Care Quality Commission

Inspection Evidence Table

Severn Surgery (1-570872420)

Inspection date: 27 November 2019

Date of data download: 14 November 2019

Overall rating: Good

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

Safe Rating: Good

Safety systems and processes

The practice had clear 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
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.	Y
Explanation of any answers and additional evidence: The safeguarding lead had undertaken an evaluation of in-house safeguarding processes to ensure their most vulnerable patients were being identified and managed safely. The management team explained the evaluation involved a monthly review of the safeguarding process; attending quarterly safeguarding forums as well as discussions during the practice clinical meeting.	

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.	Y
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:	

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: 03/10/2019	Y
There was a record of equipment calibration. Date of last calibration: 16 January 2019	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: 02/09/2019	Y
There was a log of fire drills. Date of last drill: 21/11/2019	Y
There was a record of fire alarm checks. Date of last check: Annual maintenance was undertaken by a contractor in June 2019, and weekly alarm checks were undertaken and recorded by practice staff.	Y
There was a record of fire training for staff. Date of last training: All completed within the last 12 months	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 29 January 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Records showed actions to ensure compliance with recommendations following the practice fire risk assessment had been acted on. For example, records showed evidence of six monthly fire drills, a fire alarm had been installed and arrangements for yearly servicing was in place. A comprehensive legionella risk assessment was completed for the premises in March 2019. The risk assessment identified various recommendations and the practice had taken action to address these. The practice had implemented systems to record water temperatures and the flushing of specified water outlets. Remedial work to the site identified within the risk assessment had been completed, and we saw evidence of this at our inspection.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: March 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2019	Y
Explanation of any answers and additional evidence:	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were mainly 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: 14 May 2019	Y
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.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

The management team provided evidence of engagement with local infection prevention and control (IPC) nurse leads to ensure compliance with IPC audit recommendations. For example, the practice had received quotes to replace the carpet in consulting rooms with washable laminated flooring and were seeking guidance regarding the requirements of the type of flooring most appropriate to ensure compliance. During the negotiation and planning stages the practice carried out a risk assessment which included ensuring risky procedures were carried out in the one clinical room which had laminated flooring. Risks had been placed on the practice risk register and the anticipated completion of work required to replace flooring was set for nine months from the date of the IPC audit. The practice also obtained quotes for the replacement of sink taps in consulting rooms and explained financial constraints had delayed completion of this action.

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	Y

impact on safety.	

Explanation of any answers and additional evidence:

Members of the management team explained the practice used dashboards to monitor staffing levels which enabled timely actions such as the management of annual leave to ensure cover was arranged in advance.

The practice carried out a successful recruitment campaign which enabled them to strengthen the clinical team. Recently recruited members of the nursing team were progressing through training to support their role within primary care and we saw records which showed this process was being managed safely.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

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

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.69	0.86	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). (01/07/2018 to 30/06/2019) (NHSBSA)	12.5%	10.3%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	4.79	5.24	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.64	2.29	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
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.	Y
The practice had a process and clear audit trail for the management of information about	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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:

The practice demonstrated awareness of their antibiotic prescribing which was higher than local and national averages. The practice identified the root causes and held discussions with locums regarding local and national prescribing guidelines. Discussions were also recorded as part of locums' monthly supervisions.

Clinical leads carried out retrospective audits of medicine prescribing across all members of the clinical team. For example, an ANP prescribing audit was carried out between March and August 2019. Records showed 100% (27) of patient reviewed by the ANP were prescribed medicines in line with national prescribing guidelines. The ANP received monthly clinical supervision and records we viewed evidenced this; we also saw evidence of monthly supervisions carried out with locum GPs.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months: (recorded since June 2019 inspection)	Three
Number of events that required action:	Three
Explanation of any answers and additional evidence: Significant events were a standing agenda item on both clinical and general staff meetings and we saw meeting notes where significant events were discussed.	

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

Event	Specific action taken
Samples left in vaccination fridges and not sent off for analysis.	Discussed with clinical staff, samples discarded and identified patients contacted; invited in to repeat tests.
Vaccination fridge stopped working and went outside of the recommended range	The practice notified NHS England and contacted the vaccine manufacturers for guidance. Vaccines were discarded in line with recommendations and practice policy. The practice obtained data loggers (an electronical temperature monitoring device for fridges and freezers storing vaccines). Temperature readings were downloaded weekly and the practice protocol included testing of the data logger battery and replacement.

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: Following the appointment of senior managerial staff, the practice had reviewed and strengthened processes to disseminate and act on information from external sources which could affect patient safety. Safety alerts were a standing agenda item at clinical meetings; a log of safety alerts was maintained and monitored by the management team. Systems were in place to ensure all future safety alerts were actioned.	

Effective Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was mainly delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

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

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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.76	0.59	0.75	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.

