

Care Quality Commission

Inspection Evidence Table

OHP-Handsworth Medical Practice (1-4208215700)

Inspection date: 4 May 2021 to 11 May 2021

Date of data download: 26 April 2021

Overall rating: Good

At our previous inspection in March 2019 we rated the practice as Requires Improvement overall. We identified issues relating to the management of risks and staff support and supervision. At this inspection we found that these areas had been addressed and have moved the overall rating to good.

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

Safe

Rating: Good

At our previous inspection in March 2021 we rated the practice as requires improvement for providing safe services, the practice was unable to demonstrate suitable indemnity arrangements for non-medical staff in extended roles and for the completeness of risk assessments in the absence of some emergency medicines. At this inspection we have rated the practice as good for providing safe services. We found the practice had reviewed and made adjustments to staff extended roles and had also completed risk assessments for recommended emergency medicines that were not routinely stocked.

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 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

Safeguarding	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The principal GP was the safeguarding lead for the practice and staff we spoke with were aware who they needed to go to for safeguarding concerns. • The Advanced Nurse Practitioner (ANP) met with the Health Visitor on a quarterly basis to discuss children at risk. The ANP then met with the practice manager and principal GP at an internal safeguarding meeting to identify any action they needed to take. • Clinical system alerts were in place to ensure staff were aware of patients and other household members who may be at risk of harm. Information was also placed on the patient's summary care record so that other agencies, such as out of hours services were aware. • There were child and adult safeguarding policies in place to support staff which included contact details for relevant agencies. • Staff were able to give us examples of recent safeguarding concerns and actions taken to help safeguard those at risk of harm. • Training records showed that all staff were up to date with their safeguarding children and vulnerable adults. We saw that staff were trained to the appropriate level for their roles. • The practice had nominated chaperones who were DBS checked and had undertaken chaperone training. There was a Chaperone Policy in place to support these staff. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We reviewed three staff files and found appropriate recruitment checks were in place to ensure suitable persons were employed • The practice monitored staff vaccination status and undertook risk assessments where staff may not have immunity. • Clinical staff registration checks were undertaken against their relevant professional bodies to ensure they were able to practice in their professional capacity. • At our previous inspection in March 2019 we found the practice was unable to demonstrate indemnity arrangements were in place for all staff undertaking extended roles. At this inspection staff told us that the roles identified during the last inspection were no longer being undertaken by non-medical staff. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 31/03/2021	Y
There was a record of equipment calibration. Date of last calibration: 10/02/2021	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
A fire risk assessment had been completed. Date of completion: 03/10/2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw records which showed systems were in place to manage risks in relation to equipment and the premises. • The practice undertook weekly fire alarm checks and had recently undertaken a fire drill to ensure staff knew what to do in the event of fire. • All staff had completed fire safety training and those nominated as fire marshals had undertaken additional training to undertake for the role. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 08/04/2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 08/04/2021	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw risk assessments in place in relation to health and safety and the premises. No specific actions had been identified in relation to the risk assessments. • The premises appeared well maintained during our site visit. • Health and safety was included in the new staff induction programme. • Training records showed health and safety training had been completed by non-clinical staff and moving and handling training by the clinical staff in the last year. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: December 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The Advanced Nurse Practitioner was the nominated Infection Control lead for the practice. • There were infection control policies in place and all staff had completed infection prevention and control training within the last 12 months. • We saw evidence of appropriate arrangements for the management of hazardous waste • We observed the premises to be clean and tidy. • The practice's most recent infection control audit undertaken in December 2020 scored 99%, the practice told us of action taken to address issues identified in the audit. • The practice used an external cleaner for the premises, cleaning schedules were in place for them to follow although these were not signed. The practice manager advised that they had not requested the cleaner to sign any schedules during the pandemic as part of infection control measures. 	

