

# Care Quality Commission

## Inspection Evidence Table

### Clifton Medical Centre (1-4071801165)

Inspection date: 14 September 2020 to 2 October 2020

Date of data download: 07 September 2020

## Overall rating: Not rated

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

## Safe

## Rating: Not rated

We inspected the practice in January 2020 and rated the practice inadequate for providing safe services. The previous rating remains unchanged.

### Safety systems and processes

**The practice did not have 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.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
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.	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.	Partial
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<p>Staff were aware of safeguarding systems, processes and practices; however, we found that practices were not embedded into routine practice. Clinical leads explained non-clinical managers monitored vulnerable patient registers and kept them updated. A random sample of records viewed remotely showed that vulnerable patients records were not routinely updated. In particular, records showed vulnerable patients who had not been reviewed in the last 12 months; patients who were under a child protection plan (CPP) did not have all correspondence scanned into their clinical records; and alerts on clinical records were not consistently used to easily identify vulnerable patients. There were also records which showed a uniform approach was not adopted to ensure all siblings records included safeguarding information.</p>	
<p>Following our inspection, the provider submitted a safeguarding review template which staff were required to commence using when reviewing patients records. The provider also submitted details of actions taken to contact and review identified vulnerable patients and explained that reconciliation of registers was scheduled to take place during the scheduled multi-disciplinary team meeting (MDT).</p>	
<p>Records provided by the provider showed staff had completed safeguarding training relevant to their role. During our December 2019 comprehensive inspection, a sample of records viewed showed no evidence to confirm that vulnerable patients had been discussed as part of a multidisciplinary meeting with the health visitor. During this inspection, we found little change in record keeping. In particular, Child protection conference reviews were not routinely added to patients records, safeguarding meetings were not always recorded and children who were presented at accident and emergency were not routinely being followed up.</p>	

Recruitment systems	Y/N/Partial
<p>Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).</p>	Y
<p>Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.</p>	Y
<p>There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.</p>	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our December 2019 comprehensive inspection, the provider took action to ensure appropriate recruitment checks were carried out. Records viewed as part of this inspection, showed staff employment files included relevant information demonstrating pre employment checks had been carried out. Information showed the practice had gained assurance that disclosure and barring service (DBS) checks had been carried out.</p> <p>The practice training matrix showed staff had received training identified by the provider as mandatory training.</p>	

<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. Clifton Medical Centre and Victoria Health Centre date of last inspection/test: 20/08/2020	Y
There was a record of equipment calibration. Clifton Medical Centre and Victoria Health Centre date of last inspection/test: 20/08/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Clifton Medical Centre Date of last check: May 2020	Y
There was a log of fire drills. Clifton Medical Centre date of last drill: January 2020 Victoria Medical Centre date of last fire drill: March 2020	Y
There was a record of fire alarm checks. Date of last check:	Partial
There was a record of fire training for staff. Date of last training: All staff completed in the last 12 months.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Clifton Medical Centre date of completion: July 2020 Victoria Medical Centre date of completion: September 2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:  Members of the management team explained new cleaning products had been added to cleaners' stock; therefore, the Control of substances hazardous to health (COSHH) was updated to prevent, reduce as well as control exposure to hazardous substances in order to prevent ill health to staff. The management team explained the COSHH risk assessment was last updated August 2020.  The management team told us that safety systems and records for Victoria Health Centre was maintained and managed by NHS property services. At the time of our interviews; senior staff we spoke with did not have the dates of the last fire extinguisher checks, fire alarm checks. The management team explained there were no fire alarms installed at Clifton Medical Centre; however, risk assessments had been carried out to mitigate potential risks.	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Clifton Medical Centre date of last assessment: May 2020	Y

Victoria Medical Centre date of last assessment: June 2020	
Health and safety risk assessments had been carried out and appropriate actions taken. Clifton Medical Centre date of last assessment: May 2020 Victoria Medical Centre date of last assessment: June 2020	Y
The management team explained the practice self-monitored and managed risks associated with legionella during COVID-19 pandemic. Assessment carried out by an external specialist in September 2020. Staff explained the practice received confirmation from NHS property service they had been monitoring legionella risks and at the time of our inspection, the practice were awaiting documentation to evidence this.	

