

# Care Quality Commission

## Inspection Evidence Table

### RHR Medical Centre (1-3169167732)

Inspection date: 18<sup>th</sup> June 2019

Date of data download: 13 June 2019

## Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

### Safe

### Rating: Requires Improvement

The practice was rated as requires improvement for providing safe services because:

- There were gaps in systems to assess, monitor and manage risks to patient safety.
- When things went wrong, reviews and investigations were not always sufficiently carried out and improvements were not always identified.
- There were gaps in recruitment and training records for staff.

#### Safety systems and processes

**The practice had 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.  | Y                    |
| Policies took account of patients accessing any online services.  | NA                   |
| Policies and procedures were monitored, reviewed and updated.   | Y                    |
| Policies were accessible to all staff.  | Partial <sup>1</sup> |
| Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs). | Partial <sup>2</sup> |
| There was active and appropriate engagement in local safeguarding processes.  | Y                    |
| There were systems to identify vulnerable patients on record.   | Y                    |
| There was a risk register of specific patients.   | Partial <sup>3</sup> |
| Disclosure and Barring Service (DBS) checks were undertaken where required.   | Y                    |

| Safeguarding   | Y/N/Partial |
|--|-------------|
| 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> <ol style="list-style-type: none"> <li>1. Policies were available on the computer system for staff to access however it was not clear where they were stored. Some staff were not able to locate up to date policies.</li> <li>2. The practice used an agency to book locums which provided the staff training. At the time of our inspection there was no record of safeguarding training for three locum GPs.</li> <li>3. The register of patients with safeguarding concerns did not always include icons on patients' notes to easily alert clinicians to ongoing concerns. This had been identified as an issue with the community services and the practice management were working to try and correct this. We also found that siblings or parents of patients with safeguarding concerns were not always identified.</li> </ol> |             |

| Recruitment systems  | Y/N/Partial |
|--|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).  | Partial     |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.  | Partial     |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.  | Y           |
| Staff had any necessary medical indemnity insurance.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>We reviewed the practice's recruitment files and found gaps in documents that were required, including locum staff. There were also gaps in staff vaccination records.</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.<br>Date of last inspection/test: 18/06/2018  | Y                  |
| There was a record of equipment calibration.<br>Date of last calibration: 18/05/2018  | 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.<br>Date of last check: July 2018  | Y                  |
| There was a log of fire drills.<br>Date of last drill: April 2019   | Y                  |
| There was a record of fire alarm checks.  | N                  |
| There was a record of fire training for staff.  | Y                  |
| There were fire marshals.   | Y                  |
| A fire risk assessment had been completed.<br>Date of completion: September 2017  | Y <sup>1</sup>     |
| Actions from fire risk assessment were identified and completed.  | Y                  |
| Explanation of any answers and additional evidence:   |                    |
| 1. The last full fire risk assessment was completed September 2017. The practice completed monthly checks on the risk assessment and completed an ongoing action plan for any findings. |                    |

| <b>Health and safety</b>  | <b>Y/N/Partial</b> |
|---|--------------------|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: July 2018                                   | Y                  |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: January 2019 | Y                  |
| 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.  | Y           |
| Staff had received effective training on infection prevention and control.                  | Y           |
| Date of last infection prevention and control audit: 06/03/2019                             | Y           |
| The practice had acted on any issues identified in infection prevention and control audits. | Y           |
| The arrangements for managing waste and clinical specimens kept people safe.                | Y           |
| Explanation of any answers and additional evidence:   |             |

## 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.  | Partial <sup>1</sup> |
| There was an effective induction system for temporary staff tailored to their role.   | Y                    |
| Comprehensive risk assessments were carried out for patients.   | Y                    |
| Risk management plans for patients were developed in line with national guidance.   | Y                    |
| Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.   | 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.   | Partial <sup>2</sup> |
| There was a process in the practice for urgent clinical review of such patients.  | Y                    |
| There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.  | Y                    |
| There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.  | Y                    |
| When there were changes to services or staff the practice assessed and monitored the impact on safety.  | Partial <sup>3</sup> |
| Explanation of any answers and additional evidence:   |                      |
| <ol style="list-style-type: none"> <li>1. We saw evidence of times where clinical capacity had been poor however the practice had amended its clinical rota to have a GP in the practice each morning and afternoon. The new rota was due to be implemented the week after our inspection.</li> <li>2. Receptionists were aware of symptoms of deterioration and would contact a clinician if they</li> </ol> |                      |

required assistance. However, the management had training planned to train receptionists on urgent symptoms and signs of patients requiring urgent medical attention. We found evidence of a child who required medical assistance however did not receive an appropriate appointment and did not have any follow up organised which put the patient at risk.