- Birthday cards were sent to patients on their 75th birthday inviting them for an annual health check
- 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 such as specialist diabetic nurse to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. We also saw some specific training as well as shadowing for newly recruited clinical staff were ongoing and there were areas where staff were awaiting sign off.
- 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. The practice recognised the decline in performance and arranged designated COPD clinics to improve performance. Unverified data provided by the practice demonstrated positive impact since the recruitment of practice nurses and implementation of the designated clinic.
- 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)	76.9%	82.0%	79.3%	No statistical variation
Exception rate (number of exceptions).	1.7% (6)	10.4%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	57.2%	76.6%	78.1%	Variation (negative)
Exception rate (number of exceptions).	4.5% (16)	10.2%	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)	76.8%	83.2%	81.3%	No statistical variation
Exception rate (number of exceptions).	8.4% (30)	12.4%	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)	70.7%	74.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	4.0% (10)	8.8%	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)	78.9%	89.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	7.3% (3)	12.3%	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)	81.1%	82.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.1% (13)	4.2%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	92.7%	94.7%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.5% (2)	5.4%	5.9%	N/A

Any additional evidence or comments

Quality Outcomes Framework (QOF) indicators for long-term conditions:
Members of the management team explained a period during the 2018/19 QOF year where the practice did not have a permanent practice nurse coupled with the practice going through significant staff restructuring as well as reduced clinical provisions had impacted on QOF performance. The practice carried out a successful recruitment campaign which resulted in recruitment of a permanent practice nurse and a health care assistant (HCA). The practice continued working with a specialist diabetic nurse who attended the practice on a two weekly basis and introduced dedicated COPD clinics. The management team explained the skill mix of the newly appointed nursing team was much broader and unverified 2019/20 QOF data provided by the practice showed positive impact on performance. Staff explained the practice was moving in the right direction to achieve QOF points while improving clinical outcomes.

Families, children and young people Population group rating: Good

Findings

- The practice has not met the minimum 90% target for three of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice was aware of childhood immunisation uptake and were working with external stakeholders as well as developing engagement with external services commissioned to update Child Health Surveillance (CHIS) to improve the accuracy of data. Engagement with stakeholders enabled the development of an action plan which detailed areas where the practice was advised to priorities. Records showed the practice had commenced taking action.
- The practice strengthened their system for contacting parents or guardians of children due to have childhood immunisations and we saw appointments had been booked for children who were overdue their immunisation.
- 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)	24	27	88.9%	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)	26	30	86.7%	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)	26	30	86.7%	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)	26	30	86.7%	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 demonstrated awareness of the decline in the uptake of childhood immunisation between 2017/18 and 2018/19; the practice received support from the local screening and immunisation coordinator who identified various issues which impacted on the accuracy of data. For example; during May 2019 vaccines were being administered by locum staff and despite uptake being recorded in patient notes the information had not been forwarded to the relevant external service so that the CHIS could be updated. Staff we spoke with explained action had been taken and processes had been established to ensure historical as well as future data was faxed to the relevant services.

The practice made contact with all parents or legal guardian of children identified as priority as well as children who were overdue their vaccination by either letter or phone contact. We saw appointments had been booked and the practice established a dashboard which enabled the management team to monitor progress. The practice dashboard showed out of a total of seven children, five had been booked in with the nursing team, one patient had moved out of area and one patient was all up to date with all vaccinations which was confirmed by parent. Staff explained arrangements had been made with Leicestershire Partnership NHS Trust (LPT) who would be carrying out home visits.

Newly appointed nursing staff had completed childhood immunisation training and were preparing to support efforts to improve immunisation uptake.

The practice had a system which enabled staff to receive lists from child health of children who required vaccination. The process was coordinated by the practice administration team who made contact with parents or legal guardians and booked children in for immunisations.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. Patients were also able to view their summary care record online, and more detailed medical records access upon request.
- The Electronic Prescription Service (EPS) enabled patient to collect their medicines directly from their preferred pharmacy.

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) (01/04/2017 to 31/03/2018) (Public Health England)	71.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	77.5%	78.2%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	52.9%	62.5%	57.3%	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. (01/04/2017 to 31/03/2018) (PHE)	81.8%	64.3%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to	76.2%	54.5%	51.9%	No statistical variation

31/03/2018) (PHE)				

Any additional evidence or comments

The practice promoted 'Cervical Cancer Screening Week' in their newsletter. This gave general information about the screening programme's purpose.

The practice was part of the Leicester, Leicestershire and Rutland (LLR) cervical screening pilot where identified patients were encouraged to attend cervical screening clinics held on a Saturday at the University Hospitals of Leicester NHS Trust. Staff explained as part of the Primary Care Network (PCN) the practice had signed up to offer Saturday clinics to improve uptake of cervical screening. Staff explained this pilot was in its infancy and discussions were ongoing with a view to commence within four weeks of the date of our inspection.

