

# Care Quality Commission

## Inspection Evidence Table

### Abbotswood Medical Centre (1-540127764)

Inspection date: 22 August 2019

Date of data download: 27 August 2019

## Overall rating: Good

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

## Safe

## Rating: Requires improvement

We rated the practice as requires improvement for providing safe services because:

- The practice's systems and processes to keep people safe and safeguarded from abuse were not always comprehensive.
- There were some gaps in systems to assess, monitor and manage risks to patient safety.
- Some infection prevention and control measures were lacking.
- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.

### Safety systems and processes

**The practice's systems, practices and processes to keep people safe and safeguarded from abuse were not always comprehensive.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
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

Safeguarding	Y/N/Partial
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>The staff we spoke with demonstrated they understood the relevant safeguarding processes and their responsibilities to varying degrees. Among the GPs, awareness of safeguarding processes was comprehensive. The knowledge and understanding displayed by other staff was acceptable, if more basic and limited. Some non-clinical staff were not recorded as having completed adult or child safeguarding training. Most staff had completed adult and child safeguarding training to the appropriate level before the intercollegiate guidance on safeguarding competencies was published in August 2018 (adult safeguarding) and January 2019 (child safeguarding). (Intercollegiate guidance is any document published by or on behalf of the various participating professional membership bodies for healthcare staff including GPs and nurses). Following publication of the guidance, nurses at the practice were required to complete higher levels of safeguarding training.</p> <p>During our inspection, we saw there were some comprehensive safeguarding systems and processes in place and any concerns were well recorded and discussed. The process in place to follow up on 'was not brought' children was not comprehensive. ('Was not brought' is a term used to refer to children who were not taken to clinic appointments such as secondary care (hospital) and child immunisation appointments. As children, it is not their responsibility to attend an appointment, but a parental responsibility to take them).</p> <p>We saw the practice received written communication from secondary care services when children were not brought to their appointments. The practice then sent a letter to the patient (through their parent/s or guardian/s) inviting them to the practice for an appointment. If no action was taken in response, and the child was not brought to the practice, no further action was taken. Staff told us that if a child was not brought to an immunisation appointment at the practice, the same initial written communication process would be followed. If a further appointment was made and the child was not brought for a second time, the nurses would phone the parent/s or guardian/s. If a further appointment was not made, no further action was taken.</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.	N
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>During our inspection, the practice couldn't demonstrate that all staff had received the required vaccinations for their roles. A process was not adhered to for the practice to be assured that all staff had received the required vaccinations for their roles and that this was appropriately documented. There were no risk assessments in place for any staff where complete and appropriate vaccination records were not available. We saw that for two GPs, one of the nursing staff and all non-clinical staff, there were no complete and appropriate records of their tetanus/polio/diphtheria status. For two GPs, two of the nursing staff and all non-clinical staff, there were no complete and appropriate records of their measles,</p>	

mumps and rubella (MMR) status. For one of the GPs there was no appropriate record of their BCG status, and for two GPs and two of the nursing staff this was also the case for their varicella (chickenpox) status. For one of the nursing staff, there was no appropriate record of their Hepatitis B status.

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: August 2019	Y
There was a record of equipment calibration. Date of last calibration: August 2019	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. Date of last check: March 2019	Y
There was a log of fire drills. Date of last drill: August 2019	Y
There was a record of fire alarm checks. Date of last check: Weekly test records were mostly completed from April to August 2019 and there was a full alarm inspection in March 2019.	Y
There was a record of fire training for staff. Date of last training: Most staff between April 2014 and August 2019.	Partial
There was a fire marshal.	Y
A fire risk assessment had been completed. Date of completion: July 2019	Y
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence:  Our review of the practice's training records showed that two non-clinical staff were not documented as having completed essential fire training. One was a new member of staff who had recently joined the practice. We saw that two staff were documented as having last completed the training more than three years ago. Staff we spoke with said they were not aware of a policy requirement for how often the training should be completed. All the staff we spoke with demonstrated a good understanding of fire safety and the actions to take should a fire occur. They had all participated in a fire drill.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2019	Partial

Explanation of any answers and additional evidence:

A Legionella risk assessment was completed in May 2019. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). In adherence with the assessment's recommendations, the practice completed regular water temperature checks. These showed hot water temperatures at the practice were regularly below the required levels and no action had been taken to investigate or rectify this.