3. The practice had arranged more clinical GP cover for the practice to ensure a GP was on site morning and afternoon.

### Information to deliver safe care and treatment

#### Staff mostly 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.  | Partial <sup>1</sup> |
| There was a system for processing information relating to new patients including the summarising of new patient notes.   | Y                    |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.  | Y                    |
| Referral letters contained specific information to allow appropriate and timely referrals.   | Y                    |
| Referrals to specialist services were documented.  | Y                    |
| 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                    |
| The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.  | Y                    |
| Explanation of any answers and additional evidence:  |                      |
| 1. We reviewed consultations and found some documentation lacked information to provide a full account of care given. Consultations also lacked details of examinations and specific information given to patients in order to understand what to do if their conditions deteriorated. |                      |

## Appropriate and safe use of medicines

### The practice had some 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) (01/04/2018 to 31/03/2019) <small>(NHS Business Service Authority - NHSBSA)</small>   | 1.00     | 0.79        | 0.88            | No statistical variation             |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>                                       | 7.6%     | 7.5%        | 8.7%            | No statistical variation             |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) <small>(NHSBSA)</small> | 5.49     | 5.29        | 5.61            | No statistical variation             |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) <small>(NHSBSA)</small>   | 1.05     | 1.82        | 2.07            | Tending towards variation (positive) |

| Medicines management   | Y/N/Partial          |
|--|----------------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff.   | Y                    |
| Blank prescriptions were kept securely and their use monitored in line with national guidance.   | Y                    |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).  | Y                    |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | N <sup>1</sup>       |
| 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 <sup>2</sup> |
| The practice had a process and clear audit trail for the management of information about   | Y                    |

| Medicines management   | Y/N/Partial          |
|--|----------------------|
| changes to a patient's medicines including changes made by other services.   |                      |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.  | Partial <sup>3</sup> |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).  | Y                    |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.  | Y                    |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.   | NA                   |
| 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.  | NA                   |
| 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.  | Partial <sup>4</sup> |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.   | Partial <sup>5</sup> |
| 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> <ol style="list-style-type: none"> <li>1. There was no system to review prescribing competence of non-medical prescribers or review any consultations.</li> <li>2. There was no common understanding of non-medical prescribers prescribing limitations and we found evidence of nurses prescribing repeat medicines outside of their competencies. Management were not aware that this was happening.</li> <li>3. Most patients taking high risk medicines had their monitoring completed in the appropriate timescale. We found evidence of one patient who was overdue monitoring however had the medicines prescribed. Staff were unsure of the system for ensuring monitoring was completed.</li> <li>4. The practice had the appropriate emergency medicines however there was no atropine within the emergency medicines. Atropine is a medicine which is required in the emergency medicine store if the practice is carrying out any fitting or removal of coils. We found atropine within the nurse's emergency kit who carried out coil removals, however management were not aware that the nurse was carrying out coil removals.</li> <li>5. Emergency medicines were all within their expiry dates however there had been a gap of monitoring due to the designated person being unable to carry out the monitoring.</li> </ol> |                      |

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

**The practice had some systems to learn and make improvements when things went wrong.**

| Significant events  | Y/N/Partial          |
|---|----------------------|
| The practice monitored and reviewed safety using information from a variety of sources.   | Partial <sup>1</sup> |
| 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.  | Partial <sup>2</sup> |
| Number of events recorded in last 12 months:  | 1                    |
| Number of events that required action:  | 1                    |
| Explanation of any answers and additional evidence:   |                      |
| <ol style="list-style-type: none"> <li>1. The practice had not received all MHRA safety alerts however had begun to complete retrospective searches to ensure patients were not at risk.</li> <li>2. Learning from significant events was not comprehensive and did not evidence any systems which implemented learning or quality improvement for the practice.</li> </ol> |                      |

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

| Event   | Specific action taken             |
|---|-----------------------------------|
| An accident which occurred with a member of staff | The immediate danger was removed. |

| Safety alerts   | Y/N/Partial          |
|---|----------------------|
| There was a system for recording and acting on safety alerts.   | N                    |
| Staff understood how to deal with alerts.   | Partial <sup>1</sup> |
| Explanation of any answers and additional evidence:   |                      |
| <ol style="list-style-type: none"> <li>1. The practice had become aware they were not receiving all relevant safety alerts and had begun to go through retrospectively to identify any patients that were at risk. Staff members were not aware that they had not been receiving alerts.</li> </ol> |                      |



## Effective

## Rating: Requires Improvement

The practice was rated as required improvement for providing effective services because:

Care and treatment was not always delivered in line with national guidance

There was no clinical oversight of clinicians and management were not aware of competencies of clinical staff

There was limited evidence of quality improvement.

