

Care Quality Commission

Inspection Evidence Table

Dr P Kerr & Partners (1-589589298)

Inspection date: 29 September 2021, 12 and 13 October 2021

Date of data download: 17 September 2021

Overall rating: Good

At our previous inspections in July 2019, we rated the practice as Requires Improvement. This was because we found breaches of regulation in the Safe and Effective domains.

At this inspection we found the practice had responded to the issues raised at the previous inspection and was now rated Good. For example, all staff had received safeguarding training, appropriate recruitments checks were being completed, patients with long-term conditions and mental health conditions were being fully assessed. The practice had met the minimum 90% for four of five childhood immunisation uptake rates.

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

Safe

Rating: Good

At our last inspection the practice could not always demonstrate:

- Children and adults at risk were always identified on the clinical system using alerts.
- All staff had received safeguarding training to an appropriate level for their role.
- Appropriate recruitment checks and the ongoing monitoring of the registration of clinical staff was completed.
- Evidence of the completion of actions resulting from safety alerts.

At this inspection we found these areas had been addressed, improvements had been made and providing safe services was now rated as Good.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection, we found that alerts were not consistently appearing as expected within clinical records. We also found that correspondence on safeguarding concerns had not always been responded to promptly.</p> <p>At this inspection, we saw evidence that persons at risk were appropriately flagged on the practice systems. The practice provided information to demonstrate that when concerns were raised, they took appropriate action to communicate these concerns and respond to information being shared with them.</p> <p>We saw a new policy put in place on 8 October 2021. This was a combined adult and child safeguarding policy that included the names of the practice leads and the information required to contact external agencies to report safeguarding concerns. Staff we spoke with could identify the safeguarding leads and the actions to take if they were concerns about the welfare of a child or adult.</p> <p>All staff were up to date with their safeguarding training. In addition to this, a weekly safeguarding webinar series by the Surrey Safeguarding Team was put in place that the practice provided protected time for all staff to attend. The practice promoted awareness of domestic abuse and had posters on this subject for patients on the back of toilet doors.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection, we found some staff recruitment records were incomplete. For example, one file did not contain evidence obtained prior to employment of satisfactory conduct in previous employment (usually found in the form of references).</p> <p>Records we saw at this inspection confirmed that appropriate checks had been carried out before staff took up employment with the practice. This included proof of identity, confirmation of the suitability of the person to undertake the role in the form of written references, application forms and/or CVs. The practice also maintained a record of interview questions and responses.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: September 2021	Y
There was a record of equipment calibration. Date of last calibration: June 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 27 July 2021	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 27 July 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 27 July 2021	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided a health and safety risk assessment. This indicated that the practice was required to take immediate action on a number of areas including provision of training for the fire marshal, emergency lighting testing and carrying out a fire evacuation/drill. The practice manager provided an action plan to demonstrate how these areas had been or will be addressed.</p> <p>We saw evidence of a fire evacuation/drill carried out on 16 September 2021 and a report on what went well and what needed to be improved. This had been circulated to all staff.</p> <p>We found areas within the practice were not always free from clutter, in particular the “boiler room”. This was cluttered and contained potentially combustible materials. This was dealt with immediately during the inspection by the practice manager.</p> <p>We noted that not all sharps containers had been removed and disposed of in line with national guidelines of three months. For example, one sharps container was dated ‘06/20’ and another ‘05/20’.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y

Date of last infection prevention and control audit: 26 June 2021	
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
The new practice manager had introduced a new annual statement on Infection Prevention Control (IPC) to be reviewed and updated by the IPC lead and partners annually.	
We saw a basic audit of IPC procedures undertaken by the lead in June 2021. A hand hygiene audit was also carried out on five staff on this date. A more detailed hand hygiene audit was carried out in September 2021 including an analysis of the outcome and action plan.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence:	
We saw sepsis and acutely unwell protocols in place to assist staff in taking prompt action when concerned about a patient. Staff have received training in emergency procedures and basic life support.	