Explanation of any answers and additional evidence:

### Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of Clifton Medical Centre last infection prevention and control audit: February 2020 Date of Victoria Medical Centre last infection prevention and control audit: August 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
<p>Explanation of any answers and additional evidence:</p> <p>Staff explained issues had been identified in the infection prevention and control audit such as placing labels on bins to identify domestic and clinical waste had been carried out.</p> <p>Since our previous inspection, staff explained actions taken to strengthen the management of infection prevention and control to ensure standards of cleanliness and hygiene were being met. Staff explained systems and processes for ensuring clinical waste was stored securely. For example, clinical waste was segregated and placed in lockable storage bins. Designated leads had been established and staff had completed training to enable them to carry out their roles safely. The provider had an overarching infection prevention and control policy however, this lacked detail and did not include areas such as the management of sharps.</p>	

### Risks to patients

#### There were gaps in systems to assess, monitor and manage risks to patient safety.

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

There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our last inspection the provider had sought to strengthen the practice workforce. This included clinical and managerial staff to support the practice.</p> <p>The provider was also able to demonstrate an effective induction process was in place for new staff.</p> <p>The management team explained equipment to enable assessment of patients with presumed sepsis in line with national guidance was available in all clinical rooms. Training records provided showed staff had received Basic Life Support (BLS) training as well as sepsis training.</p> <p>On reviewing a sample of patient records we found comprehensive risk assessments that followed national guidance were not always carried out for all patients. For example, in relation to the assessment of patients symptoms and potential red flags and during medicine reviews.</p> <p>Staff explained the use of logs to monitor emergency medicine expiry dates and stock level. However, as part of this inspection, we did not visually check the practice stock of emergency medicines.</p>	

## Information to deliver safe care and treatment

**Staff did not have 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.	Partial
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.	Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>A random view of clinical records showed gaps in some clinical record keeping. In particular we found clinical notes did not always contain adequate documentation of history, examination, diagnosis, follow up arrangements or detail of medication reviews undertaken.</p> <p>We were told the backlog of Lloyd George notes requiring summarising dating between 2017 and 2018 identified during our previous inspection, had been addressed and a system to ensure timely summarizing of notes had been embedded. However, no evidence was provided to demonstrate that there was no longer a backlog.</p> <p>Members of the management team explained how the practice used an electronic document management, workflow and transfer software system across the two sites. Staff explained this enabled the management team to monitor and ensure actions were being taken and anything urgent was prioritised and pulled out for clinical attention.</p> <p>Non-clinical staff explained systems for managing clinical correspondence which involved supporting GPs with clinical administrative tasks. For example, incoming correspondence about patients were processed by non-clinical staff and then sent to GPs who reviewed information and took appropriate actions such as adding appropriate clinical codes or tasking non-clinical staff to contact patients and arrange appointments.</p>	

## Appropriate and safe use of medicines

### The practice did not have systems for the appropriate and safe use of medicines, including medicines optimization

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.85	0.82	0.85	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA)	6.0%	5.9%	8.6%	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 (01/01/2020 to 30/06/2020) (NHSBSA)	5.95	5.15	5.35	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	0.85	1.35	1.92	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N/A
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.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial



Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N/A
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.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our review of clinical records we found some patients that had not received appropriate reviews or monitoring of their medicines. We were told that monthly searches were carried out to identify patients who required monitoring and these patients were contacted. However; a random samples of clinical records showed high-risk medicines were not consistently being monitored appropriately and there were areas where monitoring was not in line with National Institute for Health and Care Excellence (NICE) recommendations.</p> <p>We identified a high number of clinical records which had been coded as medication review completed between June and September 2020; however, clinical notes did not include details of what had been done. There was evidence of codes being added over the weekend and up to 19 codes added within the space of one hour with a lack of records detailing what had been reviewed.</p> <p>The provider was unable to demonstrate that staff employed as independent prescribers were carrying out regular reviews and assessments of their prescribing in line with national guidance.</p> <p>The system for monitoring medicines stored at the practice had been strengthened and the management team explained recording forms were being completed and checked to enable staff to safely monitor stock levels and expiry dates. Log forms also enabled staff to record dates when medicines had first been opened to provide assurance that these medicines were not out of date. Staff explained members of the practice nursing team kept track of expiry dates on a monthly basis as well as ensure content matched the recording form.</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.	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:	Six
Number of events that required action:	Six
<p>Explanation of any answers and additional evidence:</p> <p>The management team explained actions taken to strengthen processes for recording incidents and sharing learning. Staff were required to report all significant events to the leadership team. Incidents were investigated and learning discussed during practice and clinical meetings; minutes were then circulated by email. Senior staff members explained a total of two formal practice meetings and two clinical meetings had been held since February 2020. During COVID-19 pandemic there were provisions for staff who were shielding to join these meetings remotely through video calls.</p> <p>The practice held their annual significant event analysis meeting in September 2020. Staff reviewed all six significant events to identify common themes which related to electronic document management, workflow and transfer software failures.</p>	

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

Event	Specific action taken
Unable to pull documents from electronic document management, workflow and transfer software.	Staff contacted IT support as well as secondary care. The practice worked with IT and secondary care to address the technical issues identified.
Boiler failure	Arrangements were made to repair the boiler; engineers attended the practice on the same day.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Members of the management team and non-clinical staff we spoke with described systems in place to manage receipt and dissemination of safety alerts. Members of the management team explained the clinical pharmacist maintained oversight of all incoming safety alerts; which included reading, disseminating and ensuring staff had read alerts. Staff explained actions taken following receipt of an alert relating to Speculums (a device used to see inside part of the body). Pharmacists confirmed that they were responsible for receiving, disseminating and actioning relevant safety alerts. Records of</p>	

alerts received through the Central Alerting System (CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance) were held.

However, not all clinical staff we spoke with were aware of the process for receiving or actioning Medicines and Healthcare products Regulatory Agency (MHRA) and drug safety updates. They were unable to describe any activities relating to recent updates. Clinical records showed patients prescribed a combination of medicines which were not recommended by MHRA following an alert had not been identified and actions had not been taken to reduce risk.

## Effective

## Rating: Not rated

We inspected the practice in January 2020 and rated the practice inadequate for providing safe services. The previous rating remains unchanged.

### Effective needs assessment, care and treatment

**Patients' needs were not routinely assessed, and care and treatment were not always being 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had systems to keep clinicians up to date with current evidence-based practice; however, a random view of clinical records showed clinicians did not always assess patients' needs and deliver care and treatment in line with current guidance. For example: patients prescribed a high-risk medicine were not routinely monitored in line with NICE guidance.</p> <p>As part of the response to COVID-19 pandemic the practice used digital technology such online consultations as well as telephone and video consultation. However, clinical records we viewed did not routinely demonstrate that clinicians were checking patients' demographics as part of security checks to confirm they were speaking with the correct patient.</p> <p>A random sample of clinical records viewed remotely showed patients treatment was not always reviewed or updated. In particular, we saw the use of medication review clinical codes being added to clinical records; however, no evidence of an actual review being carried out and monitoring being overdue. Records viewed showed in a three-month period a total of 823 medication reviews had been coded as completed by clinicians.</p>	

We identified patients who had potential missed diagnoses of diabetes that had not been adequately reviewed or referred for the National Diabetes Prevention Programme of diabetic eye screening when appropriate. We also saw records in which appropriate safety netting advice and guidance had not been provided.

We found gaps identified during our December 2019 comprehensive inspection were still present during this inspection. For example, a random sample of medical records showed that care plans for patients on the palliative care register or patients with a learning disability had not been completed.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) <small>(NHSBSA)</small>	0.28	0.67	0.70	Variation (positive)

## Older people

## Population group rating: Not rated

### Findings

- The practice carried out some annual medication reviews for older patients, however on reviewing a sample of clinical records we found medication reviews were inadequate and did not follow recommended guidelines.