This affected all population groups which were also rated as requires improvement.

### Effective needs assessment, care and treatment

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

|  | Y/N/Partial          |
|--|----------------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice.   | N <sup>1</sup>       |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.   | Partial <sup>2</sup> |
| 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 were in place 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.   | Partial <sup>3</sup> |
| Explanation of any answers and additional evidence:  |                      |
| <ol style="list-style-type: none"> <li>1. There was no evidence that new guidance was being discussed with clinicians and they were not aware of all safety alerts.</li> <li>2. We reviewed consultations and found that patients were not always receiving appropriate care from the appropriate clinicians. There was no system in place to identify which clinicians should be treating specific health conditions; however, the practice was going through changes in management and this was due to be introduced.<br/><br/>Documentation in patients record did not contain comprehensive details.</li> <li>3. We saw records stating that patients had been "safety netted" however there was no information of what advice was given to them.</li> </ol> |                      |

| Prescribing   | Practice performance | CCG average | England average | England comparison               |
|---|----------------------|-------------|-----------------|----------------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group | 0.07                 | 0.67        | 0.77            | Significant Variation (positive) |

| Prescribing  | Practice performance | CCG average | England average | England comparison |
|--|----------------------|-------------|-----------------|--------------------|
| Age-sex Related Prescribing Unit (STAR PU)<br>(01/04/2018 to 31/03/2019) <small>(NHSBSA)</small> |                      |             |                 |                    |

## Older people

## Population group rating: Requires Improvement

| Findings  |
|---|
| <ul style="list-style-type: none"> <li>• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.</li> <li>• The provider had a system to follow up on older patients discharged from hospital which was ran from the Boulevard Surgery (a nearby practice also part of the Beechdale Medical Group). It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>• Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>• Health checks were offered to patients over 75 years of age.</li> </ul> |

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

| Diabetes Indicators   | Practice     | CCG average | England average | England comparison               |
|---|--------------|-------------|-----------------|----------------------------------|
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>                        | 54.7%        | 71.5%       | 78.8%           | Significant Variation (negative) |
| Exception rate (number of exceptions).  | 6.8%<br>(10) | 11.0%       | 13.2%           | N/A                              |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 84.2%        | 72.8%       | 77.7%           | No statistical variation         |
| Exception rate (number of exceptions).  | 5.4%<br>(8)  | 8.0%        | 9.8%            | N/A                              |

|  | Practice    | CCG average | England average | England comparison       |
|--|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 71.7%       | 76.0%       | 80.1%           | No statistical variation |
| Exception rate (number of exceptions).   | 6.1%<br>(9) | 12.1%       | 13.5%           | N/A                      |

| Other long-term conditions  | Practice    | CCG average | England average | England comparison       |
|---|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>          | 78.8%       | 74.6%       | 76.0%           | No statistical variation |
| Exception rate (number of exceptions).  | 1.3%<br>(3) | 6.6%        | 7.7%            | 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 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 92.7%       | 86.9%       | 89.7%           | No statistical variation |
| Exception rate (number of exceptions).  | 0<br>(0)    | 10.8%       | 11.5%           | N/A                      |

| Indicator   | Practice    | CCG average | England average | England comparison       |
|---|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)   | 83.6%       | 81.7%       | 82.6%           | No statistical variation |
| Exception rate (number of exceptions).  | 2.1%<br>(6) | 3.5%        | 4.2%            | 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 (01/04/2017 to 31/03/2018) (QOF) | 90.5%       | 90.4%       | 90.0%           | No statistical variation |
| Exception rate (number of exceptions).  | 0<br>(0)    | 9.2%        | 6.7%            | N/A                      |

#### Any additional evidence or comments

QOF was being managed by a staff member who was not based at the practice.