Information to deliver safe care and treatment

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

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

There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.57	0.63	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	15.5%	11.7%	10.0%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	6.13	6.10	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	67.1‰	74.7‰	126.1‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.53	0.76	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	3.7‰	5.3‰	6.8‰	Tending towards variation (positive)

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

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

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>As part of this inspection we conducted remote searches of patient records. The searches we carried out and subsequent examination of patient records during our inspection found that, in most instances all the required up to date health monitoring had been completed. However, some areas required further action.</p> <p>We looked at the prescribing of short-acting beta-agonist (SABA) inhalers (used in the treatment of asthma and COPD). We looked at five patient records and found that not all had received a recent review. For example, one patient had been prescribed 24 inhalers in the last 12 months and their last asthma review was in February 2020. They had been sent a questionnaire to complete and invited to book an appointment, but none had been booked. This was discussed and acknowledged by the lead GP that asthma was an area that required further work to review patients prescribed this set of medicines. The practice told us that more patients were being invited for review with staff being utilised to undertake asthma and COPD reviews.</p>	

Medicines management	Y/N/Partial
<p>Our searches on Chronic Kidney Disease (CKD), indicated that potentially 692 patients may have CKD and required further reviewing. This was an indicative finding and required further investigation. We reviewed five records and found that whilst the records demonstrated patients had received appropriate care and treatment, they did not always demonstrate that patients have been coded as having CKD and informed of this diagnosis. The practice lead was informed of this finding and undertook to review patient records.</p>	
<p>The practice was aware of the prescribing rates for cephalosporins and kept this under review. We were provided with the outcome of a review undertaken by the practice pharmacist to demonstrate appropriate prescribing following our remote access of the practice systems.</p>	
<p>We noted that some consultation rooms were left unlocked while unoccupied on the day of our visit to the premises. When checked, we found that printers in two consultation rooms contained prescription paper. We were informed that printer locks were available for these machines however they were not in situ. The practice took immediate action to secure the two rooms. All other rooms not occupied were seen to be secure.</p>	
<p>We looked at the electronic records for Patient Group Directions (PGD) and found these to be up to date and appropriately authorised. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We also saw an example of the use of Patient Specific Directions (PSDs) used by health care assistants to administer certain medicines to patients.</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:	57
Explanation of any answers and additional evidence:	
The practice record all events for review including unusual and rare diagnosis as a learning opportunity.	

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

Event	Specific action taken
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Delayed pick up for abdominal tumor in child. Rare diagnosis in young child.	Practice reviewed their actions and interventions. Clinicians agreed to reduce the number of contacts regarding a young child to trigger face to face consultation in future. Outcome shared with team.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw examples of actions taken on recent alerts; for example, a medicine for the treatment of epilepsy that has potential risks for patients of childbearing age.</p> <p>We saw a policy that set out the practice approach to the receipt, review, actioning and dissemination of alerts received by the practice. The process was overseen by a Primary Care Network (PCN) pharmacist who worked one day a week in the practice. The practice had started to use a new system as a repository for practice information. We saw the system in use and this included actions taken by staff together with receipt acknowledgments. For example, we saw a recall alert for disposable forceps on the system this had been acknowledged by clinical staff and one of the GP partners had confirmed that these devices had been removed.</p>	

Effective

Rating: Good

At our last inspection the practice was rated as Requires Improvement.

The practice could not demonstrate that the immediate and ongoing needs of patients with long-term conditions and mental health conditions were being fully assessed. The practice's childhood immunisation uptake rates had not all met World Health Organisation (WHO) targets.

At this inspection we found improvement in the assessment of patients with long-term conditions and childhood immunisations met the 90% minimum from the latest verified figures.

Effective needs assessment, care and treatment

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

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

Older people

Population group rating: Good

Findings

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had set up a group known as 'The Wall House champions'. They were a group of 12 patient volunteers gifting their time for the wellbeing of the surgery and its patients. Some of the work they had undertaken includes:
 - Running dementia cafes and walking groups prior to the pandemic and during the pandemic initially supported by delivering shielding letters to patients and checking in on their welfare.

- They have acted as befrienders for patients struggling with isolation, having received training via the Samaritans. One champion has been supporting a patient to document their life story for their family.
 - They also served to deliver prescriptions when pharmacies were unable to offer the service and delivered oxygen saturation monitors as part of their 'Covid at home' programme.
 - From the start of the pandemic to March 2021 they had supported 90 patients as befrienders, making 600 calls over 10 months.
- Patients were referred to the wellbeing plus advisor (if housebound) for help with lifestyle management advice, support for tackling loneliness or isolation, weight loss, smoking cessation and accessing state and third sector agencies to improve their quality of life.
 - The practice clinical pharmacist and team of PCN pharmacists and prescriptions team reconciled medications after discharge. The team called patients to check that they were taking what was on their medication list and checked for any side effects / compliance issues to ensure safe care.
 - The practice care coordinator ensured that those identified as frail and at risk of unplanned admissions were contacted after discharge and had a case load of vulnerable patients whom they contacted regularly to check for any unmet needs, including carer checks.
 - All patients had a named GP who was in a buddy group to foster continuity of care for patients. Each buddy group cares for approximately 7,000 patients.
 - The practice had regular chronic disease review / complex patient appointments available for each clinician to support their patient via phone or face to face to address their health needs in a longer appointment that can be booked in advance.
 - Additionally they offered testing of D-dimer (A D-dimer test can show if you have a blood clotting disorder) to avoid unnecessary referral to hospital for suspected DVTs, thus keeping care of older patients near to home wherever possible.