## People with long-term conditions

## Population group rating: Not rated

### Findings

- Some patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met, however we identified gaps in reviews and monitoring when reviewing a sample of patient records.
- Due to the lack of information recorded during consultations with patients, the practice were unable to evidence that clear and accurate information with relevant professionals was shared when deciding care delivery for patients with long-term conditions.
- We identified issues with the management and coding of patients at risk of developing diabetes who did not receive appropriate support and follow up.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	69.9%	75.2%	76.6%	No statistical variation
Exception rate (number of exceptions).	2.2% (7)	6.1%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	55.4%	85.9%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	2.4% (2)	10.1%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	91.2%	91.5%	91.8%	No statistical variation
Exception rate (number of exceptions).	1.7% (1)	3.2%	4.9%	N/A

#### Any additional evidence or comments

Clinical staff explained that due to the absence of nurse consultant provision and nurses trained in Chronic obstructive pulmonary disease (COPD), the management of patients with a respiratory condition had been impacted.

The Clinical Commissioning Group's (CCG) Primary Care Commissioning Framework (PCCF) report showed the practice had failed to achieve the 2019/2020 standards for shared care prescribing, diabetes treatment targets, all coronary vascular disease and most respiratory standards. The PCCF is a scheme with eleven standards with the aim to develop general practice, encourage partnership working and deliver improvements in clinical outcome for patients.

#### Families, children and young people

#### Population group rating: Not rated

#### Findings

- The practice had not met the minimum 90% for one of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators.
- Since the last inspection, the practice told us they had implemented improvements to ensure all information on the safeguarding register was accurate. However on reviewing a random sample of records we found no evidence that the practice had been proactive in reviewing or discussing the possible risks the children may be exposed to.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	62	78	79.5%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	62	65	95.4%	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) (01/04/2018 to 31/03/2019) (NHS England)	61	65	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	61	65	93.8%	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>

### Any additional evidence or comments

Staff we spoke with explained processes to encourage in improve the uptake of childhood immunisations. Management received lists of all children who had not received their immunisations. Designated admin support managed the booking system and contacted parents or guardians to offer appointments at a suitable time.

Staff explained during COVID-19 pandemic patients were being referred to alternative locations (amber sites, offering face to face consultations for non Covid-19 symptomatic patients). Staff had access to four additional appointments daily which were used as catch up appointments. Staff explained that they contacted the parent or legal guardian of children who missed their vaccinations due to COVID-19, and made an appointment for them to attend the amber site.

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

**Population group rating: Not rated**

### Findings

- The practice was below the national target for uptake of cervical screening. Trends over time showed the practice had consistently been low for cervical screening uptake. The practice told us that following the pause in the cervical screening programme from March 2020 to June 2020 due COVID-19 pandemic, clinics were implemented and accessed at the Amber site based at



Stone Cross Medical Centre. Members of the nursing team explained they went through a list of identified patients and took action to contact patients and book them in for a screening appointment. within practice to encourage patients to attend for screening.

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: 31/03/2020) (Public Health England)	58.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	68.1%	65.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	45.7%	43.8%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	48.0%	68.1%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	62.5%	48.7%	53.8%	No statistical variation

#### Any additional evidence or comments

Members of the practice nursing team explained cervical screening appointments were available at the amber site. Staff explained to increase the uptake of cervical screening the practice worked through a list of identified patients and actively contacted them to arrange screening appointments. The practice nurses explained on average three to four patients attended the designated smear clinics which were held daily.

#### People whose circumstances make them vulnerable

Population group rating: Not rated

#### Findings

- The practice took part in the local primary care commissioning framework (PCCF), which was a set of standards to monitor patient care. The practice had failed in a series of outcome measures between 2018/19 and 2019/20 for this indicator. For example, the practice had not met the target for the number of carers offered health checks in the last 12 months.
- Records viewed during our previous inspection as well as this inspection did not show that patients on the learning disability register had a care plan in place. Records did not demonstrate that patients with a learning disability were being offered an annual check.

