Care Quality Commission

Inspection Evidence Table

[redacted]

Inspection date: [redacted]

Date of data download: [redacted]

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Overall rating: Requires Improvement

At the previous inspection on 12 February 2020, we rated the practice as inadequate. This was because the practice had not acted upon several issues we identified during our February 2019 inspection, which included lack of prescription security, the validity of patient group directions (PDG's) in use at the practice and evidence of oversight the work of clinical staff working at the practice. In addition, we found ineffective governance in some areas.

At this inspection we found the practice had made improvements and had introduced new policies, procedures and ways of working to improve the quality of the service. However, these had not yet had time to be reviewed or to embed and evidence results.

Safe Rating: Requires Improvement

At the previous inspection on 12 February 2020 we rated safe as inadequate, this was because the provider had failed to rectify the issues found at the previous inspection on 27 February 2019.

At this inspection on 9 and 10 November 2020 we found that the practice had responded to the issues raised at the previous inspection regarding safeguarding, medicines management, recruitment, risks to patients, and the management of significant events and safety alerts, and had started to make some improvements in all areas. However, further work still was required to fully implement, embed and then review these systems.

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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y

Safeguarding	Y/N/Partial
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	Partial

Explanation of any answers and additional evidence:

At the inspection in February 2020, the practice was unable to provide evidence of staff training, practice safeguarding policies, evidence that Disclosure and Barring Service (DBS) checks had been completed for staff, and the practice was not having regular discussions with health and social care professionals to support and protect adults and children at risk of harm.

At this inspection we found: -

- Seven out of eight non-clinical staff and five out of six clinical staff had completed PREVENT (safeguarding and supporting those vulnerable to radicalisation) training.
- Seven out of eight non-clinical staff had completed safeguarding adults' level two training and six out of eight had completed children's safeguarding level two, where staff had not completed level two training, they had completed level one training.
- All clinical staff had completed adults and child safeguarding training to an appropriate level for their role.
- The safeguarding policy was last reviewed in September 2020 and was used in conjunction with the local GP and Primary Care Safeguarding Handbook.
- The safeguarding policy included the protocol to follow up children if they did not attend appointments.
- The practice had completed DBS checks for all staff.
- The practice manager, who started working at the practice in September 2020, explained they had identified during the inspection process that the practice's patient record system did not alert staff to children under protection or those who may be vulnerable. The practice manager took immediate action and updated the patient record system. A review of six patient records by the inspection team confirmed this had been carried out.
- We reviewed two multi-agency safeguarding hub reports and found the GPs had completed and responded to them appropriately.
- The clinical staff told us prior to the COVID-19 pandemic they met monthly with other health professionals to discuss any child and adult safeguarding issues, however at present due to the pandemic this was not regularly carried out.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y

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.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, the practice was unable to provide any evidence that they were carrying out the recruitment of staff in accordance with the regulations. At this inspection we found: -

- We reviewed the recruitment file for a member of staff who had commenced employment following the previous inspection and found the practice manager had carried out appropriate recruitment checks.
- The practice provided information to demonstrate all staff had their hepatitis B vaccinations. However, we found they had not checked if staff had received any other vaccinations, as per Green Book guidance.
- The practice had an induction pack for all staff, which had been updated in August 2020.
- The practice held a record of professional registration dates for clinical staff, and this was checked during staff members' appraisals.
- The practice had a recruitment policy in place, which had been most recently reviewed in September 2020.
- The practice stated all the GP's and practice nurse medical indemnity cover was in place.

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: The practice had moved into new premises in December 2019 and as part of the move the practice had purchased new electrical equipment. The practice had arranged for a portable appliance testing for December 2020.	Y
There was a record of equipment calibration. Date of last calibration: 13 February 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 20 December 2019	Y
There was a log of fire drills. Date of last drill: 11 July 2020	Y
There was a record of fire alarm checks. Date of last check: Downstairs 27 October 2020, first floor 6 October 2020	Y
There was a record of fire training for staff. Date of last training: All within 12 months.	Y
There were fire marshals.	Y
A fire risk assessment had been completed.	Y

Date of completion: July 2020	
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, we found the practice was unable to provide evidence to demonstrate premises and equipment were safe.

At this inspection we found the practice had rectified this. For example: -

- A fire risk assessment had been carried out in July 2020 and the practice had acted on any identified issues.
- Staff had implemented a fire policy in June 2020, which identified the two designated fire marshals for the practice.
- All staff had completed their fire safety training and 11 had completed fire marshal training out of a staff team of 15.
- Staff checked fire alarms on alternate floors weekly.
- An independent company had carried out a legionella risk assessment in July 2020.