Patients were able to book cervical screening appointments using the online booking facility, the practice operated a text reminder service and first appointments could be offered at 7.30am; last appointment available between 5.30pm and 5.45pm. Staff explained appointment flexibility accommodated patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Quarterly palliative care multi-disciplinary team meetings took place. After-death reviews were undertaken to look at any learning points to enhance future care.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and mainly monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term

medication.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. This included working with the local mental health crisis team.
- 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, and clinicians had undertaken training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- 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)	82.1%	94.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	17.6% (6)	47.5%	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)	93.3%	96.3%	90.2%	No statistical variation
Exception rate (number of exceptions).	11.8% (4)	36.7%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	72.2%	78.9%	83.6%	No statistical variation
Exception rate (number of exceptions).	14.3% (3)	9.4%	6.7%	N/A

Any additional evidence or comments

Members of the management team explained GPs had carried out home visits to engage with hard to reach patients as well as patients who repeatedly did not attend (DNA) their appointments. The practice had a recall system in place where non-clinical staff made efforts to contact patients as well as engage with carers to reduce the risk of further appointment DNAs. The practice monitored activities through a dashboard and unverified data for the 2019/20 QOF year showed the practice was working towards achieving 2019/20 QOF targets. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record was 70%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review was 67%.

Monitoring care and treatment

The practice had a programme of quality improvement activity to monitor the effectiveness and appropriateness of the care provided

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	510.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	91.4%	No Data	96.4%
Overall QOF exception reporting (all domains)	3.7%	No Data	No Data

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

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

A clinical audit had been undertaken to review the monitoring of hypertension for patients prescribed long-term diuretics (used to increase the amount of water and salt expelled from the body to help reduce blood pressure and control other conditions). This first-cycle audit identified findings for the practice to consider improving the monitoring of patients.
The practice carried out an audit to evaluate the benefits of the walk-in/minor injuries clinic which was ran by advanced nurse practitioners (ANP) to identify whether there had been uptake of this service by the patients. Records provided by the practice showed between June and December 2018 a total of 30 patients had attended the minor injury clinic. A total of 23% (7) patients were seen by a GP and out of the seven seen 86% (6) could have been seen by an ANP. The audit also identified out of the 86% of patients identified as being suitable to see an ANP, 67% (4) were seen by a GP on days that the ANP was not on duty and 33% (2) patients were seen by a GP on days that the ANP was running a walk in clinic. The practice developed an action plan which included exploring the possibility of increasing the number of ANP sessions as well as auditing the number of consultations that GPs and ANPs see for minor illness as this audit only looked at minor injury. Staff were also reminded to make all patients aware of the walk in minor injury clinic run by the ANP.
The practice provided evidence of three audits which were first stage audits. For example, audit of ANPs prescribing of contraception carried out August 2019, antibiotic prescribing in urinary tract infection (UTI) carried out June 2018 as well as co-amoxiclav and quinolones antibiotics carried June 2019.

Any additional evidence or comments
The management team used key performance indicators (KPI) dashboards to monitor QOF performance and explained performance were discussed during clinical meetings. The practice operated a programme of clinical and internal audit. However, we found that the practice did not routinely revisit audits carried out in the last 12 months to establish whether changes resulted in positive improvements. The management team recognised the increase in Urgent Care Centre (UCC) usage and explained this was a standing agenda item at practice meetings. The practice also checked UCC access data on a monthly basis and peer reviewed treatment plans to check whether anticipatory care plans could have been put in place to reduce UCC access.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	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:

The management team explained following an unstable period after the dissolution of the previous partnership of five GPs, a GP had joined with the remaining GP in a partnership approximately two years ago. The partners now had three salaried GPs working at the practice, including one under the GP retainer scheme. This had created greater stability in the medical model. GPs had been supported by the input of an additional advanced nurse practitioner since 2018 for three sessions each week.

There had been a period without a dedicated practice nurse prior to our inspection. This had led to loss of continuity, reliance on locums, and had also been a factor which impacted on 2018/19 QOF performance. However, the practice had been successful in recruiting a practice nurse in March 2019 who had experience working in secondary care services.

As part of the recruitment campaign the practice recruited an HCA to increase the skill mix across the clinical team. The management team explained this enabled the practice to improve the management of patients' conditions such as respiratory illness and diabetes.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence:	

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.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence:	

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)	97.5%	94.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (5)	1.1%	0.8%	N/A

Consent to care and treatment

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

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

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients varied with a mixture of positive as well as less positive comments about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Training records showed all staff had received equality and diversity training.	

