

# Care Quality Commission

## Inspection Evidence Table

### Forge Medical Practice (1-540510137)

Inspection date: 10 September 2021

Date of data download: 16 August 2021

#### Overall rating:

**Requires Improvement**

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

We rated the practice as requires improvement overall because:

- Patients' needs were not always being assessed, and care and treatment was always not delivered in line with current legislation, standards and evidence-based guidance.
- The arrangements around prescribing warfarin (a high risk medicine) were not always effective and placed patients at risk.
- The review process for patients with long term conditions were not always effective at supporting patients to manage their conditions and improve their health and wellbeing.

#### Safe Rating:

**Requires Improvement**

At this inspection we have identified concerns the arrangements around prescribing warfarin (a high risk medicine) were not always effective and placed patients at risk.

#### 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: June 2021	Yes
There was a record of equipment calibration. Date of last calibration: 4 August 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 19 October 2020	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The company contracted to calibrate equipment had cancelled a planned visit in August 2021. This has been rebooked for 20 October 2021.	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: 30 April 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 31 March 2021	Yes

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

## Appropriate and safe use of medicines

The practice had some systems for the appropriate and safe use of medicines, including medicines optimisation, but the prescribing of high-risk medicines was not always safe

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.80	0.91	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	9.7%	9.0%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	4.53	4.88	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	152.4‰	265.6‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.43	0.54	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	5.3‰	6.6‰	6.7‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Due to concerns raised internally and through external investigation, the practice had identified an area for improvement around medicine reviews and safe prescribing.</p> <p>The practice had already implemented several protocols into their clinical system, to support safe prescribing. These protocols automatically checked a number of factors relevant to each medicine, and alerted the clinician, via a pop-up message, where further checks were required to make sure prescribing was safe.</p> <p>In August 2021 the practice had also implemented a new medicine review policy. This was developed to support clinical staff in prescribing safely, particularly around high-risk medicines, such as warfarin. The practice showed us the associated quality assurance and audit arrangements they planned to support the implementation of this policy. However, the practice had not had the opportunity to implement these at the time of the inspection. Therefore, we were unable to check these were effective at identifying and addressing any areas of concern.</p>	

Medicines management	Y/N/Partial
<p>We carried out a number of remote searches on the practice clinical system and analysed the data to check how the practice assessed, monitored and provided care and treatment for patients. We found:</p> <ul style="list-style-type: none"> <li> <b>High risk medicines – Methotrexate, Azathioprine, Leflunomide and lithium</b>  We found appropriate monitoring in place from the clinical records we reviewed </li> <li> <b>High risk medicines – warfarin</b>  Of the 44 patients prescribed warfarin we reviewed the clinical records of eight patients. We found examples where the practice had not checked an up to date blood test result had been received and was in range, before prescribing. There were also examples, where a new blood test was due shortly, but the practice issued a prescription beyond the date of the due blood test. This meant the patient was at risk of being on the wrong dose of warfarin between the new blood test date and the date they requested a new prescription. For some of the patients this was in excess of a month. The practice told us some patients were monitored by the hospital service and as such the responsibility for monitoring was not with the practice. They told us they had raised a significant event through the local Safeguard Incident and Risk Management System (SIRMS) to highlight their concern about not getting timely communication of results from the local anticoagulation clinic. </li> </ul> <p>The practice had achieved a 69% reduction in benzodiazepine prescribing over a two-year period.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	58
Number of events that required action:	58
Explanation of any answers and additional evidence: The practice carried out informal reviews of all significant events raised to check for themes and repeated events. However, there was no formal process in place.	

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

Event	Specific action taken
Handwritten prescription used by a former member of staff	Improved audit trail of blank prescription stationery to improve safety and security.
Missed opportunities to diagnose cancer earlier.	Discussion at clinical meeting on when to convert a remote telephone consultation into a face to face appointment.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:  We saw evidence that the practice acted on safety alerts. For example, the practice had searched for patients being prescribed simvastatin in conjunction with amlodipine at more than 20 mg/day, following a safety alert that indicated this was no longer considered safe. The patients were reviewed in line with the guidance in the safety alert and had their medication reviewed and amended.	

## Effective

## Rating: Requires Improvement

At this inspection we have identified concerns in relation to effective care and treatment for patients. Patients' needs were not always being assessed, and care and treatment was always not delivered in line with current legislation, standards and evidence-based guidance.

