 70% of those eligible for cervical cancer screening between 25 to 49 years had been adequately screened within 3.5 years. • 82% of those eligible for cervical cancer screening between 50 to 64 years had been adequately screened within 5.5 years.

People whose circumstances make them vulnerable

Population group rating: Outstanding

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. The practice had continued its previous bespoke work at the local homeless centre supporting patients with two GP-led clinics and two nurse-led clinics a week. An audit produced by the practice in January 2020, showed that it had seen an increase in the uptake of appointments; for example, 680 appointments were accessed between January 2019 and January 2020, compared to 565 in 2018. The same audit demonstrated the work of the practice had led to a 12% reduction in those patients visiting the local accident and emergency department. By offering the service, the practice had helped those patients by reduce their benzodiazepine prescribing rate by 8% and had returned its sleeping agent prescribing rate to the same it was two years following a slight increase in 2018/19. • 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.
- Following an in-house focused session on mental health on 11 February 2020, the practice demonstrated an increase its in mental health care plan documentation. As a result of that in-house session, the number of completed care plans for the 162 patients eligible for one had increased from 95 to 124 care plans.
- 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)	91.8%	92.1%	89.4%	No statistical variation
Exception rate (number of exceptions).	12.2% (22)	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)	90.1%	90.9%	90.2%	No statistical variation
Exception rate (number of exceptions).	10.6% (19)	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)	89.5%	84.5%	83.6%	No statistical variation
Exception rate (number of exceptions).	6.7% (11)	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)	537.5	550.5	539.2
Overall QOF score (as a percentage of maximum)	96.1%	98.5%	96.7%
Overall QOF exception reporting (all domains)	6.9%	5.3%	5.9%

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

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

Lithium prescribing safety audit:

- Cycle 1 (August 2019): 31 patients were identified as taking Lithium. Of those 31, 22 (71%) had had a blood test to check the level of Lithium in the last six months; 20 (64%) had received a thyroid function test in the last 6months; 22 (71%) had received a kidney function test in the same period.
- Cycle 2 (January 2020): 33 patients were identified as taking Lithium. Of those 33, 32 (97%) had had a blood test to check the level of Lithium in the last six months; 31 (94%) had had both a thyroid function test and a kidney function test in the same period.

Non-steroidal anti-inflammatory drugs (NSAID) prescribing safety audit:

- Cycle 1 (October 2019): 181 patients were identified as receiving a repeat NSAID prescription. Of those 181, 70 (39%) had received a medication review in the previous 12 months. Of those 181 patients, 97 (71%) were taking gastro-protection medicine.
- Cycle 2 (November 2019): Of the unchanged 181 patients identified as receiving a repeat NSAID prescription, the number of patients who had received a medication review had increased to 85 (47%).
- Cycle 3 (January 2020): The number of patients who had received a medication review had again increased to 101 (56%). The number of patients taking gastro-protection medicine had also increased to 107 (79%).

An initial hypertension (high blood pressure) clinical audit in January 2020 had demonstrated to the practice several areas for improvement included the technique of measuring blood pressure more effectively, the use of ambulatory and home blood pressure monitoring and the organisation of end-organ target damage investigations.

Effective staffing

The practice was able 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.	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:

At our last inspection, we identified the practice did not have appropriate oversight in place to ensure staff training and appraisals were completed in line with its own policies. At this inspection, we found all staff had received an appraisal by the end of March 2019, and the practice had since implemented a new protocol for all appraisals to be completed annually during February and March.

Oversight of staff training was maintained by the practice's online training provider, and completion of specific training has been documented previously in this evidence table. The practice told us staff received email prompts when training modules were about to expire and regular updates about training was included in the practice's staff newsletter. On review of the practice's training records, we found gaps in staff compliance in relation to Information Governance, Infection Prevention and Control and Safeguarding Adults Level 1 training. Gaps were mitigated by appropriate reasons such as long-term absence.

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, for example, stop smoking campaigns, tackling obesity.	Yes

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	94.5%	93.9%	95.0%	No statistical variation
Exception rate (number of exceptions).	2.3% (86)	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

Explanation of any answers and additional evidence:

The practice had not stipulated that Mental Capacity Act training be completed by all staff as part of its training summary. Instead it was an optional extra available via its online training provider. On review of the practice's training records, we found 13 staff out of a total of 52 had a record for completing Mental Capacity Act training. Of those 13 staff, eight were clinical staff including four GPs, three members of the nursing team and one healthcare assistant.

Well-led Rating: Good

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 practice had undergone significant leadership and management restructuring since our last inspection. The number of GP partners had decreased from 10 to seven, and the practice had recruited more salaried GPs. The practice's previous practice manager left in December 2019 and its previous deputy practice manager had been promoted to operations manager. Further in-house promotions had created an operations co-ordinator role to support the newly appointed operations manager with the day to day running of the practice. We were told the practice was actively seeking to recruit a business manager to support the existing leadership from a strategic point of view and to support the development of its involvement with the local Primary Care Network (PCN).

Vision and strategy

The practice had a clear vision and strategy to provide high quality sustainable care, but further work was still required.

	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.	Partial
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.	Partial

Explanation of any answers and additional evidence:

The practice told us it continued to be aware it had shortfalls in its current situation, for example the practice's premises remained unchanged since our last inspection. The practice had experienced significant delays in getting new premises confirmed for elsewhere in the city and minimal progress had been made since our last inspection in January 2019. The practice told us it had decided to not make extensive improvements to the premises as it felt it would not be in its current location for much longer.

The practice told us it felt 2019 had been a hard year in view of its staffing levels. Not only had the management and leadership structure changed, but also its clinical team with the loss of a number of practice nurses and health care assistants, as well as non-clinical staff, some of whom had been at the

practice for a number of years. The practice told us it knew recruiting new staff had not allowed them to focus fully on all areas that they wished to improve upon, but it now felt it had a more stable team with which to move forward with.