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

Explanation of any answers and additional evidence:

At the inspection in February 2020, as a result of the premises move in December 2019, the inspection team found some of the required building checks and assessments relating to the building had been not been completed. At this inspection we found: -

- The practice had an independent health and safety risk assessment and a disability access audit carried out in July 2020.
- Staff had carried out any recommended actions from the health and safety risk assessment. For example, they had displayed insurance, covered exposed wires on the ground floor and ensured fire exits were free of any combustible materials.
- Thirteen out of 15 staff members had completed health and safety training in 2019/20.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 01/06/2020 and 02/11/2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y

The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, the practice did not have an infection control risk assessment in place. At this inspection we found the practice had made improvements. For example:

- The practice had comprehensive infection control policies in place.
- The practice had implemented an infection control risk assessment from 1 June and reviewed this on 2 November 2020. The risk assessment stated it would be reviewed regularly during the COVID-19 pandemic and included specific infection control checks relating to COVID-19.
- There was a designated infection control lead.
- During the site visit we saw that the premises were clean and tidy, and staff were following national guidance in regard to coronavirus.
- All staff had completed infection control training.
- All non-clinical staff had completed hand hygiene training.
- The practice had a policy regarding the use of protective equipment. However, this required updating to ensure it complied with current guidance.
- Any patient invited to an appointment was triaged to assess any symptoms.
- The practice manager explained that all suspected COVID-19 cases were not seen at the practice but referred to the Primary Care Network commissioned services.
- After each patient's appointment, staff had clinical 'wipe-down time', to ensure all required surfaces were cleaned to reduce the risk of cross-contamination.

Risks to patients

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

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

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, the practice had not appointed a practice manager and there was no evidence that staff had completed sepsis training. At this inspection we found: -

- The practice had employed a practice manager from September 2020 who worked 35 hours per week. They were supported by a reception manager and six administration staff.

- The clinical staff consisted of the three partners, who carried out a total of 22 sessions a week and a permanent locum GP who carried out two consultancy sessions a week. (A session is approximately half a day)
- The practice had been unable to recruit a practice nurse but had a locum practice nurse who worked three sessions a week.
- The practice had a pharmacist who worked two sessions a week.
- All but one non-clinical staff had completed their child basic life support.
- Five out of six clinical staff and all the non-clinical staff had completed their adult basic life support training.
- All but one staff member had completed their sepsis training.
- Six out of eight non-clinical staff had completed first aid training.
- The practice manager provided examples of the changes made in response to the COVID-19 pandemic.

Information to deliver safe care and treatment

Staff generally had the information they needed to deliver safe care and treatment. However, further improvements were required in relation to oversight of pathology results.

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

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, the practice did not have effective oversight of pathology results. At this inspection we found: -

- The practice had a 'pathology tasks to action protocol' which had been updated in September 2020 and which clearly set out staff members' responsibilities for checking and responding to test results. In addition, the reception and practice manager checked these were actioned. Where test results identified borderline abnormalities, staff would contact the patient and ask them to return to the practice or have another blood test, however if the patient did not attend there were no further actions taken to follow up the patient.

- The staff had a system in place and a designated member of the administration team to ensure all referrals were made promptly and followed up.
- The practice had summarised patient computer records and checking patients' records transferred digitally from one GP to another where summarised appropriately. Summaries provide clinicians with a snapshot of patient's medical and social history.
- The practice had recently opted to digitalise all the patient paper records, although this had been delayed due to the COVID-19 pandemic.

Appropriate and safe use of medicines

The practice mostly had systems for the appropriate and safe use of medicines, including medicines optimization. However, further improvements were required to ensure a comprehensive recall system for annual medical reviews and for patients who did not attend appointments.

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) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.97	0.73	0.85	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). (01/07/2019 to 30/06/2020) (NHSBSA)	14.6%	9.0%	8.6%	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 (01/01/2020 to 30/06/2020) (NHSBSA)	7.22	6.92	5.35	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	0.88	No Data	1.92	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, we found unsafe storage of medicines, staff did not have the appropriate authorisation to administer medicines, there was a lack of review of antimicrobial usage and there were no child pads for the defibrillator. At this inspection we found:

- Medication was now stored safely, and the practice followed a cold chain procedure for the maintenance of vaccines.
- The practice has a pharmacist that worked one day a week, their role included medication reviews and independent prescribing, which was supervised and monitored by the partners.
- We reviewed high-risk medication and found they had been monitored appropriately and the practice had completed an audit of patients prescribed methotrexate and made improvements.
- Patient group directions for clinical staff to administer medicines were in place.
- The GPs explained the system they had previously used to carry out annual medication reviews was no longer functional. This was evidenced by the practice not identifying over-prescribing of