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial <sup>1</sup>
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial <sup>1</sup>
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Explanation of any answers and additional evidence:

<sup>1</sup> We carried out a number of remote searches on the practice clinical system and analysed the data to check how the practice assessed, monitored and provided care and treatment for patients.

### High risk medicines

The arrangements around prescribing warfarin (a high risk medicine) were not always effective and placed patients at risk. The practice was in the process of implementing a new policy and quality assurance process to address concerns but there had not been enough time since it was implemented to evidence this was effective yet.

### Missed diagnosis

In the clinical records we reviewed, we found the practice had identified and followed up those patients with a potential missed diagnosis of diabetes.

### People with long-term conditions

We reviewed the care plans and associated clinical records for five people diagnosed with diabetes. We found evidence of some patients with poor diabetic control, where there was no recorded discussion of risk with the patient and no record of discussion of alternative treatment options to help the patient better control their diabetes.



We reviewed the care plans and associated clinical records for 11 people diagnosed with asthma. We found the annual review process was not always effective at supporting patients to control their asthma. We found high use of Short-Acting Beta Agonists (SABAs) was not addressed at annual reviews. These medicines are the first step rescue treatment for patients with intermittent asthma. However, for patients with mild, moderate, or severe persistent asthma they should be used as needed, along with another medicine, such as an inhaled steroid. Overuse carries a risk to patient and can lead to death in rare cases.

We also found where patients failed to attend annual reviews, the practice did not incentivise them to attend, as their medicine continued to be prescribed and prescribed at the same interval frequency.

### **People experiencing poor mental health**

There was a lack of rigour in the review process for patients who experience poor mental health. When patients reported new symptoms, these were not always considered as part of the patients' annual review and there were examples where these were not taken into account when considering the patients repeat prescribing. Although the practice told us they considered all patients with significant mental illness who were not engaging with treatment or with local mental health services on an annual basis, this was not clearly recorded and we were concerned there was a risk that patients may not receive appropriate care and treatment.

## **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 medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. However, these had been put on hold during the pandemic. The practice planned to offer these to patients again in due course.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## **People with long-term conditions**

## **Population group rating: Requires Improvement**

### **Findings**

This population group was rated as requiring improvement because:

- For patients living with diabetes we found where patients had poor diabetic control, there was no recorded discussion of risk with the patient and no record of discussion of alternative treatment options to help the patient better control their diabetes.

- For patients living with asthma, the annual review process was not effective at supporting patients to control their symptoms. High use of Short-Acting Beta Agonists (SABAs) was not addressed and patients who failed to attend were not incentivised to attend.

We also found:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	74.1%	77.6%	76.6%	No statistical variation
PCA* rate (number of PCAs).	14.0% (97)	16.2%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	91.2%	91.0%	89.4%	No statistical variation
PCA rate (number of PCAs).	15.2% (49)	13.6%	12.7%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

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) (QOF)	87.9%	85.9%	82.0%	No statistical variation
PCA* rate (number of PCAs).	4.4% (14)	5.9%	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) (QOF)	71.4%	70.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	16.2% (69)	21.6%	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) (QOF)	79.2%	75.5%	72.4%	No statistical variation
PCA rate (number of PCAs).	6.4% (81)	7.7%	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) (QOF)	91.9%	94.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.3% (5)	5.3%	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) (QOF)	81.9%	80.3%	75.9%	No statistical variation
PCA rate (number of PCAs).	13.1% (56)	11.8%	10.4%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

## Findings

- The practice had met the minimum 90% for all five childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of 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 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) (01/04/2019 to 31/03/2020) (NHS England)	87	87	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	87	88	98.9%	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)	87	88	98.9%	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)	85	88	96.6%	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)	91	98	92.9%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The practice continued to be under the 80% target for cervical cancer screening, despite having an improvement plan in place. Take up of screening had been impacted by the pandemic because although the practice had offered screening to patients throughout, they found some patients were reluctant to attend during lockdown periods.
- 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. However, these had been temporarily paused during the pandemic to keep patients safe and to focus on areas of most risk. 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 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: 31/03/2021) <small>(Public Health England)</small>	68.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	67.4%	70.0%	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) <small>(PHE)</small>	57.2%	64.0%	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) <small>(QoF)</small>	94.3%	93.5%	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) <small>(PHE)</small>	37.9%	51.9%	54.2%	No statistical variation

### Any additional evidence or comments

The practice had not made progress in improving cervical cancer screening rates. At the last inspection we carried out in January 2018, we found the practice should take steps to improve the screening rate. Data from 2016/2017 which we reviewed at that inspection, showed the practice had achieved 71%. The practice was now at 68%.