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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
Explanation of any answers and additional evidence:	

- The practice advised that there had been occasions where staffing had been affected by COVID-19 during the last year. This had led them to recruiting additional staff to ensure cover was available.
- The practice advised that they were still trying to recruit an additional GP but had not needed to use any locum staff in the last year. The exception being the amber site which was open during the start of the pandemic for seeing patients in person.
- Practice staff had the option to work remotely if needed. Equipment to do this had been provided through the Clinical Commissioning Group (CCG).
- We saw that the practice had emergency medicines and equipment in place and that these were checked regularly to ensure they were in date and fit for use when needed.
- Staff advised us that they would contact the doctor or emergency services if they had concerns about a patient. Sepsis guidance was available to reception staff as a reminder of potential symptoms.
- Training records showed all staff had completed Basic life support and sepsis training in the last year.

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
Referrals to specialist services were documented, contained the required information 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We identified no concerns with the standard of clinical record keeping during our remote searches on clinical records. • Summarising of new patient records was undertaken by clinical staff. We were advised that there were no backlogs with this. • Information was shared with other appropriate agencies via the summary care record. • We found workflow was completed in a timely way during our search of the clinical system. • We saw a sample of patient referral letters and found these contained appropriate information. • There were systems in place for monitoring two week wait referrals so that they could be followed up. 	

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) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.38	0.75	0.76	Significant Variation (positive)
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). (01/01/2020 to 31/12/2020) (NHSBSA)	4.4%	6.4%	9.5%	Variation (positive)
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 (01/07/2020 to 31/12/2020) (NHSBSA)	6.47	5.09	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	39.4‰	130.9‰	127.1‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	0.37	0.70	0.67	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice compared well against other practices locally and nationally in relation to prescribing. • We reviewed a sample of patients on four high risk medicines which required regular monitoring. We found in the majority of records reviewed, appropriate monitoring had been completed. We identified one high risk medicine where blood tests had been delayed due to the pandemic however there was evidence that all the patients reviewed had been risk assessed as low and were now being followed up. • We saw that medicines, vaccines and prescription stationery were appropriately stored and monitored in the practice. • Clinical staff advised us that they routinely checked patient identification when undertaking remote consultations and prescribing. • At our last inspection in March 2019 we found a lack of comprehensive risk assessments in the absence of some emergency medicines. At this inspection we found risks had been fully assessed for recommended emergency medicines not routinely stocked by the practice. 	

Track record on safety and lessons learned and improvements made

The practice had systems to learn and make 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:	9
Number of events that required action:	9
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We saw that the practice had arrangements for recording and learning from significant events however, we did note that these were largely about incidents by other organisations rather than from the practice itself. Incidents had been shared with staff via staff communications. 	

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

Event	Specific action taken
Locum checks revealed doctor was suspended by the General Medical Council (GMC).	Locum GP recruited by the amber site on behalf of the GP practice. The practice identified that the locum had been suspended by GMC and informed the amber site who recruited another locum.
The practice had undertaken two sets of tests and sent them on to the laboratory but only was returned.	The practice contacted the hospital who advised the second request had superseded the first. Staff were made aware to ensure that any requests now include subsequent requests that have yet to be completed.

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:	
We looked at two recent safety alerts, we saw that these had been acted on. However, we noted that in two of the records seen there was no pregnancy prevention alert noted on the patients records for a particular medicine.	

Effective

Rating: Good

At our previous inspection we rated the practice as requires improvement for providing effective services, this was because there was no formal supervision in place for staff undertaking extended roles, and no evidence of recent training updates completed to ensure competency was reviewed and maintained. At this inspection the rating has moved to good for providing effective services. Staff roles had been reviewed and comprehensive supervision arrangements put in place.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Our review of a sample of patients' records indicated patients received appropriate care and treatment.• Clinical staff told us how they kept up to date through access to best practice guidelines, guidance and advice received from hospitals during the pandemic, journals and learning events.• The practice worked with a diabetic consultant to discuss the appropriate management of patients with more complex care needs.	

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. The practice advised that these patients were predominantly on the shielding list and were followed up with the support of the social prescriber.