Medicines management	Y/N/Partial
repeat salbutamol inhalers. The practice had carried out an annual medication review of 58% of patients on repeat medicines from April 2019 to 12 November 2020. • We reviewed five out of 24 patients who were prescribed a specific medicine and found three had not had their creatine clearance recalculated when there were changes to their weight. This was discussed with the GPs who agreed that a system needed to be set up to ensure this was recalculated when there was any change to the patient's circumstances. • A review of some high-risk medicines demonstrated that the patients were contacted, and appointments made but the practice did not have a system in place should they not respond to the requests to make contact. For example, we reviewed 15 patient records on methotrexate, Ace Inhibitors and azathioprine which identified patients were contacted twice, but if they did not turn up for these appointments there was no further action. • The practice carried out a review of antibacterial usage in October 2019, the recommendation for this was for the practice to prescribe by the antibiotic guidance.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, however the new systems implemented by the practice required further time to embed.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	1
Number of events that required action:	1

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, the practice could not evidence that they were identifying and responding to significant events appropriately. At this inspection we found: -

- The practice had implemented a new system to log all significant events. However, this was not fully embedded during the inspection. For example:
  - Although we were provided with one significant event raised in June 2020, which demonstrated that staff had reviewed the issue and had made recommendations for the practice, the GP partners told us about a further significant event which had not been recorded.
  - There was no evidence that significant events were discussed at staff or clinical meetings and that any learning was shared with staff.

Example of significant events recorded and actions by the practice:

Event	Specific action taken
The patient's relative was unhappy about the	In response the practice had: - • Reviewed all patients records on the Palliative Care Register.

number of visits to their relative.	• Engaged more with the Palliative Care Team. • Planned in future clinical meetings to discuss all patients on the palliative care register. • Planned to sign up to the Gold Standard Framework to adapt the benefits of the toolkit for palliative care.

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

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, we found the practice did not have a system in place for the management of safety alerts. At this inspection we found:-

- The practice had a safety alert protocol and procedure in place which had been reviewed in September 2020.
- The practice manager received safety alerts and under the instruction of the GPs carried out clinical searches to identify any patients that maybe affected.
- A review of the clinical records demonstrated that, in response to safety alerts received, the practice had identified any affected patients and taken appropriate action.
- However, the locum practice nurse told us they had not received any information about safety alerts.

Effective Rating: Requires Improvement

At the previous inspection on 12 February 2020, we rated the practice as requires improvement. This was because the practice had low uptake rates for child immunisation and cervical screening for 2018 to 2019. In addition, patient indicators demonstrated an issue with diabetes management, and the practice had carried out a minimal number of NHS health checks for patients between the ages of 45-70.

At this inspection we have continued to rate the practice as requires improvement. Although we found the practice had made some improvements, such as in relation to training and systems to ensure patients had received appropriate care and treatment, these had not had time to embed and demonstrate results. In addition, further improvements were required to ensure that all patients' care and treatment was reviewed and updated regularly.

The issues we identified (set out in the above paragraph) did not affect all the population groups. The population groups of 'people whose circumstances make them vulnerable', 'people experiencing poor mental health' and 'older people' are rated good. The population groups 'people with long-term conditions', 'families, children and young people' and 'working age people' are rated as requires improvement.

Effective needs assessment, care and treatment

Patients' needs were mostly assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, further improvements were required to ensure patient treatment was regularly reviewed and updated.

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

The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Explanation of any answers and additional evidence:

- Staff had completed General Data Protection Regulation (GDPR) training.
- The practice had implemented a policy to instruct staff on the use of the online consultation service in September 2020.
- The practice manager explained that all suspected COVID-19 cases were offered appointments by the Primary Care Network commissioned services. The discharge summaries of the appointments were returned to the practice via the surgery email and where required the GP provided follow up.
- The practice did not have an effective system to review patients on repeat medicines and to follow up on some blood tests, which resulted in some patients' treatment not being reviewed and updated regularly.

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) (01/07/2019 to 30/06/2020) (NHSBSA)	0.82	0.72	0.70	No statistical variation

Older people — Population group Good

Findings

- Immunisations continued to be offered to older people including shingles, pneumonia and seasonal influenza where safe to do so. For example, the practice had immunized 251 patients for seasonal influenza over the age of 65 years at the time of the inspection and were planning to hold two further clinics.
- For older patients who could not leave their homes, flu vaccinations were offered by specially commissioned services.
- During the COVID-19 pandemic the practice had telephoned the registered carers or next of kin of the patients on the frailty register and asked how they were managing and offer any support available. Carers were encouraged to telephone the practice for repeat medication and were informed any chronic diseases would be reviewed over the phone.
- The pharmacist carried out some annual medication reviews by telephone.
- During the pandemic older people were risked assessed prior to inviting them to attend an appointment at the surgery.
- The practice had postponed NHS Health checks for patients over 75 due to the COVID-19 pandemic and planned to recommence this once it was deemed safe for them to attend the surgery.
- 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.