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met. Some infection prevention and control measures were lacking.**

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2019	Partial
The practice had acted on any issues identified in infection prevention and control audits.	N/A
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:

There were appropriate processes in place for the management of sharps (needles) and clinical waste. Hand wash facilities, including hand sanitiser were available throughout the practice. All staff except one recently employed member of the team had completed infection control training.

An infection control audit was completed in August 2019. From our review of documentation and conversations with staff, we found this was not an embedded process at the practice. We saw the audit completed in August 2019 was basic and did not identify or implement action to rectify some issues we found during our inspection. For example, the staff we spoke with knew that equipment was cleaned and how this should be done but were not fully aware of who had responsibility for this. There were no records available to demonstrate that a schedule was adhered to for cleaning equipment at the practice. This included, but was not limited to the portable, wipe clean privacy screens used. Despite this, we saw the practice and all the equipment was visibly clean and tidy.

The GP consultation rooms contained carpet type flooring which was not wipe clean. The clinical staff we spoke with said they reduced the risk of contamination to the floors in those rooms by completing any procedures where there was an identified risk in the nurse treatment room, which contained wipe clean flooring. This was not identified in the infection control audit.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Partial
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
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection, we saw that built-in emergency buttons were available on the computers throughout the practice.</p> <p>We saw that locum GPs were used at the practice and a suitable induction process, including a comprehensive induction pack, was in place for these staff.</p> <p>We found that a process was in place for patients prescribed the oral contraceptive pill to be reviewed by the nurses before the GPs re-authorised their prescriptions. From our conversations with staff we found the reviews were basic and included taking weight and blood pressure measurements. The reviews did not routinely include discussing family history risk factors or assessing symptoms of possible side effects or complications.</p> <p>We saw that appropriate sepsis guidelines were available in all GP consultation rooms. The GPs we spoke with demonstrated a good understanding of the condition and their role in identifying patients with presumed sepsis and ensuring their urgent clinical review. We saw that nursing and non-clinical staff did not have access to any guidelines and had not received any sepsis training appropriate to their roles. The nursing and non-clinical staff we spoke with demonstrated a basic understanding of the condition and their role in identifying patients with presumed sepsis, although all of them said they would refer to the GPs if they were concerned about any patient.</p>	

## 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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented 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
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

## Appropriate and safe use of medicines

**The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.**

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.74	0.84	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	5.5%	9.5%	8.6%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	5.99	5.87	5.63	No statistical variation
Average daily quantity of oral NSAIDs	1.56	1.62	2.08	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)				

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
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/A
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
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y



Medicines management	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>We found the practice's lower than local and national averages prescribing of co-amoxiclav, cephalosporins and quinolones demonstrated good medical practise and adherence to national guidelines.</p> <p>There was a partial system in place to monitor the use of blank prescription forms. Prescription stationery was securely stored before being allocated one box each time to the whole GP team. A record was maintained to demonstrate this. The system did not allow for the identification of which individual GPs had which serial numbers of blank prescription forms.</p> <p>We saw that a process was in place for patients to be contacted when test results showed a practice-initiated prescription was necessary and ready for collection. Staff we spoke with said any uncollected prescriptions were checked and patients may or may not be contacted to check why the prescriptions were not collected. There was no established process to ensure patients were contacted about every uncollected prescription. From our conversations with staff, we found they were aware of this issue and it was part of an action plan to improve processes at the practice.</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:	Five
Number of events that required action:	Three
<p>Explanation of any answers and additional evidence:</p> <p>There was an effective system in place for reporting and recording incidents and significant events. The staff we spoke with were clear on the reporting process used at the practice and we found that lessons learnt were shared to make sure action was taken to improve safety in the practice.</p>	