The practice had a plan in place to encourage uptake. There was promotional material in the practice waiting area. Practice nurses rang patients who had not booked appointments or failed to attend, to answer any questions and encourage uptake. Patients who were on the cusp of becoming eligible for screening (as they were about to turn 25) were sent a letter direct from the practice inviting them to screening. Patients could book appointments online and early morning and evening appointments were available for patients in education or work. We asked the practice if they had done any analysis of patients who had not come forward for screening. They told us it was the younger age group (25-49) but they had not identified any other characteristics which would help them target their promotion of screening.

The cervical screening programme coverage statistics from NHS digital, updated quarterly to 22 July 2021, showed that the uptake for those aged 50 to 64 had risen from 70.8% in quarter four 2018/19 to 74.6% in quarter four 2020/21. Comparatively, for those aged 25 to 49 data for quarter four 2018/19 showed 66% had been screened, compared to 64.6% in quarter four 2020/21. The practice told us they planned to review the records of patients aged 25 to 49 who had not attended for screening to inform and adopt a more personalised approach to encouraging uptake of screening.

## People whose circumstances make them vulnerable

## Population group rating: Good

### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The practice employed the nurse who was also the CCG clinical lead nurse for people with a learning disability or autism. From August 2020 to August 2021 the practice had carried out 47 reviews of the 73 on their list of patients with a learning disability. The pandemic had impacted on capacity for this, but the practice planned to carry out an annual review for all patients with a learning disability by the end of the financial year.
- 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.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Requires Improvement**

**Findings**

This population group was rated as requiring improvement because:

Although the practice told us they considered all patients with significant mental illness who were not engaging with treatment or with local mental health services on an annual basis, this was not clearly recorded and we were concerned there was a risk that patients may not receive appropriate care and treatment.

We also found:

- 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) <small>(QOF)</small>	100.0%	92.0%	85.4%	Variation (positive)
PCA* rate (number of PCAs).	14.3% (7)	21.9%	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) <small>(QOF)</small>	79.7%	80.6%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.5% (4)	7.9%	8.0%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.



## Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	551.8	533.9
Overall QOF score (as a percentage of maximum)	98.7%	95.5%
Overall QOF PCA reporting (all domains)	7%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- The practice had achieved a 69% reduction in benzodiazepine prescribing over a two-year period. The quality improvement work, evidenced by the clinical audit, demonstrated reduced prescribing rates from 16.36 items per 1,000 patients in 2018 to 5.03 items per 1,000 patients in 2020. This had considerably reduced the risks for these patients. At the last data collection, the practice found the last 16 patients with inappropriate prescriptions identified (0.16% of the practice population), all were on reducing regimens and there were zero instances where inappropriate benzodiazepine prescribing had not been discussed with the patient.
- Audit of those patients with high blood sugar levels who did not have a clinical diagnosis of diabetes.

### Any additional evidence or comments

The practice provided us with a detailed audit plan for the current and next financial year. This included the national quality improvement work the practice was participating, as well as that they had instigated themselves. These set a clear framework for quality improvement work in the practice.



## Effective staffing

**The practice was able to demonstrate 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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> The practice had good arrangements in place for new staff joining the practice but had identified a need for a more coordinated approach across the practice to incorporate all staff, particularly clinical staff. The practice had become a training practice and had a GP trainer in place. This GP was taking a lead role in clinical assessments and supervision within the practice. Another GP was in progress of training to be a GP trainer and would share this role in the future. The practice plan was for:</p> <ul style="list-style-type: none"><li>• All clinical staff to have one to one sessions on a rotational basis;</li><li>• Proactive identification of learning needs, through work-based assessments;</li><li>• Random case analysis for clinicians;</li><li>• Identified learning and development plans for all clinicians based on the above.</li></ul> <p>This was yet to be implemented but the practice anticipated this would help them address any inconsistencies in the implementation of policies and identify issues with clinical practice at the earliest stages to allow them to offer support and additional training where needed.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: The remote clinical searches we carried out as part of this inspection demonstrated appropriate arrangements were in place for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions.	