People with long-term conditions — Population group rating: Requires Improvement

Findings

- The practice had continued to perform below the national average for the management of blood glucose for patients with diabetes. For example, the practice had achieved 49.9%, which was considerably lower than the CCG average of 66.6% and the national average of 62.2% for 1 April 2019 to 31 March 2020.
- A search of patient records indicated that 29 patients had a blood test result which had indicated a potential diagnosis of diabetes, but this had not been diagnosed or treated. A review of seven patient records identified four which had missed follow up appointments and two which were incorrectly coded in the patient records. This was discussed with the provider who submitted a review of the finding. This found most patients had not been correctly identified on the patient record system and were categoriesd as low risk and four patients were required follow up.
- During the COVID-19 pandemic, where patients with hypertension had a blood pressure machine at home, the practice asked the patient or their carer to take the readings and send them to the practice by email or text message.
- Staff offered patients with chronic diseases telephone consultations for their reviews.
- Patients were invited in for diabetic foot checks and the urgent essential asthma reviews.
- Asthmatic patients were advised use peak flows equipment at home and let the surgery know of their readings.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- 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.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	84.5%	No Data	76.6%	No statistical variation
Exception rate (number of exceptions).	8.7% (29)	7.1%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	86.0%	89.6%	89.4%	No statistical variation
Exception rate (number of exceptions).	6.5% (3)	No Data	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison

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 (01/04/2019 to 31/03/2020) (QOF)	89.1%	-	91.8%	No statistical variation
Exception rate (number of exceptions).	9.8% (6)	No Data	4.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had not met the World Health Organisation target of 90% for all four childhood immunisation indicators.
- The practice manager commenced in September 2020 and had implemented a system to ensure that children due for immunisations were recalled by telephone call, text messages and letters. This included introducing a system whereby if a child did not attend their appointment, staff would call them the next day to arrange a further appointment and, if they declined, an appointment would be made with the GP to discuss their reasons.
- During telephone consultations GP's have had the opportunity to give health promotional advice as regards to immunisations and screening.
- In response to the COVID-19 pandemic, to reduce visits to the surgery, post-natal appointments were carried out at eight weeks so the childhood immunisations could be completed at the same time.
- The practice nurse provided evidence of their immunisation and vaccination training for 2019 and 2020.
- 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.

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)	66	80	82.5%	Below 90% minimum
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)England)	52	65	80.0%	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)	49	65	75.4%	Below 80% uptake
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)	53	65	81.5%	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 provided data from the patient record system, which had not been verified by CQC, to demonstrate current performance from 1 April 2020 to 31 March 2021: - • 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) out of 64 eligible patients approximately 58 had received the vaccine. • 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) out of 68 eligible patients approximately 64 had received the vaccine. • The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) out of 68 eligible patients approximately 56 had received the vaccine. • The percentage of children aged 2 who have received immunisation for measles, mumps and rubella out of 68 eligible patients approximately 59 had received the vaccine.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings
• The practice's uptake rate for cervical screening as of March 2020 was below the Public Health England target of 80% at 63%. • The practice had carried out seven NHS health checks prior to the COVID-19 pandemic. However, during the pandemic they had postponed inviting patients for health checks. • The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. • 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	63.1%	N/A	80% Target	Below 70% uptake

to 64). (Snapshot date: 31/03/2020) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	75.6%	No Data	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)	46.6%	48.1%	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. (to) (PHE)		-		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)	71.4%	No Data	53.8%	No statistical variation

Any additional evidence or comments

- The practice submitted a copy of the 'cervical screening patient follow-up protocol', last updated in October 2020, which set out that staff would contact patients who did not attend appointments and, if the patient declined an appointment, they would be booked in with the GP to discuss their reasons.
- The 'management of inadequate cervical smear' policy had been reviewed in October 2020. This stated all inadequate smears were to be recorded onto the clinical system and patients were to be entered into the diary. An audit was carried out every six months to ensure these were all followed up.
- The practice told us that, due to the COVID-19 pandemic, cervical screening was stopped in April 2020 and recommenced in mid-June 2020. From June patients were invited in for cervical screening, following a telephone call where coronavirus triage questions were asked, and reassurance was given regarding the wearing of personal protective equipment by staff.
- At the time of the inspection the practice manager submitted data not verified by CQC that showed the practice had completed 58% of eligible patient aged 25 to 49 and 84% of patients aged 50 to 64 years.
- The practice manager explained the lack of a full-time practice nurse had impacted upon the service, however they hoped to employ a permanent practice nurse shortly.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- During the COVID-19 pandemic, patients with learning disabilities annual consultation reviews were carried out by telephone. Prior to the review patients and their carers were asked to complete and submit a care plan.
- The practice liaised with various support multi-disciplinary teams.
- Patients were offered self-referral to Improving Access to Psychological Therapies (IAPT) services where required.