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

**Population group rating: Not rated**

**Findings**

- The practice took part in the local primary care commissioning framework (PCCF) which showed the practice had not met the performance targets from 2018/19 to 2019/20 on mental health and dementia standards.
- Nationally reported patient outcome data showed the practice performance for mental health and dementia indicators was significantly below local and national averages.

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)	18.4%	84.1%	85.4%	Significant Variation (negative)
Exception rate (number of exceptions).	2.0% (1)	20.2%	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)	14.3%	79.0%	81.4%	Significant Variation (negative)
Exception rate (number of exceptions).	12.5% (2)	9.0%	8.0%	N/A

Any additional evidence or comments
Members of the management team demonstrated awareness of data relating to mental health indicators and explained actions to improve areas which were below local and national averages. This included offering video consultations as well as telephone consultations to review patients diagnosed with dementia care plans. The management team explained mental health indicators was a working progress and there were plans to explore reasons for low uptake in more detail. Staff explained patients often declined reviews as they felt there was stigma surrounding being labeled as having mental health related condition.

### Monitoring care and treatment

**The practice had a programme of quality improvement activity. However, this was not comprehensive with limited monitoring of the outcomes of care and treatment.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	481.2	536.8	539.2
Overall QOF score (as a percentage of maximum)	86.1%	96.1%	96.7%
Overall QOF exception reporting (all domains)	3.8%	6.7%	5.9%

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

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

Prior to our inspection, the provider submitted evidence of audits carried out. For example, audit carried out to identify patients prescribed Non-steroidal anti-inflammatory drugs (NSAIDs) without gastroprotection to ensure guidelines were being followed. The audit found 41% of patients were not being managed in line with national guidelines. Identified patients were contacted and a repeat audit was carried out five days after the first audit which showed actions had been taken to address identified risk; however, the audit did not demonstrate whether actions had positively impacted on patient care.

#### **Any additional evidence or comments**

Clinical staff we spoke with during our inspection, were unable to demonstrate knowledge or involvement in these clinical audits. Staff explained that an audit may have been carried out during May 2020; however, unable to confidently confirm this or explain actions as a result of any findings.

There were areas where clinical oversight was not managed effectively. For example, the practice did not operate or establish an audit cycle to enable effective monitoring of clinical records to ensure they included a comprehensive record of patients care and treatment as well as details of medication reviews.

## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, some areas lacked clinical oversight.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
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> <p>Since our previous inspection, actions had been taken to strengthen the monitoring of the practice online matrix. Staff in lead roles explained how they used the matrix to identify and respond to training needs. Records showed staff were up to date with training identified by the provider as mandatory training. In particular, we found update training such as infection prevention and control (IPC) and sepsis had been completed.</p> <p>The management team ensured staff at the branch site (Victoria Health Centre) were aware of the appointment booking process and ensured staff were following a structured process to ensure patients were being offered appointments with the appropriate clinical staff to effectively respond to patients' clinical needs. Non-clinical staff we spoke with described following a flow chart and clearly demonstrated their awareness of how to ensure patients were being booked in with the most appropriate clinician.</p> <p>On reviewing a sample of clinical supervision sessions, there was minimal clinical supervision in place and limited discussions of consultations. We were told that clinical leads were now in place to support clinical supervision and GPs were given 10 minutes at the end of each day for peer support. Regular clinical meetings were being held every four to six weeks.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	92.9%	94.7%	94.5%	No statistical variation
Exception rate (number of exceptions).	1.0% (14)	0.7%	0.8%	N/A

## Well-led

## Rating: Not rated

We inspected the practice in January 2020 and rated the practice inadequate for providing well led services. This rating remains unchanged.