The practice told us it was aware that its Quality and Outcome Framework (QOF) performance had decreased, especially with regards to its diabetes performance and its childhood immunisation uptake had also reduced. However, on the day of inspection, the practice offered more recent, but unvalidated, performance data which demonstrated an improvement had been achieved. The practice told us it felt its staffing issues had impacted on its ability to offer the necessary appointments to gather and monitor the relevant performance data, but it felt that was improving now its nursing team was more stable.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: The practice had not listed Equality and Diversity training as a required module. However, out of a total of 52 staff, 35 staff members, including eight GPs, had completed a relevant training module online.	

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

Source	Feedback
Staff interviews	Staff told us they enjoyed working at the practice. Staff reported the practice had made a lot of changes since our last inspection, staff felt the practice was attempting to come into the 'modern age' and the changes would benefit staff and patients alike. Staff said they felt supported by managers and leaders and there was an open and honest culture in which they felt they could raise concerns. Staff told us they did not think they were currently well-staffed due to staff departures and they said they were feeling thinly spread to cover the workloads. Staff were aware that the practice was actively recruiting to replace staff, so staff were prepared to work flexibly to cover shifts as required.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management but there was evidence of staff not being compliant with the practice's training expectations.

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

Explanation of any answers and additional evidence:
We saw records of regular meetings, that had an agenda and had been minuted. These included nursing team meetings, clinical meetings, and practice meetings. Policies had been reviewed but the practice felt that its business continuity plan still needed to be updated due to staff departures. The practice told us it was slowing introducing a workflow optimisation project, initiated by its local clinical commissioning group, to reduce the administrative workload on its GPs. The practice told us it had not yet implemented it fully as it did not want to rush in and risk missing important documents.

Staff we spoke to were able to tell us about staff roles and responsibilities in the practice, especially in relation to the Safeguarding lead, the infection control and prevention lead and the Caldicott Guardian. However, on review of the practice's training records, we found gaps in staff compliance in relation to the practice's expected training requirements. One such example included 34 staff, out of a total of 52, had a current completed training record for Information Governance. The practice had listed Information Governance as a requirement in its annual refresher training programme.

During our inspection, we saw one incident of a staff member having left a treatment room unlocked, with its computer unlocked and the staff member's smartcard still in-situ. This demonstrated that staff were not complying with expected General Data Protection Regulations to ensure the protection of patient information. We raised this with the practice during the inspection.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance. This was an existing area of concern following our previous inspection with new concerns identified at this inspection.

	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.	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: At our last inspection, we found the practice did not have adequate systems in place to address and manage risks that had been previously identified via its own risk assessments, such as fire or premises. At this inspection, the practice had made limited improvements, for example, we saw building inspections were taking place. These had been intended to be monthly but were instead completed quarterly. All identified actions from the one inspection report we had sight of, dated March 2019, had not been fully addressed. Nor could we establish if further inspections had taken place and if the identified actions from those reports been addressed. The practice's infection prevention and control (IP&C) systems had deteriorated since our last inspection. We saw no records of legionella water testing happening between January 2019 and January 2020. On restarting the water checks, the practice's water temperatures were found not to be in line with national guidance relating to the prevention of legionella. We also saw evidence of ineffective cleaning measures and poor compliance with local clinical commissioning group IP&C audit standards, especially in relation to its domestic cleaning. The practice told us it had previously looked at changing its external domestic cleaning contractors but that it had not yet acted upon it due to the practice's commitment to recruiting new staff.	

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 to a limited extent.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	No
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 told us it did not formally undertake additional patient feedback survey other than the National GP Patient Survey. The practice told us its result in relation to patients' feedback about the overall experience of the practice had remained unchanged from 2018 to 2019, with a score of 89%. The practice's result for that question was higher than local and national averages. The practice showed us the aspirational plans it had to improve patient experience which included the introduction of a new user-friendly website and the offering of e-Consult to patients. Both actions were due to be implemented in April 2020.

The practice told us its previous patient participation group was defunct due to minimal engagement and poor representation of its demographic. As a result, the practice said it was looking at ways to move towards a virtual group to engage with patients. This was again aspirational as it was not due to implemented until April 2020.

Following the inspection, the practice told us its new website, which included links to e-Consult and the practice's patient participation group, was implemented in March 2020.

CQC comments cards	
Total comments cards received.	9
Number of CQC comments received which were positive about the service.	8
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC Comment cards	Positive comments provided by patients reported staff to be courteous, friendly and professional. Patients felt they were listened to and well looked-after. Staff had responded to concerns of a patient being unwell in the practice and acted upon those concerns to ensure a patient received the most appropriate care. Negative comments reported a deterioration at the practice, especially with regards to accessing prescriptions.
NHS UK Website	The practice had received four reviews on the NHS UK website since our last inspection. Of the four reviews, two were rated as 5-stars and two were rated as 1-star reviews. The practice had responded to all the reviews accordingly, including offering patients the opportunity to speak with the practice manager directly. Positive comments referred to staff supporting unwell patients, as well as providing appropriate and easy to understand information.

	Negative comments referred to the practice being in a period of transition but also a marked deterioration in supporting patients, in accessing appointments and acting upon patient requests for referrals.

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 continued to be a training practice, with four registered GP trainers. At the time of the inspection, the practice had three trainee GPs attached to it.	

Examples of continuous learning and improvement
Since our last inspection, the practice had implemented or participated in the following projects to continual learn and improve its service: • Productive general practice project to improve administrative role and free up clinical time for clinicians. • Workflow optimisation project to again improve the practice's administrative programme. • WISDOM project to support its diabetic care programme.

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.