CQC comments cards	
Total comments cards received.	30
Number of CQC comments received which were positive about the service.	28
Number of comments cards received which were mixed about the service.	Two
Number of CQC comments received which were negative about the service.	Nil

Source	Feedback
CQC comment cards	Staff were described as helpful, friendly, supportive and listened to patients' needs. Patients were satisfied with the care they received; felt issues were resolved professionally and comments made reference to individual clinical and non-clinical staff who patients felt went above and beyond to address any health concerns. Mixed comments related to access and not the level of care provided. For example, patients felt it sometimes challenging trying to get an appointment with a GP.
Patient participation group (PPG)	The practice operated an active PPG and meeting minutes provided by the practice showed active discussions regarding patients concerns, practice developments and planned changes. PPG members we spoke with as part of the inspection, explained they had discussed concerns regarding interaction and exchange of information between the practice management team and PPG members; highlighting the impact this had on patient's satisfaction in questions related to how they are treated.
NHS Choices	There was a total of two comments posted on the NHS Choices website since our June 2019 inspection. Both comments were less positive; for example, patients described difficulties accessing appointments; lack of continuity of care with patients commenting that they rarely get to see the same GP throughout their treatment journey. Patients also commented on staff attitude describing reception staff as

	having poor customer service.
Interviews with patients	Patients we spoke with during our inspection made reference to specific individual receptionists; describing them as, lovely, friendly, pleasant and very helpful. However, found they were unable to make an appointment with the GP of their choice.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4085.0	287.0	113.0	39.4%	2.77%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	83.0%	88.9%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	81.8%	87.8%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	92.5%	95.5%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	52.5%	81.7%	82.9%	Variation (negative)

Any additional evidence or comments
The practice demonstrated awareness of the 16% decline in patient satisfaction with the overall experience of their GP practice and developed an action plan to improve satisfaction in areas such as access and staff attitude. For example, staff were placed on customer service training in the last 12 months; the practice increased their opening times to 7.30am and explained that the practice no longer closed during the afternoon. Phone lines were also increased from four to 10 lines in October 2019.

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

Any additional evidence
The practice carried out an internal survey during August 2019. This is not comparable with the national GP patient survey. Data provided by the practice showed a total of 17 completed survey forms were received and 94% of patients who responded to the practice survey responded positively to the overall experience of the GP practice.

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 reviewed the main ethnicities of patients that were registered with the practice. This resulted in the practice providing copies of the practice information leaflet, and patient comments and concerns slips in the five main languages of English, Polish, Hindi, Latvian and Slovak. Chaperone posters were displayed throughout the practice.	

Source	Feedback
The 2019 national GP patient survey	The survey results indicated that despite patients feeling involved as much as they wanted to be in decisions about their care and treatment during their general practice appointment; there was a 6% decline in patient satisfaction since the 2018 national GP survey. The practice demonstrated awareness of this and held discussions with clinical staff regarding the importance of empowering patients so that they feel involved in their care and treatment.
CQC comment cards and interviews with patients.	Patients who had completed a CQC comment cards as well as those we spoke with during our inspection, felt they were involved in their care and treatment and commented that they felt they were treated with dignity and respect.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	89.7%	94.8%	93.4%	No statistical variation

Any additional evidence or comments
Data from the practices in house survey undertaken in August 2019, showed 100% of patients who responded to the survey felt involved as much as they wanted to be in decisions about their care and treatment.

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

Carers	Narrative
Percentage and number of carers identified.	The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 109 (2%) patients as carers and 113 (5%) had a carer.
How the practice supported carers (including young carers).	The practice had a carers register, and proactively tried to identify carers. A carers pack was available which included information on local support services and benefits. Leaflets were available for young carers which included information on websites which provided appropriate advice and support. Carers were invited to attend for an annual flu vaccination and a health check could be arranged if this was required. The practice had promoted 'Carers Week' in their June edition of the patient newsletter. This encouraged patients to make the practice aware if they had caring responsibilities so that they could receive help and support. There was limited carers information on the practice website and there was no carers display board or information regarding support services within the practice.
How the practice supported recently bereaved patients.	A leaflet was available on bereavement support, and the practice website included a contact telephone number for bereavement counselling. Families and carers were usually called and offered condolences and support if this was required. The practice had commenced sending bereavement cards.

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	Y

issues.	
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

Responsive Rating: Requires improvement

The practice has been rated requires improvement because:

There were occasions where patients found it difficult to get an appointment and get through to the practice by telephone. There were issues with the premises which impacted on the practice ability to routinely provide a responsive service. The 2019 national GP survey results showed areas where patient satisfaction had declined.

Responding to and meeting people's needs

The practice mainly organised and delivered services to meet patients' needs; however, there were some shortfalls which reduced the responsiveness of service delivery.

	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.	Partial
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
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 explained the constraints with the premises which impacted on the ability to provide a completely responsive service. For example, there were no automated doors at the entrance to enable independent access for patients who used wheelchairs or scooters. However, there was a doorbell which enabled patients to alert staff when they required assistance to gain access. One consulting room was placed on the upper floor and as there was no lift available staff explained clinicians would arrange to see patients with mobility issues in a ground floor clinical room. Disabled toilet facilities were not available on site. There was no storage area for wheelchairs and pushchairs when not in use.