### Leadership capacity and capability

**There was effective leadership at some levels. However, changes implemented since our previous inspection were not fully embedded and some areas of clinical leadership was ineffective.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
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:	
<p>Following our previous inspection, the practice received support from the local Clinical Commissioning Group (CCG) who commissioned the Royal Collage of General Practice (RCGP) to support the practice. The provider had also recruited a partner and needed to update their CQC registration.</p> <p>The provider strengthened the non-clinical management team by recruiting local managers to support the day to day management of the practice. Non-clinical managers demonstrated a clear vision in relation to improving service delivery and providing effective patient care. Clinical leadership had been strengthened since our previous inspection. However, changes within clinical leadership were in their infancy and had not been fully embedded; therefore, we identified areas where patients were exposed to potential risk.</p> <p>During our previous inspection, as well as this inspection we identified failings in the care of patients, this included; oversight of safeguarding registers, overall management of patients with long term conditions and a lack of clinical oversight to ensure patients were receiving adequate care and treatment in line with NICE guidelines. The provider demonstrated plans to recruit additional clinical leadership within the practice and were at the early stages of the recruitment campaign such as awaiting approval from NHSE.</p> <p>Staff we spoke with along with evidence provided demonstrated actions had been taken to address non-clinical issues identified during our previous inspection. In particular, management of environmental risks and improved oversight of Infection Prevention and Control as well as processes for monitoring training needs and recruitment.</p> <p>The provider made use of technology to help centralise governance arrangements within the practice.</p>	



## Vision and strategy

**The practice had a vision and strategy; but systems and processes did not routinely support delivery of high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N/A
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with were able to describe the practice vision and actions taken to enable delivery of high quality, sustainable care. We found actions were in their infancy with some embedded and others not quite embedded or operating effectively. This was mainly due to the lack of clinical leadership therefore, the provider was unable to demonstrate a fully embedded strategy to improve patient outcomes.</p> <p>The practice had implemented some systems since our previous inspection, to support visions surrounding strengthening non-clinical management. However, the provider did not demonstrate an effective system to monitor progress or enable prompt actions to ensure services were meeting the clinical needs of their practice population.</p>	

## Culture

**The practice culture did not routinely effectively support high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N/A
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
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> <p>The management team told us practice meetings were held every eight weeks; clinical and MDT meetings took place monthly. Management also explained regular update meetings within the team; however, staff explained these meetings were informal and no minutes were taken for these meetings. Records provided showed two formal practice meetings and clinical meetings held since February 2020.</p> <p>On speaking with a cross section of clinical and non-clinical staff, we found a divided culture amongst them. There was no coherent response in regards to questions about the culture within the practice. In particular; staff did not always feel able to work autonomously.</p>	

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

Source	Feedback
Staff	We received mixed responses on the support received at the practice. Some staff told us they felt well supported, whilst others declined to comment.

## Governance arrangements

**There were some improvements to the overall governance arrangements however, processes and systems in place to support the delivery of good quality and sustainable care were not fully embedded.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Since our previous inspection, the provider strengthened local leadership to support the day to day management of the service. We saw areas such as non-clinical governance arrangements which had been improved. In particular, non-clinical structures, systems of accountability were set out and understood which we saw resulted in improved management of environmental risks and respond appropriately without delay where environmental safety was being compromised. However, the oversight of clinical governance arrangements was not fully embedded and arrangements with stakeholders was an ongoing process.</p> <p>Formal meetings had been introduced; and documents provided demonstrated that the practice was holding practice and clinical meetings. There were standing agenda items which included Infection Prevention and Control, safety alerts, complaints, incidents as well as health and safety. Members of the management team explained daily informal management meetings were held; however, these meetings were not minuted.</p> <p>Recruitment processes had been strengthened and records we viewed contained evidence of pre employment checks as well as professional registrations, indemnity cover and completed training.</p> <p>The provider had taken some action to strengthen clinical governance. However, changes were in their infancy and had not progressed far enough to ensure patients were not exposed to potential risk. In particular, there was ineffective oversight of medicine management as well as monitoring and supporting non-clinical prescribers. We also found management of vulnerable patients was not effective and that processes for the managing MHRA alerts needed further improvement. Following our inspection, the provider submitted documents detailing actions taken since our inspection to address identified areas. However, actions were in their infancy and there was no evidence that these were embedded into day to day working practice.</p>	