People with long-term conditions

Population group rating: Good

Findings

- The practice had the ability and facilities to care for their patients with COVID-19 symptoms. They told us of the positive feedback from their most vulnerable respiratory patients that they felt safely cared for during the pandemic and supported.
- The practice told us they started 'Covid at home' oxygen saturation monitoring before the national programme was put in place as they recognised the value of early detection of deterioration.
- The practice had risk stratified a further asthma / COPD catch up programme for those who did not attend reviews in the last 12 months. This was to ensure those at highest risk of COVID-19 or of deterioration were reviewed as a priority prior to the onset of winter pressures. This would help to keep those patients out of hospital and prevent morbidity. They had a catch up programme in place with the aim of achieving 100% in QOF by the end of financial year.
- The practice told us that, for children, any discharge summaries of children with asthma were sent to a paediatric nurse to review. All patients were reviewed by telephone or face to face within 5 days of discharge. A management plan was reviewed and agreed with the child and their carers.
- The practice offered 24-hour ECG and 24-hour BP service in house.
- Patients were referred to the wellbeing advisor in house to access support with lifestyle changes and signposting for accessing further support available.

- The practice used templates, 'share my care' care plans and the Surrey Care Record to ensure communication of end of life wishes with the ambulance service, out of hours services, hospice and district nursing team with patients fully involved in their care planning including RESPECT forms. Regular MDT with palliative care meetings were held. Patients were followed up regularly by their named GP and family were supported after bereavement.
- One of the partners had written a self-management care plan for patients with heart failure to encourage timely use of medicines as appropriate. Clinical pharmacist reviews were supporting the care of these patients.
- The practice cancer lead was completing the European Certificate in Essential Palliative Care and the practice was registered with the Gold Standard Framework to become accredited. They had also signed up to the Daffodil Standards and were working through analysing their care against the standards.

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>	73.9%	75.5%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.4% (21)	10.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	91.5%	89.9%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.9% (2)	13.7%	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) <small>(QOF)</small>	74.4%	81.3%	82.0%	No statistical variation
PCA* rate (number of PCAs).	5.7% (15)	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) <small>(QOF)</small>	75.6%	69.5%	66.9%	No statistical variation
PCA rate (number of PCAs).	19.6% (117)	14.8%	15.3%	N/A

The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	66.8%	70.4%	72.4%	No statistical variation
PCA rate (number of PCAs).	7.3% (118)	7.0%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	89.2%	91.0%	91.8%	No statistical variation
PCA rate (number of PCAs).	1.4% (5)	4.9%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	85.8%	76.1%	75.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	10.2% (61)	12.3%	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 four of five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of five childhood immunisation uptake indicators. The minimum target for the percentage of children aged 5 who have received immunisation for measles, mumps and rubella.
- The practice had an acute team to ensure children who are acutely unwell would receive on the day advice either over the phone or face to face as needed.
- The practice had arrangements for following up failed attendance of children's appointments; 'Child not brought letters' regarding appointments were proactively followed up by named GP. Presentations to A&E of under 5s were reviewed by the named GP to monitor for safeguarding red flags and patterns.
- 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. For example, the practice had an experienced primary care nurse consultant in paediatrics on the team. They provided support both for acutely unwell children, to those with asthma, those with deliberate self-harm and mental health problems and provided early developmental assessments, reviews and advice for parents. This member of staff also led on coordination for families with a child with chronic illnesses and life limiting conditions; actively supporting the family as part of the team around the child.
- The practice was a registered "Breastfeeding Friendly" practice with a GP Infant Feeding Champion. Infant feeding training was included in the training programme for all staff. The lead GP had developed an infant feeding EMIS template to aid evidence-based management of infant feeding issues and prescribing in breastfeeding.
- The practice actively promoted attendance for vaccination clinics making use of social media and text-based systems and an administrator called mothers at two weeks to remind them to book in. Saturday immunisation clinics were held and with 'covid safe' promotions to demonstrate to mothers they had a quieter surgery that they could bring their babies 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) (01/04/2019 to 31/03/2020) (NHS England)	222	236	94.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	231	251	92.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	231	251	92.0%	Met 90% minimum
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)	232	251	92.4%	Met 90% minimum
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)	258	323	79.9%	Below 80% uptake