- NHS England guidelines and actions for the vulnerable patients during the pandemic were acted on. For example, informing patients with stage five kidney failure that they will be contacted by their renal unit.
- Same day appointments and longer appointments were offered when required.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice had 46 patients on the mental health register, who were offered a telephone consultation for their annual review.
- We reviewed four patient records and found that care plans were completed.
- All patients with dementia had regular reviews by a telephone consultation and their care planning was carried out with close liaison with their next-of-kin or carers. If appropriate, they were referred for the integrated care management.
- The surgery worked with the multi-disciplinary teams in the management of people with poor mental health, and dementia.
- The surgery during the pandemic has continued to signpost patients with poor mental health to the appropriate teams or support groups.
- When patients with poor mental health reviews were seen by the community teams these were flagged to the GP's and where appropriate and required telephone reviews have been made.
- Seven out of eight non-clinical staff had completed dementia awareness and mental health training.
- 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.

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 (01/04/2019 to 31/03/2020) (QOF)	86.1%	86.3%	85.4%	No statistical variation
Exception rate (number of exceptions).	7.7% (3)	No Data	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	74.4%	-	81.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	No Data	8.0%	N/A

Monitoring care and treatment

The practice had implemented a comprehensive programme of quality improvement activity. However, this was yet to be fully embedded.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	506.1	539.5	539.2
Overall QOF score (as a percentage of maximum)	90.5%	No Data	No Data
Overall QOF exception reporting (all domains)	5.1%	4.9%	5.9%

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

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

- The practice manager had introduced a list of planned quality improvement audits, however these had yet to be carried out. These included: -
  - An audit of urgent referrals.
  - Cervical screening carried out and Inadequate Smears Audit
  - Repeat prescribing audit.
  - Hand hygiene survey.
  - Antimicrobial usage audit
- The GPs described their improvement work within the clinical commissioning group and their local primary care network.
- We were provided with two completed audits where recommendations had been made: -
  - From 1st January and 30th June 2020, a review of 12 patients prescribed methotrexate to compare with the shared care guidelines for the methotrexate five standards. This found three of the standards sets were met completely, however appropriate patient blood monitoring intervals were not always met. A review demonstrated this may be due to the pandemic and blood tests authorised by secondary care which the practice had not received. Recommendations from this were this should be identified in the patient records and followed up.
  - From 1 January to 30 June 2020 a review of patient records for patients aged over 75 who were not on the osteoporosis register. This generated eight patients referred for a bone density scan and three were commenced on calcium and vitamin D supplements.

Effective staffing

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

Explanation of any answers and additional evidence

At the previous inspection we found the practice did not have a programme of learning and support in place for staff. At this inspection we found: -

- The new practice manager had put a robust programme of learning in place for staff.
- Most staff had completed the necessary training to ensure they were skilled for their role.
- The practice manager had a plan in place to ensure that staff had an annual appraisal
- The practice nurse provided evidence of her immunisation and vaccination training for 2019 and 2020.
- The practice manager started work in September 2020 and informed us they had not had enough time to update staff appraisals. At the time of the inspection, three non-clinical staff had completed their appraisals.
- We were told the locum practice nurse and pharmacist both feedback to the GP on site at the end of their sessions regarding any clinical queries. However, this was not recorded as part of their clinical supervision.
- Information demonstrated that for a clinical member of staff, the practice had not ensured their training was updated appropriately or reviewed, and the practice had not identified this as a possible risk.

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: • At the previous inspection in February 2020, we found the practice did not have any evidence they were attending meetings with other health professionals. At this inspection, the GPs and practice manager explained the meetings had not been as often as normal due to the COVID-19 pandemic and when carried out were by telephone conference.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: • Most non-clinical staff had completed a care navigation course, which instructed them on how to offer patients social support options. • The primary care network was implementing a wellbeing service in November 2020, which the practice could refer patients to. • The practice provided information to patients regarding obesity and smoking cessation. • The practice had ceased NHS health checks due to the COVID-19 pandemic, but had planned to reintroduce them as soon as it was safe to do so.	

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 (01/04/2019 to 31/03/2020) (QOF)	94.5%	95.8%	94.5%	No statistical variation
Exception rate (number of exceptions).	0.6% (10)	No Data	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: • The practice's electronic patient record system was used to review whether consent was sought appropriately. • The practice did not carry out surgical procedures. • All clinical staff and six out of eight non-clinical staff had completed Mental Capacity Act and Deprivation of Liberty training. • All non-clinical staff had completed patient consent training.	

Caring Rating: Good

At the previous inspection on 12 February 2020 we rated the practice as requires improvement because the practice's national GP patient survey results were lower than the national average and the practice had not acted on these results or undertaken any in-house patient satisfaction surveys.

At this inspection we have rated the practice good because they have completed an in-house satisfaction survey and have recently commenced an action plan to improve patients' experience.