The practice had completed an Equality Access audit in March 2019. All areas had been assessed as low risk. The practice informed the inspection team of their plans for premises development subject to funding.

The practice was aware of shortfalls with the premises and were actively engaged in discussions with stakeholders and receiving support from PPG regarding funding to improve and expand the site. The management team explained renovating the premises formed part of the practice five year plan with an aim to improve compliance with the Equality Act 2010; and compliance with infection control standards, improve the patient environment; and provide the opportunity to deliver more services on site.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	7.30am – 6.30pm
Tuesday	7.30am – 6.30pm
Wednesday	7.30am – 6.30pm
Thursday	7.30am – 6.30pm
Friday	7.30am – 6.30pm
Appointments available:	
Monday	8.30am to 11.10am and 4.30pm to 6pm
Tuesday	8.30am to 11.10am and 4.30pm to 6pm
Wednesday	8.30am to 11.10am and 4.30pm to 6pm
Thursday	8.30am to 11.10am and 4.30pm to 6pm
Friday	8.30am to 11.10am and 4.30pm to 6pm
	Morning appointments with HCA from 7.30am till 1pm Monday to Friday.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4085.0	287.0	113.0	39.4%	2.77%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	84.9%	94.2%	94.5%	Tending towards variation (negative)

Any additional evidence or comments
The practice demonstrated awareness of the 9% decline in respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met. The clinical team reflected on patients' feedback, developed an action plan and the practice carried out their own internal survey. Data from the practice August 2019 survey showed 100% of respondents to the practice internal survey stated that at their last general practice appointment, their needs were met.

Older people

Population group rating: Requires improvement

Findings

- Issues relating to access to appointments, the premises and decline in patient satisfaction affected all population groups including this one. Therefore, this impacted on the responsiveness of service provided for this population group.
- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- Double appointments were available upon request to enable clinicians to deal with more than one problem or provide more time for complex issues.
- 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.
- A specific telephone line was available to patients at risk of hospital admission and care homes to enable timely access to advice and care.

People with long-term conditions

Population group rating: Requires improvement

Findings

- Issues relating to access to appointments, the premises and decline in patient satisfaction affected all population groups including this one. Therefore, this impacted on the responsiveness of service provided for this population group.

- Challenges faced over the past 12 months regarding nurse recruitment limited nurse prevision within the practice. The management team recognised the impact this had on the practice 2018/19 QOF performance where the overall performance had declined.
- The management team explained that the practice went through a significant restructuring of the practice team and successfully recruited a practice nurse as well an HCA with a wider skill mix to enable the practice to improve the responsiveness of care provided to patients. Staff explained this enabled the practice to be less reliant on GPs who previously had been undertaking some patient reviews in the absence of a practice nurse, as well as less reliance on agency staff.
- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires improvement

Findings

- Issues relating to access to appointments, the premises and decline in patient satisfaction affected all population groups including this one. Therefore, this impacted on the responsiveness of service provided for this population group.
- Early and late appointments were available for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- A midwife held a weekly session at the practice.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Issues relating to access to appointments, the premises and decline in patient satisfaction affected all population groups including this one. Therefore, this impacted on the responsiveness of service provided for this population group.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, following patient feedback the practice stopped providing a Saturday morning clinic and extended opening hours during the week; opening from 7.30am Monday to Friday.
- The practice held open surgeries on a Monday and Friday morning which was on a first come first serve basis.
- The recruitment of a practice nurse enabled the practice to provide better access to cervical screening. The practice was also involved in a cervical screening pilot where identified patients were encouraged to attend cervical screening clinics held on a Saturday at the University Hospitals of Leicester NHS Trust.
- Meningitis vaccines for 18-year olds and students going to university were available at the practice.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- Issues relating to access to appointments, the premises and decline in patient satisfaction affected all population groups including this one. Therefore, this impacted on the responsiveness of service provided for this population group.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. For example, double appointments could be booked in recognition that more time may be required during a consultation. Information was available in easy-read formats to help understanding.
- The practice understood the needs of the patients, such as people who may be approaching the end of their life and people who may have complex needs, such as housebound patients. Staff had received training in Gold Standards Framework (GSF) (an evidence-based guideline to deliver high quality end of life care) and were using GSF to coordinate end of life care with other health care professionals.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- Issues relating to access to appointments, the premises and decline in patient satisfaction affected all population groups including this one. Therefore, this impacted on the responsiveness of service provided for this population group.
- 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.
- A visiting counselling service held sessions at the practice. Patients were able to self-refer into this service.
- There was a process to monitor uncollected prescriptions for prescribed medicines to control their mental health related symptoms. This included regular liaison with local pharmacies.

Timely access to the service

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

National GP Survey results

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

Explanation of any answers and additional evidence:

The management team explained patients' feedback regarding the Saturday clinics which were held between 8am and 10.30am were less positive and patients preferred longer opening times during the week. As a result, the practice responded to this feedback by stopping the Saturday clinics and opening earlier during the week from 7.30am. Appointments with the HCA were available from 7.30am to 1pm Monday to Friday.