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

Any additional evidence or comments

The practice reported that current immunisation rates were lower and recognised that this was a lower rate than their aim. We were told that this was partly due to coding not being completed for new patients. They had a high new patient rate, at a time of significant COVID-19 related absences amongst administration staff. They had a catch up programme in place for both recall of those needing vaccine and the coding outstanding for children who have been vaccinated at other surgeries. They had put on extra vaccination clinics and continued to offer Saturday mornings to help working parents bring their children for vaccinations.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- The practice offered early morning and Saturday extended hours GP and nurse appointments to improve access for working patients. Patients also had access to Hub appointments across the Primary Care Network (PCN) in the evenings. Patients could also access appointments via video consultation (LIVI) 8am to 10pm Monday to Friday and 8-8 at weekends as part of the improved access offer.
- The practice was currently working with their online consultation provider to train staff and increase the online consultation offer. The practice currently offered remote chronic disease, Hormone replacement Therapy (HRT), contraception reviews. In response to feedback about access, the practice had a staged approach for introducing e-consulting for new problems following a recent change to their appointment system.

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) (Public Health England)	72.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	74.7%	71.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	65.2%	63.7%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	90.9%	92.8%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	48.4%	55.2%	54.2%	No statistical variation

Any additional evidence or comments

The practice had continued cervical screening throughout the pandemic. The practice told us that they encouraged women to continue to attend and provided unverified information to show they had achieved 75% of age 25-49 year olds and 76% of 50-64 year olds. They told us the lower figures linked to staff sickness within the nursing team (both COVID-19 and non-COVID-19 related). They had recruited two new nurses who required training before they could undertake cervical screening. They had appointed a new nurse who was competent in respiratory, diabetes review and cervical screening. The two new nurses, who were on the new to practice fellowship, had completed their cervical screening training and they will be able to run a catch up programme with additional cervical screening clinics, including encouraging those who declined during the pandemic to attend.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- 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 told us that at the start of the 'covid at home' programme they actively searched for patients with characteristics of vulnerability including severe mental illness, living with learning disability, patients from the black and ethnic minority communities, patients coded as at risk of domestic abuse, English as a second language, poor mental health and dementia. Those patients were also added to the saturation monitoring at home programme in addition to the nationally prescribed at risk groups, as they felt that they were high risk of late presentation if they deteriorated.
- The practice had continued annual health check reviews for patients with learning disabilities throughout the pandemic, remotely when that was more appropriate.
- The practice team proactively reached out to patients not engaging. The practice gave an example of a resident of a care home for people with learning disabilities who had not attended their health check. The care home advised that they had gone to live with their family but had not been deregistered or registered elsewhere. The practice escalated this within the care home as a potential safeguarding issue. The outcome was a new offer and uptake of a health check and ensuring this person's care and treatment remained within the practice.
- Staff received autism awareness training. We were told that this developed a further interest amongst staff, and they were setting up a patient forum for patients and carers living with autism.
- The practice utilised the care coordinator role, working with their PCN care coordinator, social prescribing link worker and council social prescribers, they managed a list of frail and vulnerable patients and their carers. This included regular calls for check ins and to follow up any unmet needs. This was coordinated with other community services and working with the anticipatory care hub. The practice provided an example of this; a patient recently joined the practice with a diagnosis of a progressive neurodegenerative disorder who had been rapidly deteriorating. They arrived at the practice with no local secondary medical care identified and no social care involvement. The care-coordinator worked with the patient's named GP to support them and their

family, liaising with a range of secondary and community healthcare services and social care to help arrange the respite care that they both needed and to ensure they were safe and supported at home.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- Staff attended a 'Dementia Friend' training course 2019 to become Dementia Friends. The practice had arranged follow up dementia awareness training for staff in addition to the e-module learning that staff undertake.
- One of the practice 'Champions' set up a dementia café at Morrisons prior to the pandemic. This grew into befriending and telephone support offered by the champions when covid prevented face to face meetings. The practice manager was working with the champions to review how they can safely promote support of their carers and patients living with dementia.
- We were told that the practice actively promoted regular physical health review of patients with Severe Mental Illness and these continued throughout the pandemic including additional check ins during the lock down with support from the team and the vaccine equity leads to encourage covid vaccination.
- The practice had worked with social services to provide support for patients that have been discharged from a mental health hospital.
- 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. The practice regularly promote suicide awareness training and it was part of their regular training review.
- The practice told us about new work they were involved in. They were about to launch a mental health hub for the PCN. Recruitment was underway by the PCN to appoint a mental health practitioner, Occupational Therapist, Clinical pharmacist and they were collaborating with the acute mental health trust around joint recruitment for a mental health practitioner, clinical psychologist and psychiatrist via the general practice integrated mental health service (GPIHMS) model of care. The practice was arranging training for both clinical and non-clinical staff around supporting patients with personality disorders for a protected learning time event.