Kindness, respect and compassion

Staff treated with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: • Seven out of eight non-clinical staff had completed customer care training.	

Source	Feedback
NHS choices	The practice has one review following the previous inspection in February 2020 which was very positive, stating that the GPs were good and knowledgeable and that most reception staff were good.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	80.3%	No Data	88.5%	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 (01/01/2020 to 31/03/2020)	80.6%	No Data	87.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and	83.6%	92.6%	95.3%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	69.3%	No Data	81.8%	No statistical variation

Any additional evidence or comments
• For the previous GP survey carried out from 1 January to 31 March 2019 the practice achieved 63.7% for patients who responded positively to the overall experience of their GP practice. The data for 1 January to 31 March 2020 had risen to 69.3%. • The practices own survey carried out from 7 to 14 August 2020, where between 88 and 244 patients had responded to the questions about how they would rate their overall experience 92% stated they were good or very good.

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

Any additional evidence
• In response to the GP survey, the practice had carried out its own survey from 7 to 14 August 2020, where between 88 and 244 patients had responded to the questions. The survey questions corresponded with the national GP survey. Results were: - ➢ 70% of patients were satisfied or very satisfied with the way tests and treatments were explained by the GP. ➢ 80% of patients stated the last GP they saw was good at listening to them. ➢ 85% of patients stated they thought the GP was confident and trustworthy. ➢ 81% of patient populations said the GP treated them with care and concern ➢ 100% of patients stated they found the nurse confident and trustworthy. ➢ 90% of patients rated the practice either very good or good.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: • The practice had both easy read and pictorial materials available for patients. • Non clinical staff had completed a care navigation course.	

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 (01/01/2020 to 31/03/2020)	85.9%	90.2%	93.0%	Tending towards variation (negative)

Any additional evidence or comments
• In response to the GP survey, the practice had carried out its own survey from 7 to 14 August 2020, where between 88 and 244 patients had responded to the questions. The survey corresponded with the GP survey. Results were: - ➢ 86% of patients stated the last GP they saw or spoke to was good at involving them in decisions about their care. ➢ 88% of patients stated they were satisfied or very satisfied with the way tests and treatments are explained to them.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	N
Explanation of any answers and additional evidence: • Staff had completed the care navigation course to enable them to advise patients about the availability of support groups. • The practice manager explained they had information available in braille, easy read and pictorial. • The practice's website had not been updated and did not contain the relevant information, however the practice manager explained they had recently moved the internet provider of their website and hoped this would enable them to easily update it.	

Carers	Narrative
Percentage and number of carers identified.	The practice had 43 carers out of a patient population of approximately 7,191 patients. 0.7% of the practice population group.
How the practice supported carers (including young carers).	• The practice was now using the patient record system to identify carers and added an alert to the system. • The practice provided longer appointments.

	• The staff offered social prescribing referrals for support to other agencies.
How the practice supported recently bereaved patients.	• The GPs offered a follow up with a telephone conversation during the pandemic and staff aware of bereavement services.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence: • The practice offered an electronic prescription and appointment service. • The service offered an online consultancy service. Via e mail or teleconference. • 33% of patients had signed up to use online services at the practice.	

Responsive Rating: Requires Improvement

At the previous inspection on 12 February 2020 we rated the practice requires improvement because the practice had not complied with the accessible information standard, had not understood the needs of the local population and there was a lack of evidence that the practice had responded to complaints.

At this inspection, we have continued to rate the practice as requires improvement. This was because, although we could evidence improvements in the practice's understanding of the needs of the different patient population groups, the accessible information standards, complaints handling and the response to the patient survey, the practice's planned actions in response to the patient survey had yet to be implemented.

We identified some concerns around patients' access to the service, which affected all population groups and therefore all population groups have been rated as requires improvement for responsive.

Responding to and meeting people's needs

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

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

Explanation of any answers and additional evidence:

- The practice manager had ensured the practice met the accessible information standard by introducing
  - A braille leaflet
  - Pictorial cards with makaton signs now in use.
  - Hearing loop for patients with a hearing impairment.
  - Large Print available upon request.
  - Accessible information posters are displayed in the waiting area.
  - Wheelchair access to the building.
  - GPs and Nurse clinics available on the ground floor.
  - Staff were alerted to patients access needs in the patient records.
  - MAKATON and British Sign Language cards were made available at reception if needed.
  - Pre-Hospital Communication book
- All non-clinical staff had completed their accessible information standards training
- The practice manager explained the appointment systems had changed due to the COVID-19 pandemic. All appointments were telephone consultations with the GP. Patients could pre-book these appointments or call on the day. Any patient requiring a face to face appointment would

only be offered this once the GP had triaged the patient by telephone and if a video consultation would not suffice.