The practice had access to a locally commissioned home visiting service for acute presentations led by advanced nurse/emergency practitioners. The practice team would undertake those visits that were not referred onto the scheme or did not meet their referral criteria.

The management team explained during a period of five weeks in 2019 when the practice had limited provision within the nursing team patients who required blood tests were signposted to secondary care. Following a successful recruitment campaign, the practice was in a position where they were able to reinstate the in-house phlebotomy service. This enabled the practice to offer patients access to a practice employed phlebotomist five days per week.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	42.4%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	31.9%	63.7%	67.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to	31.2%	61.9%	64.7%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
31/03/2019)				
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	43.1%	70.8%	73.6%	Variation (negative)

Any additional evidence or comments

The practice demonstrated awareness of the variation in patient satisfaction as well as areas where satisfaction had declined since the 2018 national GP survey. The practice developed an action plan and we saw there had been progress with some actions which had been completed. For example, the procurement of a new telephone system which provided more capacity for waiting calls and options had been completed. The practice updated information on the practice website. The practice introduced the use of NHS App and supported patients to use the App. The practice monitored impact through their dashboards and unverified data provided by the practice showed 25% of patients had registered for and were using online services. The practice previously closed daily between 12 and 2pm; however, the opening times had been adjusted and the practice was no longer closed during the afternoon. Telephone consultations were being made more widely available and patients were encouraged to see members of the nursing team for minor ailments where this was more appropriate to reduce the pressure on GP appointments.

Actions which had not been completed at the time of our inspection included introducing earlier GP consultation slots which the practice was exploring at the time of our inspection. Early appointments with the ANP were available from 7.30am on Fridays.

The practice carried out an internal patient survey during August 2019 which mirrored questions in the national patient survey. However, this data is not comparable due to different methodologies. The practice received a total of 17 completed survey forms and data provided by the practice showed:

- 71% of patients responded positively to how easy it was to get through to someone at their GP practice on the phone.
- 82% responded positively to the overall experience of making an appointment.
- 71% were very satisfied or fairly satisfied with their GP practice appointment times.
- 100% were satisfied with the type of appointment (or appointments) they were offered.

The practice provided unverified data from a Clinical Commissioning Group (CCG) acute access audit which the practice had carried out in September 2019. Twenty patients were involved in the audit and data showed:

- 80% were satisfied with their overall experience of their on-the-day appointment with a GP.
- 80% found it easy to get thought to the practice by phone and felt it was easy to get through to the right person.
- 65% felt they were able to book an urgent or on the day appointment
- 75% they were able to get an appointment at a time that was convenient to them
- 35% felt they were able to see the same clinician each time for illnesses or long term conditions and 65% felt they were not always able to see the same clinician.

Source	Feedback
CQC comment cards and patient interviews	Comments placed on CQC comment cards showed patients were satisfied the care they received once they had secured an appointment. However, patients felt they did not routinely have timely access to appointments and appointments would run late at times.
NHS Choices	The practice had received a three star rating (out of five) on the website based on 26 ratings from patients. Twelve comments posted had been posted in the 12 months leading up to our inspection. Six of the twelve comments were negative and included reference to poor telephone access, a lack of online appointments and a poor environment.
Interviews with staff	Staff explained NHS Choices feedback were routinely discussed during clinical and practice meetings; and the practice explored ways to improve satisfaction and monitored progress with any actions taken.
PPG	PPG members we spoke with felt patients were not routinely able to get an appointment when they needed one and explained this had been raised with the practice. PPG also explained they recognised the practice had been going through difficult times over the last 24 months such as instability in staffing levels. However, demonstrated awareness of actions carried out by the practice aimed at improving access and patient satisfaction. PPG felt access had been improving with opening times being extended and were confident the practice was continuing to make further improvements. However; felt despite the practice extending their opening hours; GP appointments were not available between 7.30am and 8pm. Therefore, members felt the benefits of this in regard to improving access would be limited.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Nil

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: The practice received a total of 10 complaints in the last 12 months; however, two out of the 10 had been received following our June 2019 inspection. As part of this inspection we examined a total of three complaints and found they were all managed in a timely manner.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complainant felt let down by the service provided as well as staff attitude.	Complaint discussed during clinical meeting where the practice identified the lack of provision within the nursing team resulted in patient not receiving responsive care. Reception staff made aware to ensure that identified patients are booked in with the HCA. Following a successful recruitment campaign, the practice had reinstated HCA clinics. Complainant received a letter from the practice which was detailed and contained a clear explanation, actions the practice intended to take, an apology as well as details for the Parliamentary and Health Service Ombudsman.
Access to childhood vaccinations.	Complainant contacted and provided with explanation regarding cold-chain incident which resulted in the practice having to discard vaccines in line with manufacturers guidelines. Complainant was informed of changes to prevent future cold-chain incidents and actions were to contact complainant once the practice had received delivery of vaccines. Complainant received an apology as well as details for the Parliamentary and Health Service Ombudsman.
Patient referred inappropriately to a home visiting service used by the practice.	The practice highlighted the importance of obtaining full details from the patient and their records before referring onto the home visiting service.