- 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.
- Our patient record review showed structured medicines reviews for older patients had taken place in the previous 12 months.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Although, there had been some disruption to health checks during the pandemic, these had now been reintroduced.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were encouraged to undertake home blood pressure monitoring checks during the pandemic. Where this was not possible the patient would be invited into the practice to have their blood pressure taken.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. The practice advised us that the blood pressure monitor they used also picked up this condition.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020)	92.5%	75.4%	76.6%	Significant Variation (positive)
<small>(QOF)</small> PCA* rate (number of PCAs).	2.4% (5)	6.6%	12.3%	N/A

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	88.0%	89.4%	Variation (positive)
PCA rate (number of PCAs).	6.3% (1)	8.5%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	93.9%	80.6%	82.0%	Variation (positive)
PCA rate (number of PCAs).	0.0% (0)	3.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	76.5%	63.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	8.7% (34)	11.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	83.1%	70.4%	72.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	2.0% (12)	5.5%	7.1%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	93.3%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	87.8%	72.8%	75.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	3.3% (13)	8.3%	10.4%	N/A

Findings

- The practice has met the minimum 90% for all of the five childhood immunisation uptake indicators and the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access some services for sexual health and contraception offered at the practice. The practice would refer to other services if needed.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	35	37	94.6%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	51	53	96.2%	Met 95% WHO based target
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) (01/04/2019 to 31/03/2020) (NHS England)	52	53	98.1%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	52	53	98.1%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	49	57	86.0%	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 performed well against child immunisation targets. The Advance Nurse Practitioner (ANP) took responsibility for contacting and following up on child immunisations. The ANP advised that they invited parents in to discuss vaccines and the diseases the immunisations protected against. Interpretation services were used to assist, when needed. The practice ran regular audits to flag children that had not received their immunisations and offered flexibility with appointments to encourage participation. Follow up appointments for the next immunisations were made before leaving their last appointment.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice offered eligible patients 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. These had been temporarily suspended during the pandemic but had been recently reintroduced at the surgery.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/09/2020) (Public Health England)	72.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	66.1%	65.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	48.1%	N/A	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	84.6%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	25.0%	48.0%	54.2%	No statistical variation

Any additional evidence or comments

- Although the practice was not meeting the 80% cervical screening target there had been a slight improvement on the previous year from 71.5% to 72.5%. The ANP advised us that they found it was the younger age group who were not attending. They told us that they encouraged patients to attend even if it was to just discuss the process, using interpreters when needed. They asked those that attended to speak to their friends.
- The practice was also showing improvement in the uptake of bowel cancer screening from 34.7% in 2017/18 (reported at our last inspection) to 48.1% in 2019/20.

- Breast cancer screening uptake had fallen slightly between 2017/18 and 2019/20. Practice staff told us that they tried to encourage eligible women to attend. There was currently a back log in the breast screening service due to the pandemic and the practice had been advised of the current screening priorities.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- Patients with a learning disability were offered an annual health check. The practice advised us that they had reached an 85% uptake for these reviews.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. These patients were signposted to appropriate services for their needs.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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 (01/04/2019 to 31/03/2020) (QOF)	100.0%	74.4%	85.4%	Variation (positive)
PCA rate (number of PCAs).	4.0% (1)	15.6%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	92.3%	66.5%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	9.8%	8.0%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity. However, it was not always clear what impact this had on the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559	Not Available	533.9
Overall QOF score (as a percentage of maximum)	100%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	5.2%	Not Available	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
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

The practice told us that as part of their Primary Care Network (PCN) they looked at areas such as referral patterns and prescribing.

The practice shared with us two audits that they had undertaken in the last 12 months, however it was not clear from the audits that they had delivered any clear improvements or demonstrated the effectiveness of care provided.

- Prediabetes Audit 22/12/20 - looked at management of patients identified as pre-diabetic being offered medicines in line with guidance. The practice found that those offered medicines had increased from 5% (between October 2018 to March 2019) to 12% (between April and November 2020).
- PSA audit – The audit was undertaken after guidance suggested there was no benefit in routinely screening men over 50 years for prostate cancer. The GP explained that they were trying to identify whether early screening made a difference in achieving a better outcome.