- When booking telephone consultations, the reception staff gathered as much information as possible to add to the reason of the appointment. Where required, staff used the secure NHS approved messaging service for patients to reply back, where patients could take a picture of their problem if appropriate and send it to be saved onto their clinical records. This helped to ensure the GPs had effective consultations with the patient when relating to the problem and reduced the necessity of patients attending the surgery.
- Dependent on the local restrictions and safety measures required, the practice nurse's appointments for long-term conditions were telephone assessed unless the essential checks and attendances were required. At time of the inspection the practice nurse only saw patients for cervical screening, and adult and child vaccinations.
- The practice had reviewed their home visiting guidance in response to the pandemic. Some patients were presently referred to a local service which completed all home visits.
- At the time of inspection, the practice had four telephone lines for patients to call into the practice and two for staff to call out.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 7.30pm
Tuesday	8am to 7.30pm
Wednesday	8am to 7pm
Thursday	8am to 7pm
Friday	8am to 7.30pm
Appointments available:	
Monday	9.30am to 7pm
Tuesday	9.30am to 7pm
Wednesday	9.30am to 6.30pm
Thursday	9.30am to 6.30pm
Friday	9.30am to 7pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	86.6%	No Data	94.2%	Tending towards variation (negative)

Any additional evidence or comments

- The practice nurse offered appointments on Tuesday and Wednesday from 10am to 1pm and Thursday from 2pm to 5.30pm.
- The clinical pharmacist worked one day a week and would carry out patient asthma reviews.

- Patients were requested to telephone before 11am if a home visit was required that day.

Older people

Population group rating: Requires Improvement

Findings

- The practice had responded to the COVID-19 pandemic and ensured all older patients had a telephone triage appointment before they attended the practice to ensure their safety.
- The practice was responsive to the needs of older patients and worked in conjunction with the local federation to offer home visits.
- All patients over the age of 75 had a named GP.
- The practice provided effective care coordination to enable older patients to access appropriate services. Since the pandemic the GPs meet with other services via Zoom meetings.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients by the local pharmacist.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment, which were longer.
- 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. Due to the pandemic this was now carried out by video conference.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Additional nurse appointments were available until 7pm on a Thursday for school age children so that they did not need to miss school.
- The practice manager explained there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings
• The practice offered e-consultation for all patients. Dependent on the urgency of the e-consultation the patient was booked a telephone consultation with the GP. • The practice had GP appointments from telephone consultation availability and extended hours availability between 6.30pm and 7.30pm Mondays, Tuesdays and Fridays to accommodate those who worked. • The practice nurse worked flexibly to accommodate those patients and children who could not attend during work or school days. • The practice had been able to accommodate the patient needs of requiring follow up after their working hours. • Patients had access GP hub service, which was open from 2pm and 9pm on weekdays and between 9am and 6pm on Saturdays and Sundays.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings
• The practice held a register of patients living in vulnerable circumstances including homeless people, a learning disability • People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and travelers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability provide longer appointments and a named GP.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

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. • Staff had trained to help patients access Improving Access to Psychological Therapies (IAPT) support line.

Timely access to the service

People were not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y

The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

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 (01/01/2020 to 31/03/2020)	43.6%	N/A	65.2%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	45.6%	55.5%	65.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	50.1%	No Data	63.0%	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 (01/01/2020 to 31/03/2020)	51.8%	No Data	72.7%	Variation (negative)

Any additional evidence

- The practice had responded to the COVID-19 pandemic and rearranged their appointment system to ensure patients were safe and only had a face to face appointment if necessary.
- The practice's GP patient survey results for 2020 demonstrate a decrease from the previous year's results.
- However, in response to the GP patient survey, the practice had carried out its own survey from 7 to 14 August 2020, where between 88 and 244 patients had responded to the questions. The survey asked similar questions to the GP survey demonstrated a slight improvement. The results were: -

➢ 55% of patients stated it was not so difficult to make an emergency appointment and 45% stated it was difficult.
➢ 66% of patients stated it was not so difficult to make a routine appointment and 35% stated it was difficult.
➢ 44% of patients stated their experience of making a telephone appointment was not so difficult and 56% found it difficult.
➢ 66% of patients found their experience of using the online consultancy system not so difficult.
➢ 52% of the patients stated they were satisfied with the appointment system and 17 % stated they were not.
➢ 47% of patients stated they usually wait up to 15 minutes or less after their appointment time to be seen.

➢ 90% stated they usually booked their 73% of patients stated their consultation with the GP lasted longer than 10 minutes. ➢ 77% of patient stated they were given enough time.

Continuous improvement and innovation

Source	Feedback
• In response to the practice patient survey	• The practice manager had completed an action plan and recognised an area for improvement was telephone access. The recommended actions were a review of the number of telephone lines at the practice, promoting the online consultation service via e-mail and creating a telephone option system to distribute the calls.

Listening and learning from concerns and complaints

Complaints were listened and responded to.