Well-led Rating: Good

Leadership capacity and capability

There was, inclusive and mainly compassionate and 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:

The practice had encountered a turbulent period over the past 24 months which impacted on the practice ability to deliver an effective, responsive and sustainable service. The partners identified the need to undergo a significant change programme and staff restructuring. To support the significant restructuring the partners appointed a part time executive manager in January 2019 who supported the creation and delivery of the practice 2019/24 business development plan.

During our June 2019 inspection, we saw evidence of many changes that had been introduced over the preceding six months. These changes had been essential to ensure sustainability and compliance with regulations. Some workstreams remained ongoing but we saw there were clear action plans in place which were regularly monitored and updated. During our November 2019 inspection, we saw further development of changes such as strengthening newly recruited staff skill mix, installed additional phone lines and the practice had started to imbed new systems and process. We also saw evidence of ongoing discussions regarding planned work to ensure floors in clinical rooms were complaint with IPC recommendations.

Members of the management team explained there had been some significant clinical and non-clinical staff changes as well as a history of partnership changes with four of five initial GP partners leaving but with one new GP joining the partnership approximately two years ago. Management recognised this had created challenges and unrest with patients and that members of the PPG mostly understood the need to make changes; however, some patients had built up positive relationships with staff members who had left the practice which created some uncertainty.

The practice contracted external human resources (HR) advice and support. HR had supported the recent staff restructuring programme. This organisation also provided advice and support on health and safety management.

The practice was a member of the East Leicestershire and Rutland GP Federation, and told us that they were involved in the development of their Primary Care Network with other local practices. The practice also worked closely with a nearby practice as part of a local resilience scheme.

Vision and strategy

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

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

Explanation of any answers and additional evidence:

The practice vision was to provide an appropriate and rewarding experience for patients whenever they need our support. The vision 'statement' was printed out and placed on the top of each staff member's computer screen to ensure they were fully aware of it. The practice had developed a five-year business plan which was supported by an extensive annual action plan.

The development of the premises was identified as the key priority for the practice. During our June 2019 inspection, there was ongoing work to identify and secure funding to support this and in the interim some smaller scale site improvements had been made. During our November 2019 inspection, the practice had secured finances and were moving towards the next phase such as obtaining quotes and exploring dates when work on the premises would commence.

Culture

The practice had a developing culture which aimed to drive delivery of high quality sustainable care.

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

Explanation of any answers and additional evidence:

Staff we spoke with explained the culture within the practice was open and transparent. Members of the management team explained positive improvements had been noticed since changes had been made. Non-clinical staff explained over the past 24 months the practice had been through difficult times and some staff felt overwhelmed with the volume of work and pace of change; however, felt well supported by management.

Members of the PPG we spoke with explained it was noticeable the enthusiasm or receptionists and staff morale seemed to be improving.

Members of the management team explained the actions taken to develop a more integrated administrative team.

The management team carried out annual staff surveys and explained the last staff survey was carried out in July 2019. Overall the management team found staff felt their work was important, liked their job, all staff would recommend the practice as an employer to that their friends and family. Staff were satisfied with the flow of communication from the leadership team. However, negative trends related to work distribution amongst staff. The management team explained they had discussed this with staff and were addressing these concerns. Survey results also identified the need to improve communication. In response; the practice introduced two weekly staff huddle meetings.

The management team were assured, following a successful recruitment campaign staffing levels was appropriate for a practice of this size. However, explained as the practice grows staffing levels would be revisited.

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

Source	Feedback
Staff	Individuals we spoke with identified the impact changes had on staff morale and explained the practice had gone through some difficult times. Staff felt the management team were supportive during periods of change. Where increased levels of stress had been identified; staff felt the management team responded to identified concerns and took actions such as recruiting additional staff. Staff also explained the recruitment of additional clinical staff had enabled existing staff to have protected time for non-direct patient duties and staff morale had improved.
Staff	Staff recruited in the last 24 months provided positive accounts of their experience of working at the practice. Staff explained they were well supported by the partners and management team during induction as well as throughout their ongoing employment. Staff felt that they were informed and involved with regards to all relevant practice matters such as any difficult decisions aimed at strengthening the sustainability of the practice.
Policies	Practice policies were in place which supported leaders to act on behaviour and performance inconsistent with the vision and values of the practice.
Policies and management interviews	The practice had processes which enabled leaders to take action to promote equality and diversity.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. The practice was in the process of reviewing their governance arrangements and changes were ongoing.

	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:

There was a regular network of meetings including monthly clinical, bi-monthly general staff meetings, and quarterly multi-disciplinary team meetings. Comprehensive minutes of meetings were made available to staff.