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

Event	Specific action taken
Some patients were not advised about their abnormal blood test results.	The practice completed an investigation and found the results had been reviewed in the appropriate timeframe. None were of an urgent nature and no patients were at risk. Patients were advised to call for their results, but no tasks had been set on the system to notify the patients. The practice changed its policy and process so that all abnormal results requiring action were



	tasked to non-clinical staff daily to contact the relevant patients.
A message was left for a patient who was contacted about a test result requiring treatment. The patient didn't get the message and was untreated for two weeks.	The recall system was made more comprehensive so that patients are contacted twice by telephone and these are documented. If the patient hasn't acknowledged contact after two calls, a letter is sent.

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 a process was in place and adhered to for the receipt, review and monitoring of action taken in response to safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We saw examples of actions taken in response to recent alerts, including one regarding sodium valproate (a medicine primarily used in the treatment of epilepsy).</p>	

## Effective

## Rating: Good

### 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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:	
The practice assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. The practice had systems in place to keep all clinical staff up-to-date. Staff had access to National Institute for Health and Care Excellence (NICE) best practice guidelines and templates based on best practice guidelines. They used this information to deliver care and treatment that met patients' needs.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.42	0.60	0.75	No statistical variation

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- As part of a local initiative, the practice was aligned to one care home and one GP at the practice visited the home on a weekly basis to provide continuity of care and ensure residents' health needs were met.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Older people had access to targeted immunisations such as the flu vaccination. The practice had 589 eligible patients aged over 65 years. Of those, 366 (62%) had received the flu vaccination at the practice in the 2018/2019 year.
- Staff could recognise the signs of abuse in older patients and knew how to escalate any concerns.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GPs worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- GPs followed up patients who had received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease and prescribed statins had their care appropriately managed at the practice.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- All newly diagnosed patients with diabetes were managed in line with an agreed pathway.
- The practice followed up on patients with long-term conditions discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

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>	71.4%	78.1%	78.8%	No statistical variation
Exception rate (number of exceptions).	5.2% (14)	14.9%	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>	73.3%	76.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	4.1% (11)	10.8%	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>	80.4%	79.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	8.9% (24)	13.1%	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>	81.2%	75.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.1% (4)	5.5%	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>	92.5%	90.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	3.6% (2)	8.6%	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)	81.0%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.3% (14)	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)	81.8%	91.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (1)	5.8%	6.7%	N/A

#### Any additional evidence or comments

During our inspection, we reviewed the care provided to patients with long-term conditions and found these patients had received appropriate reviews or had been invited for a review. We found the practice had an organised approach towards managing these patients.

### Families, children and young people

### Population group rating: Good

#### Findings

- 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.
- People could access services for sexual health and contraception. The practice signposted or referred patients appropriately to meet their needs.
- There were six to eight week post-natal and child health checks. Baby vaccination clinics were available at the practice.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	48	59	81.4%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	50	63	79.4%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	50	63	79.4%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	50	63	79.4%	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
<p>Figures from the 2018/2019 year showed that at that time, the practice didn't meet the 90% national standard for all four childhood immunisation categories. We spoke with senior staff about this during our inspection. They told us they had investigated their childhood immunisation performance in May 2019 and found that some patients who had received their immunisations were not properly recorded as such on the system. The dates of their immunisations were not properly recorded. Following this, a more comprehensive process was introduced so that data would be reviewed quarterly. Any patients identified as requiring an immunisation would receive up to two written invitations and a final phone call reminder. We looked at the practice's own unverified data following rectification of the identified data entry issue. This showed that at the time of our inspection, of the 388 children aged five years or younger, 372 (96%) had received all the required immunisations. This exceeded the national standard and met the World Health Organisation (WHO) based target. Of the remaining 16 children, two had declined immunisations, three were new patients at the practice and 11 had been contacted about receiving their immunisations.</p>