Complaints	
Number of complaints received in the last year.	4
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.	Partial
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: • All non clinical staff had completed complaints management training. • The practice had a complaints policy and leaflet available. • However, the practice's website was awaiting an update that would include information about complaints. • The practice provided evidence of improvement from one complaint that was also raised as a significant event.	

Well-led Rating Requires Improvement

At the previous inspection on 12 February 2020 we rated well led as inadequate, this was because the provider had failed to rectify the issues found at the previous inspection on 27 February 2019.

At this inspection, we have rated the service requires improvement. This was because we found the provider had made improvements by reviewing or initiating new policies and systems. However, some of the policies or systems needed to be embedded to further ensure the quality of the service going forward and ensure any changes were sustained.

Leadership capacity and capability

There was mostly effective leadership at all levels.

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

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, we found the lack of a practice manager had affected the effective leadership of the practice. At this inspection we found:-

- The GPs explained that they understood the challenges to the practice during the pandemic.
- The provider had recruited a practice manager in September 2020.
- The practice manager was supported by a reception manager.
- The practice partnership had increased to three GPs, who were in the process of the registration of the practice with CQC.
- The GPs explained that during the COVID-19 pandemic, two of them had been unable to return to work.
- At the previous inspection staff stated that the GP partners were visible and approachable.

Vision and strategy

The practice had a vision, which was mostly supported by a credible strategy to provide quality and sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial

Explanation of any answers and additional evidence:

- The practice manager had recently implemented a development plan in November 2020 with the support of the GP partners, which stated the planned actions would enable the direct involvement of the team in the decision-making process, enhanced communications and rapid responses to business issues, and improve a collaborative working environment, and promote changes. However, this had not been fully implemented embedded at the time of our inspection.

Culture

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

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

Explanation of any answers and additional evidence:

- The practice had a whistleblowing policy which had been reviewed in September 2020.
- The practice manager was aware of achieving compliance with the requirements of a duty of candour.
- Seven out of eight non clinical staff had completed whistleblowing training.
- Seven out of eight non-clinical staff had completed equality and diversity training.
- The practice manager had completed training on how to support staff during the COVID-19 pandemic.

Governance arrangements

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

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

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, we found the governance arrangements were ineffective. At this inspection we found new governance arrangements were in place. For example: -

- The practice manager had reviewed and updated all of the practice policies and procedures in August and September 2020.
- The practice manager had allocated the non-clinical staff with lead roles to ensure that systems were more effective.
- The clinical staff had distributed clinical leads to ensure all long-term conditions were followed up.
- The GPs had clinical oversight of the practice nurse and pharmacist and offered clinical support, although this was not being documented.
- Most staff had completed the appropriate training for their role.
- The practice manager was in the process of updating the practice website.
- However, as the practice manager had only commenced work in September 2020, they had not had time to implement and embed all changes fully. For example, the system to review repeat medications and the follow up of abnormal blood results were not fully effective.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, however some were not fully implemented or embedded.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2020, we found the practice did not have effective arrangements for identifying, managing and mitigating risks. At this inspection we found: -

- The practice had put systems in place to manage risks regarding the premises and equipment, and the prevention and control of infections.
- They had introduced and begun to implement new systems that would enable them to identify risk.
- The practice manager had recently introduced a clinical and internal audit agenda.
- The practice had updated their business continuity plan and had mitigated risk during the COVID-19 pandemic.
- However further improvements were required to identify risk regarding patient care and treatment and medicines management.

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.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:

- The new practice manager demonstrated commitment to using data and information proactively to drive and support decision making.
- The practice had reviewed their performance using the quality outcomes framework, however due to the COVID-19 pandemic this was difficult to follow, at the time of the inspection the practice was looking at other ways of reviewing their performance.
- The practice manager understood their responsibilities to make statutory notifications.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

Engagement with patients, the public, staff and external partners

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

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

Explanation of any answers and additional evidence:
The practice manager planned to improve the communication with the patient participation group, as the last meeting was held on 5 December 2019 prior to the onset of the COVID-19 pandemic.

- The clinicians explained that they held weekly clinical meetings, however these had stopped due to two partners unavailability from April to September. We were provided with evidence of two clinical meetings held on 8 and 18 September 2020.

- We saw evidence the practice had held a non-clinical staff meeting in February and October 2020. The practice manager was working towards monthly teleconference meetings.
- The practice had an employee handbook updated September 2020 which provided staff with information about working at the practice.

The GPs described their contributions to the local primary care networks.

Continuous improvement and innovation

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

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

Explanation of any answers and additional evidence:

- The GP partners involved with the local primary care network.
- The practice manager had were introduced an annual audit agenda.
- The practice manager had introduced a training schedule to promote learning for non-clinical staff.
- The practice had an improvement plan in place commenced November 2020.

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.