Practice policies and procedures were being reviewed and updated. We saw that key policies, for example, safeguarding, IPC and recruitment had been reviewed and customised. The practice acknowledged others still required some customisation and updating. The practice was continuing to review practice policies to ensure they were all customised and practice specific.

The practice introduced a range of systems and processes in January 2019 such as a training dashboard as well as a new process for managing and monitoring safety alerts. Records showed that alerts received since the new process was introduced were acted on appropriately.

The management team demonstrated awareness in the decline in performance as well as patient satisfaction and explained the root causes. The practice had an action plan to address identified areas and we saw some actions had been completed. The practice carried out internal surveys and used dashboards to monitor performance. Unverified data provided by the practice showed improvements.

Staffing levels and skill mix were constantly under review. For example, the management team explained there have been extensive examining of staff roles and identified activities which could be undertaken by people other than those who have traditionally worked in specific roles. This process had enabled the practice to make significant delegation and cost savings actions as well as the ability to redeploy resources while improving job satisfaction of staff who have been given greater responsibility. The management team explained this was an area where the practice continued to work on.

The practice was actively working with Primary Care Networks (PCNs) to adopt new models of care.

Managing risks, issues and performance

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

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

During our June 2019 inspection, we found that the newly appointed Executive Manager had identified number of risk-related issues that had not been appropriately addressed after coming into post in January 2019. Actions were taken to address these and at the time of our June 2019 inspection, we saw that these issues had been resolved, or had been risk assessed and actions were in progress. Since our June 2019 inspection, we saw action had been undertaken in line with the Legionella assessment recommendations to ensure the water systems were safe by analysis of water samples. The practice had invited the CCG infection prevention and control nurse to undertake an infection control audit, and whilst this had identified many areas that needed to be improved we observed that the practice was dealing with this and had developed a plan to address longer-term issues.

During our November 2019 inspection, we identified further progress with the practice action plan. For example, IPC actions had been completed with the exception of replacing sink taps and changing the floor covering in clinical rooms to ensure compliance with IPC recommendations. The management team explained since our June 2019 inspection, the practice had secured the necessary finances required to fund the floor replacement and had set a timeframe for the work to be completed which was planned to be completed by January 2020. We also saw communication between the practice and IPC lead within the CCG regarding flooring specifications and up to date guidance.

There was a systematic programme of clinical and internal audit. However, we found that the practice did not routinely revisit audits carried out in the last 12 months to establish whether changes resulted in positive improvements.

Records showed actions to ensure compliance with recommendations following the practice fire risk assessment had been acted on. For example, records showed evidence of six monthly fire drills, a fire alarm had been installed and arrangements for yearly servicing was in place

The practice held a contract with an external company for their waste management and we saw evidence of clinical waste collection mandate sheets which were also scanned onto the practice computer system.

The practice had introduced a risk register which was monitored through the monthly Executive Meeting. Risks were rated, and actions were agreed to mitigate their impact.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

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

Explanation of any answers and additional evidence:

During our June 2019 inspection, we saw that the executive manager had developed a series of dashboards based to monitor activities. For example, audits, staffing (including training information), events (for example incidents, complaints, and safety alerts) and key performance indicators (for example QOF, enhanced services). These gave access to a range of information on performance with links to supporting evidence. During our November 2019 inspection, we saw the dashboards were embedded and observed staff were actively using them to monitor performance and activities.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
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:

Information received from external stakeholders as part of our inspection planning process related to limited engagement from the practice to build a shared understanding of challenges within the system, to support delivery of services to meet those needs of the local population. During our inspection, the management team demonstrated improvements made and provided evidence of when clinical leads had attended stakeholder engagement meetings. The practice told us they met with representatives from stakeholder's quality team approximately every four to six weeks and we saw meeting minutes to evidence this.

The practice explained actions in place to address challenges and respond to needs. For example, the practice recruited a practice nurse, HCA with a wider skill mix and applied for international GP recruitment scheme. Staff explained the next wave of international GP recruitment is scheduled for January 2020.

Feedback from Patient Participation Group.

Feedback
The practice had an active PPG; quarterly meetings held on Saturdays. Records and discussions with PPG showed they were actively involved in the practice and made a number of requests to improve service delivery. We saw that the practice provided PPG members with information regarding any planned or proposed changes. However, PPG members we spoke with provided a mixed view regarding the practice engagement. For example, PPG members recognised that practice staff attended quarterly meetings; however, felt issues raised in the past six months were often carried over due to key management who were able to make decisions were not routinely present at the meetings. PPG members explained the communication flow between the practice management team and PPG needed further development to help improve collaborative working.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: Oversight of systems for managing significant events showed that these were investigated and responded to in a timely manner. Meeting minutes showed evidence of shared learning. The practice had a system in place for managing complaints in a timely manner.	

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.