#### Families, children and young people

#### Population group rating: Requires Improvement

#### Findings

- Childhood immunisation uptake rates were below average with the World Health Organisation (WHO) targets. However, this is high in comparison to other local areas which report low uptake levels due to high deprivation.
- 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.
- The practice had no arrangements for following up failed attendance of children's appointments following an appointment in secondary care.
- Young people could access services for sexual health and contraception.

| Child Immunisation  | Numerator | Denominator | Practice % | Comparison to WHO target               |
|---|-----------|-------------|------------|--|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)<br><small>(NHS England)</small> | 39        | 45          | 86.7%      | Below 90% minimum (variation negative) |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>  | 48        | 54          | 88.9%      | Below 90% minimum (variation negative) |
| 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) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>                                    | 48        | 54          | 88.9%      | Below 90% minimum (variation negative) |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>   | 48        | 54          | 88.9%      | Below 90% minimum (variation negative) |

#### Any additional evidence or comments

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

**Population group rating: Requires Improvement**

#### Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients could access the other surgeries within the Beechdale Medical Group for appointments if required or if a preferred clinician was there.

Cancer Indicators

Practice

CCG

England

England

|  |       | average | average | comparison               |
|--|-------|---------|---------|--------------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England) | 73.1% | 70.5%   | 71.7%   | No statistical variation |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)   | 57.6% | 68.7%   | 70.0%   | N/A                      |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)   | 40.0% | 52.9%   | 54.5%   | N/A                      |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)   | 66.7% | 64.2%   | 70.2%   | N/A                      |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)  | 55.6% | 52.5%   | 51.9%   | No statistical variation |

#### Any additional evidence or comments

#### People whose circumstances make them vulnerable

#### Population group rating: Requires Improvement

##### Findings

- End of life care was delivered in the gold standards framework which considered the needs of those whose circumstances may make them vulnerable.
- The practice did not hold registers of patients living in vulnerable circumstances including homeless people or travellers.
- The practice demonstrated that they had a system to identify people who misused substances.

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

#### Population group rating: Requires Improvement

##### Findings

- There was not a system for following up patients who failed to attend for administration of long-term medication.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

| 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 (01/04/2017 to 31/03/2018) (QOF) | 100.0%       | 87.1%       | 89.5%           | Tending towards variation (positive) |
| Exception rate (number of exceptions).   | 9.1%<br>(1)  | 14.5%       | 12.7%           | N/A                                  |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)                          | 100.0%       | 88.2%       | 90.0%           | Tending towards variation (positive) |
| Exception rate (number of exceptions).   | 0<br>(0)     | 13.5%       | 10.5%           | 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 (01/04/2017 to 31/03/2018) (QOF)  | 83.3%        | 85.9%       | 83.0%           | No statistical variation             |
| Exception rate (number of exceptions).   | 14.3%<br>(1) | 6.9%        | 6.6%            | N/A                                  |

#### Any additional evidence or comments

#### Monitoring care and treatment

**There was limited monitoring of the outcomes of care and treatment.**

| Indicator                                     | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559)        | 530.8    | 528.3       | 537.5           |
| Overall QOF exception reporting (all domains) | 4.3%     | 5.6%        | 5.8%            |



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

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

|   |
|---|
| <ul style="list-style-type: none"> <li>An audit on learning disabilities was presented to us which consisted of a questionnaire being completed by staff regarding them completing learning disability reviews. The audit findings included to appoint a lead clinician for learning disabilities, to include a reminder on patient records and to review the register again after one year.</li> </ul> <p>The audit did not show any quality improvement for patients at the practice. There were no two cycle audits completed.</p> |
|---|

### Effective staffing

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

|  | Y/N/Partial          |
|--|----------------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme. | Y                    |
| The learning and development needs of staff were assessed.   | Partial <sup>1</sup> |
| The practice had a programme of learning and development.  | N <sup>2</sup>       |
| 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.  | NA                   |
| 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.                                 | N <sup>3</sup>       |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.  | NA                   |
| Explanation of any answers and additional evidence:  |                      |
| 1. Management were not always aware of the needs of staff or how they were performing.   |                      |

2. There was no programme of learning and development seen. Audits completed at the practice did not show any quality improvement.
3. Management did not review clinicians' consultations or their prescribing practices and were unaware of work they were completing.

### Coordinating care and treatment

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

| Indicator   | Y/N/Partial |
|---|-------------|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018)<br>(QOF) | Yes         |
| 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.  | NA          |
| Explanation of any answers and additional evidence:   |             |

### Helping patients to live healthier lives

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

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

| Smoking Indicator   | Practice    | CCG average | England average | England comparison       |
|---|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 94.3%       | 95.0%       | 95.1%           | No statistical variation |
| Exception rate (number of exceptions).  | 0.5%<br>(3) | 0.9%        | 0.8%            | N/A                      |

### Consent to care and treatment

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

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

## Well-led

## Rating: Requires Improvement

We have rated the practice as requires improvement for providing well-led services.