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.	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
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our last inspection in March 2019 we found that not all clinical staff had completed level three safeguarding training and not all staff undertaking chaperone duties had received training. We also found the practice was unable to demonstrate a comprehensive quality assurance system, including appropriate training and formal supervision for staff undertaking extended roles. At this inspection we found the staff training was monitored and that staff had completed training identified as mandatory by the provider. This included level three safeguarding training for clinical staff and chaperone training for those who undertook chaperoning duties. We also saw that staff had undertaken specific training for their roles and responsibilities such as immunization training and sample taking for the cervical screening programme. Staff in extended roles received regular supervision with opportunities to discuss patients' needs. These were recorded in the patient records. Records seen showed that staff received annual appraisals and new staff an induction providing opportunities to discuss any learning and development needs. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Although the practice had not been able to undertake face to face multi-disciplinary team meetings, we saw evidence of regular contact and discussions with the community teams. • The Advance Nurse Practitioner (ANP) held quarterly meetings with the health visiting team. Information was then discussed with the GP and practice manager as part of the internal safeguarding meetings. 	

Helping patients to live healthier lives

Staff were 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 and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had reintroduced health checks following the initial phase of the COVID-19 pandemic. They were supported by a social prescriber who was able to support patients to access services most relevant to their needs. • Carers were offered flu vaccinations and health checks. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a consent form for recording minor procedures and joint injections however, they told us that these procedures had been paused during the pandemic.• Staff told us that they had not needed to consider capacity but were aware of the legislation and guidance if they did need to.• Our clinical searches found no patients with a DNACPR in place.	

Well-led

Rating: Good

At our previous inspection we rated the practice as good for provided services that were well led. At this inspection we have continued to rate the practice as good.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice recognised the challenges of being a single-handed practice and had for some time been trying to recruit additional GPs to work at the practice, but had struggled to do so. They had also looked at nurse staffing and were in the process of training a new member of staff that they hoped would eventually fill this role.• The practice had joined Our Health Partnership (OHP) in 2017 to help support future sustainability of the practice. The OHP partnership model provides administrative and other support to member practices but leaves practices to run their own services how they see fit. They also worked with their Primary Care Network in addressing local priorities.• The practice advised that the last year had been challenging with the pandemic, working in different ways. They felt things were getting easier now staff had been vaccinated.• Staff told us that they found the leadership at the practice visible and approachable.	

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 had developed a mission statement and practice staff told us that they aimed to provide the best possible care to patients.
- The practice had a business plan in place which they had considered the future of the practice working within Our Health Partnership and their local Primary Care Network.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Disciplinary and grievance procedures were set out in the staff handbook given to new staff. There was a whistle blowing policy and Freedom to Speak Up Guardian located at provider level if staff felt unable to raise concerns with the practice. We saw from training records that most staff had completed their Equality and Diversity training. Additional staff had been recruited to support the delivery of the service in response to the pandemic should staff need to isolate. Measures had also been put in place during the pandemic to help keep staff safe such as the creation of staff bubbles and social distancing. Staff were aware of duty of candour and told us that they offered an apology when things went wrong. 	

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

Source	Feedback
Staff interviews	Staff told us that they felt able to approach and raise any concerns with the leadership of the practice.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	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:	
<ul style="list-style-type: none"> At our previous inspection in March 2019 we found governance arrangements for staff undertaking extended roles was not clearly defined. At this inspection we found that this had been addressed and staff told us they had clear roles and responsibilities. During the pandemic the practice manager advised that whole staff meetings had not been held in order to maintain social distancing, but they did circulate regular notes with staff to keep them informed. Staff told us that it was a small practice and that they knew who to speak to if they needed support. Staff also told us that they had time allocated for non-direct patient roles. 	

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 quality improvement programme in place.	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:	
<ul style="list-style-type: none"> At our previous inspection March 2019, we found the practice did not ensure effective clinical oversight for staff undertaking extended roles and that risk assessments in the absence of some emergency medicines were not comprehensive. We found that these areas had now been addressed. 	