## Managing risks, issues and performance

**There were practices which did not result in clear and effective processes for managing clinical risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
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.	Partial
Explanation of any answers and additional evidence:	
<p>The provider is part of the local Primary Care Commissioning Framework (PCCF helps to develop general practice, encourage partnership working and deliver improvements in clinical outcomes for patients based of a set of standards). Results from 2019/20 showed the practice had failed to meet the targets for shared care prescribing, diabetes treatment targets, all cardio vascular disease indicators and all mental health standards.</p> <p>The management team described processes to receiving and disseminating safety alerts. However, a random search of published MHRA alerts indicated that the practice were not receiving or acting on all MHRA alerts in order to reduce risks to patient safety.</p> <p>Minutes of meetings seen showed discussions of CQC previous comprehensive inspection report findings; such as IPC, Health and Safety (H&amp;S), safety alerts, complaints and significant events. Discussion with the management team indicated that enviromental risks in relation to the premises were being managed appropriately. The management team told us enviromental risk assessments had been completed for the main site and branch.</p> <p>The practice responded to previously identified risk in relation to staffing levels as well as staff training and development. There was evidence that staff had completed training relevant to their role and staff registration had been reviewed where appropriate. The provider also strengthened the practice management team and nursing provision through a successful recruitment campaign.</p> <p>The practice was unable to demonstrate they had strengthened their processes to manage current and future clinical performance. In particular, the performance of employed clinical staff could not be demonstrated through audit of their consultations, clinical supervision and prescribing decisions. However, following our inspection, the provider submitted evidence of actions taken in response to issues identified during our inspection.</p> <p>The practice had implemented some audits, but had yet to demonstrate improvements on fthe quality fo care and outcomes over time.</p>	

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### Appropriate and accurate information

#### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>During this inspection, senior staff members articulated and provided evidence which demonstrated that actions had been taken by the provided to address some concerns identified during our December 2019 comprehensive inspection. However; there were areas where inspectors were unable to gain assurance that progress had been made. We found that oversight of clinical governance did not routinely ensure that staff had access to information which was accurate and valid. The provider did not demonstrate that all streams of data and clinical information was routinely being used to adjust and improve performance.</p> <p>An independent GP review carried out in August 2020 identified a lack of consistency in clinical coding at the practice. During this inspection, we also found a similar pattern from the clinical records we viewed.</p>	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	N/A
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>In response to COVID-19 pandemic the provider utilised digital technology by increasing awareness of online and video consultation in order to reduce patient footfall within the practice as a way of preventing the spread of COVID-19. A random sample of clinical records indicated that clinicians were not routinely documenting that patients demographics were being checked before commencing telephone consultations.</p>	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an active patient participation group (PPG), the provider and practice management attended PPG meetings. Members of the management team explained face to face meetings had been halted due to the COVID-19 pandemic; however, engagement continued virtually.</p> <p>The provider and management staff worked with stakeholders such as the local CCG, within a primary care network (PCN) and received support from the Royal College of General Practitioners (RCGP). The provider also liaised with secondary care to improve the management of test results as well as the district nursing team, safeguarding team and respiratory nurses.</p> <p>During COVID-19 pandemic the provider worked with the local CCG and PCN to ensure service provision continued. During practice meetings staff discussed how services would recommence following national and local lockdown measures. The provider was also seeking to develop central structures using technology to improve communication pipelines.</p>	

## Continuous improvement and innovation

**There was some evidence of a systematic approach for learning, continuous improvement and innovation within the practice clinical governance framework.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
<p>During this inspection, we saw evidence of actions taken to improve non-clinical governance framework which resulted in positive outcomes. However, issues within the clinical governance framework showed that a systematic approach to managing and mitigating clinical risks had not been fully established or embedded.</p>	

## 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.