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>	98.1%	85.8%	85.4%	Tending towards variation (positive)
PCA* rate (number of PCAs).	13.4% (16)	15.8%	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>	72.5%	80.2%	81.4%	No statistical variation
PCA rate (number of PCAs).	3.7% (5)	5.9%	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)	547.6	533.9
Overall QOF score (as a percentage of maximum)	98%	95.5%
Overall QOF PCA reporting (all domains)	4.2%	5.9%

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

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: We noted that, historically, not all staff had a documented induction on their record. The practice manager was able to demonstrate that new staff had a plan in place and a new policy has been introduced to ensure inductions were comprehensive and timely. Staff we spoke with told us that they felt supported and had access to training and support when required.	

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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: The practice undertook a quality improvement audit on the use and recording of ReSPECT forms (a process that creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. It is currently available in many areas of the country). This found some areas that could be improved on the recording on this form. They found that more information was found on the patient's records. The audit demonstrated that the form could evidence 95% of patients had been involved in the process and only one form (5%) did not evidence the patient had been consulted.	

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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice told us that it had been a difficult time during the pandemic with staff absences and the effect of the pandemic on staff wellbeing and mental health. The previous practice manager left in June 2021. The current practice manager took up post in September 2021. The practice carried out a staff survey in July 2021 and held a feedback session, facilitated by a culture change consultant. They had started to implement changes as a result of the feedback and the work that the senior leadership team were doing with the consultant. Team leaders took part team leader training in September 2021. The practice was in the process of recruiting an operations manager and were actively recruiting to the patient services and administration team. We were told that two new GPs were starting in October 2021 and February 2022 and were in the process of recruiting a third (due to start January 2022). The practice told us they were excited about what the future held for their service and for the wider work as a PCN.	

Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Explanation of any answers and additional evidence:	
Staff we spoke with told us that they felt comfortable to raise concerns or ask for support if they needed to. We saw evidence within complaints responses and incidents that demonstrated the practice apologised when things went wrong.	

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

Source	Feedback
Staff	Staff told us they enjoyed working at the practice . Staff told us that they were encouraged to develop their skills and had opportunities to attend additional training. They were happy with the level of communication at the practice and said it was an open and friendly culture. Staff felt supported by the GPs and practice manager.
Member of the practice Champions.	Positive experience working with the staff team. Felt supported and good communication with the practice management.

Governance arrangements

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

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

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
A business continuity plan was in place with key information on actions to take in the event of an emergency or any situation where services could no longer be delivered from the premises. This included key staff and other agencies contact details, relocation details and notification processes.	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
The practice had and continued to manage patients who may have COVID-19 within their own premises. They had a dedicated 'hot' zone with separate access arrangements and equipment to ensure isolation from the rest of the building and patients.	

Staff told us that they had a good level of personal protective equipment and staff had undergone an individual Covid 19 risk assessment.

The practice had risk assessed patient groups to ensure vulnerable individuals had been identified and supported throughout the pandemic.

The practice was in the process of reviewing their approach to catching up on monitoring and review activity with the appointment of new staff to meet the needs of patients with long term conditions.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
The practice had introduced a new system for storing data. We had access to this system and could review some evidence using the system. We also noted that it allowed all staff direct access to policies, procedures and practice information.	
The practice had primary care network staff working within the practice. We saw how systems were used to assist with information review and dissemination in the practice. For example, one of the pharmacists monitored and shared safety alerts. This information was recorded on to the practices computer system and was used to track actions and responses to risk. The information was available to all staff.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
The last meeting of the PPG took place in December 2020. We saw that a wide range of subjects were discussed including improved staff recruitment, vaccination targets being achieved for COVID-19 and a review of the appointments system. We were told that the PPG was not in operation at present and a new approach was under review.	

Feedback from Patient Participation Group.

Feedback
We spoke with one of the practice 'Champions', a group set up in response to the 'All together better' scheme in 2018. The group had initially worked on projects such as organising walks and coffee mornings. This later developed into facilitating Dementia cafes for patients and carers. The pandemic saw a change in focus supporting the practice with delivering letters and prescription scripts to a befriending programme. We were told that they had a meeting with the practice manager to look at how this group will be supported and developed in the future.

Continuous improvement and innovation

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

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

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***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.