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Although the practice understood the challenges they faced to providing good quality care, they were still in progress of implementing some of their plans to address these.</p> <p>The practice had also been subject to some external scrutiny, which had helped highlight some areas of weakness and they were working with NHS England and the local clinical commissioning group to address these.</p> <p>We found the practice was in the midst of a cultural change. There had previously been some resistance to moving forward with quality improvement plans. This meant there was inconsistent adoption of new policies and procedures, which frustrated the quality improvement work. The practice planned to adopt a more equitable approach, where all staff were subject to scrutiny and oversight to encourage a culture of supportive challenge. Although the framework for this had been developed, it was not yet in place.</p> <p>Therefore, we found there were some areas of improvements the practice were implementing, which had yet to demonstrate the desired outcome. The timeliness of some improvements had been impacted by the pandemic, and the associated bearing this had on the provision of clinical care.</p>	

### Vision and strategy

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

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

<p>Explanation of any answers and additional evidence:</p> <p>The practice mission statement described the practice as being “Committed to providing Better Health &amp; Better life for our Patients”. This was supported by the practice vision and values statements.</p>
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## Culture

### The practice had started to develop a culture which would drive high quality sustainable care

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

<p>Explanation of any answers and additional evidence:</p> <p>The arrangements to deal with any behaviour inconsistent with the vision and values had historically been ineffective. We saw evidence the practice had started to develop a culture of supportive challenge but had yet to demonstrate this would lead to a whole practice approach to driving high quality sustainable care. However, we found the practice had started to put the building blocks in place to support the required change. For example:</p> <ul style="list-style-type: none"> <li>• Staff reported they were able to share ideas for how to improve and they were listened to.</li> <li>• The practice encouraged candour, openness and honesty and this was demonstrated in the way they used significant events as an opportunity to improve patient care.</li> <li>• The practice had attracted new clinical staff to join the practice who were enthusiastic about being a part of a practice with quality improvement at its heart.</li> </ul>
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### Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviews and questionnaires	<p>Staff reported they liked working for the practice. They told us managers and leaders were approachable and helpful.</p> <p>They told us team working across the practice was good. Also, they were encouraged to bring forward ideas for improvement, these were considered and where appropriate acted upon.</p>

## Governance arrangements

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

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

## 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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The practice did not have a formal approach to managing and mitigating the known business risks. The partners and management team demonstrated they had a good understanding and control of these but had not pulled them together into a risk register for ease of reference.	

**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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes

The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

### 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.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

### 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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: Although the Patient Participation Group had chosen not to meet during the pandemic, the practice had taken steps to keep in touch and keep the group informed. There were plans to reconvene the group as soon as they felt safe to do so.	

Feedback from Patient Participation Group.

Feedback
The feedback from the group was positive. The chair told us group members were looking forward to meeting again, once they felt safe to do so. But in the meantime, the practice continued to keep them updated and informed. They told us the practice had helped to resolve some issues patients had in getting the Coronavirus (COVID-19) vaccine; even though the practice were not directly responsible for administering this.

## 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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: The practice had an audit plan in place, and this was based on the involvement in national work as well as the practice's own quality improvement plans. It was clear from the evidence shared with us and interviews with staff that there was a strong emphasis on quality improvement.  The practice had been placed into special measures by the CQC in July 2015. Since then the practice had demonstrated continuous and sustained improvement in most areas.  The practice demonstrated they continued to improve the ways in which patients could access the service. They had supported and publicised the use of online consultations, with an average of 50 online consultations a week. They demonstrated repeated use by patients with 1002 having an online consultation, of which 365 had used the service more than twice, 111 used it more than four times and 11 used it more than 10 times. The practice had not yet been able to gather the views of patients on	

the use of online consultations but felt the repeat usage demonstrated patients liked the service and found it easy to use.

## Examples of continuous learning and improvement

- Sustainment of improvements implemented since last CQC inspection in February 2018.
- Significant reduction in benzodiazepine prescribing.
- Workflow and coding audits
- Audit of B12 injections to ensure patients receiving the right care for their needs.

### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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](#) ). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.