We found that:

- The practice was transitioning through a change in management and systems had not been embedded.
- The practice did not always act on appropriate and accurate information.
- We saw little evidence of systems and processes for learning, continuous improvement and innovation

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels / Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

|   | 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.  | Partial <sup>1</sup> |
| There was a leadership development programme, including a succession plan.  | Partial <sup>2</sup> |
| Explanation of any answers and additional evidence:<br>1. At the time of our inspection the practice was going through changes in management. Staff reported that they felt they could approach partners.<br>2. The practice had a plan in place for the ongoing change in management. Systems were not embedded at the time of our inspection. |                      |

### Vision and strategy

**The practice had a vision but had not got an embedded strategy 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.   | Partial     |
| Staff knew and understood the vision, values and strategy and their role in achieving them.   | Partial     |
| Progress against delivery of the strategy was monitored.  | N           |
| Explanation of any answers and additional evidence:<br>At the time of the inspection the practice was going through changes in management. The practice did not have a clear vision in place as they were restructuring the organisation. The practice had an |             |

aspirational strategy to achieve their priorities, however this had not been put in place and we did not see evidence of the plan during the inspection.

## 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.  | Partial <sup>1</sup> |
| 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                    |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.  | Y                    |
| Explanation of any answers and additional evidence:<br>1. The practice had a system of how to deal with staff who were not performing, however, at the time of the inspection, management were not always aware of the performance of staff. |                      |

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

| Source           | Feedback   |
|------------------|--|
| Staff interviews | Staff members reported that they felt supported in their work at the practice. Some staff members said that due to recent movement of staff they did not feel settled into the practice. |

## Governance arrangements

### The overall governance arrangements were not embedded.

|   | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed.   | N           |
| Staff were clear about their roles and responsibilities.  | Partial     |
| There were appropriate governance arrangements with third parties.  | Y           |
| Explanation of any answers and additional evidence:<br>At the time of our inspection the practice was transitioning through governance and management changes, and therefore governance systems were not in place. Practice staff knew who to report concerns to. |             |

## Managing risks, issues and performance

### There were some 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.   | N <sup>1</sup> |
| There was a systematic programme of clinical and internal audit.  | N <sup>2</sup> |
| There were effective arrangements for identifying, managing and mitigating risks.   | N <sup>3</sup> |
| 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: <ol style="list-style-type: none"> <li>1. Performance of staff was not always reviewed, such as prescribing or consultation reviews.</li> <li>2. There were no systematic audit plans in place. The practice was not able to demonstrate any audits which had been completed with evidence of quality improvement for patients.</li> <li>3. We identified risks to patients which the practice was not aware of.</li> </ol> |                |

## 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 <sup>1</sup> |
| Performance information was used to hold staff and management to account.  | Y                    |
| Our inspection indicated that information was accurate, valid, reliable and timely.  | N <sup>2</sup>       |
| There were effective arrangements for identifying, managing and mitigating risks.  | N <sup>3</sup>       |
| Staff whose responsibilities included making statutory notifications understood what this entails.   | Y                    |
| Explanation of any answers and additional evidence: <ol style="list-style-type: none"> <li>1. Practice management were not always aware of the performance of staff. We saw no evidence of supervision or consultation reviews.</li> <li>2. We found evidence of patients not receiving appropriate treatment in a timely manner. Consultation documentation lacked comprehensive details.</li> <li>3. The provider had taken action following a recent CQC inspection at a practice which had been part of the Beechdale Medical Group and had implemented some systems to improve patient safety.</li> </ol> |                      |

## 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           |
| 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:  |             |

## Continuous improvement and innovation

**There was little evidence of systems and processes for learning, continuous improvement and innovation.**

|   | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement.  | N           |
| Learning was shared effectively and used to make improvements.  | N           |
| Explanation of any answers and additional evidence:<br>We reviewed significant events and complaints logs and found some discussions had taken place to make improvements. However, there were missed opportunities to develop systems to ensure events did not recur. We did not always find that the changes had effectively embedded as some systems had not changed. Audits did not show any quality improvement. |             |



## 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.
- 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.

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>

### 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.