- The practice manager undertook reviews of practice performance against the Quality Outcomes Framework (QOF) and discussed these with the GP as to what needed to be done. Staff were then tasked with calling patients in for their annual health reviews.
- The practice had a Business Continuity Plan in place that had been updated to reflect issues relating to the pandemic and identified a buddy practice should the practice need to close. Staff we spoke with were aware of the plan.
- We saw that some of the policies shared by the provider with member practices had equality and environmental impact assessments in place.

The practice had systems in place to continue to deliver services, respond to risk and meet patients’ needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Practice staff told us that their preference was to work from the practice but were able to work remotely if needed. • Patients that were potentially digitally excluded could still contact the practice via telephone and were assessed by a clinical member of staff, and if a face to face appointment was required the patient was invited in. • The practice had undertaken a patient survey in February 2021 which included questions about the ease of access via the telephone. The survey was limited to the 60 patients who were members of the PPG/virtual PPG group. Responses showed over 80% of patients who responded did not have difficulty in getting through on the phone or consulting via phone or video. 	

- Practice staff advised us that they had continued services throughout the pandemic and did not have any backlogs that needed to be addressed.
- Infection prevention and control measures had been put in place to maintain staff and patient safety during the pandemic. This included symptom checking of patients and provision of hand sanitisers. The wearing of face masks for patients and staff and social distancing within the practice through staff bubbles.

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	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:	
<ul style="list-style-type: none"> • We did not identify any major concerns in relation to the patient information reviewed during the inspection. Information was available to staff in a timely way. Advice and guidance were sought from secondary care to manage patients where referral was not possible. • We found management information was available on request and well organized. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Partial
The practice ensured patients were informed how their records were stored and managed.	Y

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Partial
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice advised that they made patients aware that any photographs sent would be saved on their patient record and deleted from any emails or phones. • The practice had discovered that telephone system arranged via the Clinical Commissioning Group recorded consultations. The practice had advised that they had not signed up for this and shared with us emails they had sent to stop this from happening. We were given assurance that the recorded calls were encrypted for practice use. • Practice staff were aware of action to take to ensure confidentiality when working remotely and ensured patients identity was checked when consulting with them. 	

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.	Partial
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:	
<ul style="list-style-type: none"> • Results from the latest national GP patient survey (published July 2020) were in line with local and national averages. The practice had also undertaken an inhouse survey in February 2021 with members of their PPG and virtual PPG group but had not identified any specific actions from the results. • The practice had continued to engage with their Patient Participation Group virtually but appreciated that this way of meeting may not be accessible to all. They discussed the development of a virtual group going forward who they could contact on specific issues. • The practice was not currently holding staff meetings due to the pandemic in which staff could be formally involved in discussions about the practice. Staff we spoke with were unable to recall any examples as to how they had shaped services or been involved in any planning of the delivery of services. However, staff advised it was a small practice and that leaders were approachable if they wished to discuss anything. They also had opportunities to discuss issues with managers via the appraisal process. • The practice worked within their local Primary Care Network and local Clinical Commissioning Group to discuss and address challenges. For example, the practice had operated amber and red sites during the pandemic in the management of patients with COVID-19 symptoms. 	

Continuous improvement and innovation

There was 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:	
<ul style="list-style-type: none"> • We saw examples of audits undertaken although these did not always clearly demonstrate improvements in care and treatment. 	

- Staff had access to training and support relevant to their roles and responsibilities.

Examples of continuous learning and improvement

- Practice staff were proud of their achievements in relation to child immunisations and cancer screening programmes given the challenging population demographics. This had been achieved through taking the time to have conversations and provide explanations to patients about the benefits.
- The practice was proud of how they had managed to continue delivering services throughout the pandemic.
- The practice advised that they have achieved well in screening diabetics and hypertension and target these patients for appropriate treatment, this was achieved despite a high prevalence of diabetes in the practice population.

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 practice's 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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- $\%$ = per thousand.