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

Population group rating: **Good**

### Findings

- The practice had an opportunistic approach to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time. At the time of our inspection, the practice was considering implementing a system of proactively inviting university age patients to receive the vaccination.
- 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. The practice had 1,411 patients eligible to receive an NHS health check. Of those, 206 had been invited for, and 166 had received a health check in the past 12 months. In total, since the start of the programme, 952 checks had been completed.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	67.9%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	58.9%	69.7%	69.9%	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)	48.3%	55.2%	54.4%	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)	90.9%	75.6%	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)	66.7%	51.7%	51.9%	No statistical variation

### Any additional evidence or comments

There was evidence to suggest the practice encouraged its relevant patients to engage with nationally run and managed screening programmes. Public Health England data for the year April 2017 to March 2018 showed the practice was below local and national averages for the percentage of its eligible patients



participating in national breast and bowel cancer screening programmes. The senior staff we spoke with were aware of this. They told us that in June 2019, the practice wrote to 123 patients eligible to participate in the bowel cancer screening programme and 161 patients eligible to participate in the breast cancer screening programme. The letter emphasised the importance of participation in the screening programmes and patients were invited to make an appointment to discuss it with a GP if they wished to do so. The GPs we spoke with said they were discussing the issue with all eligible patients during appointments for unrelated issues.

Public Health England data for the year April 2017 to March 2018 showed the practice was below a 70% attainment rate for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period. We spoke with practice staff about their efforts to achieve 80% attainment (the threshold set for the National Health Service Cervical Screening Programme to be effective). They told us they had investigated their cervical screening attainment performance in May 2019 and found that the recall system in place was not comprehensive. The process relied on the national invitation process. Following this, a more comprehensive process was introduced so that data would be reviewed quarterly. Any patients identified as requiring a cervical screen would receive up to two written invitations and a final phone call reminder from the practice. Each time, any non-attenders from the previous quarter would be followed up. Two nominated staff were responsible for ensuring this process was appropriately completed. During the first quarter of the new process, we saw the practice wrote to 317 patients recorded as not having received a cervical screening.

We found the practice now operated a comprehensive reminder system for patients who did not attend for their cervical screening test. They demonstrated how they encouraged uptake of the screening programme, for example, by ensuring a female sample taker was available. We looked at the practice's current unverified data and saw that the attainment rate (the percentage of eligible patients who had attended for a cervical screening test) was 74%, an increase of approximately 6% on the 2017/2018 attainment.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

## Findings

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

**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.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- One of the GP partners had completed training in mental capacity and Deprivation of Liberty Safeguards (DoLS).

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) <small>(QOF)</small>	92.0%	90.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	2.0% (1)	7.7%	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) <small>(QOF)</small>	98.0%	89.8%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	2.0% (1)	6.5%	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) <small>(QOF)</small>	82.4%	84.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.6% (1)	4.6%	6.6%	N/A

**Any additional evidence or comments**

During our inspection, we reviewed the care provided to patients with some mental health related conditions and found these patients had the appropriate care plans in place that identified and recorded important information in relation to their care.

## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543.4	539.6	537.5
Overall QOF score (as a percentage of maximum)	97.2%	96.5%	96.2%
Overall QOF exception reporting (all domains)	4.6%	5.2%	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.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

We looked at the details of three clinical audits undertaken in the past year. These were full cycle (repeated) audits or part of a full cycle programme (scheduled to be repeated) where the data was analysed and clinically discussed, and the practice approach was reviewed and modified as a result when necessary. Findings were used by the practice to improve services.

The practice completed an audit to check adherence to guidelines that patients prescribed a type of medicine used to treat osteoporosis were reviewed after five years to check their risk factors and discontinue or pause prescribing the medicine if appropriate. The practice identified four patients who qualified for a review and managed their care appropriately to ensure that all patients prescribed the medicine were treated in accordance with national guidelines.

An audit was completed to ensure patients prescribed a type of medicine used to treat rheumatoid arthritis were having the appropriate blood monitoring tests completed and that their care was monitored and recorded accordingly. The practice took action to ensure all the identified patients were treated appropriately.

## Effective staffing

**The practice was able to demonstrate that in most cases, 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.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included role-specific training and updating for relevant staff, the use of an e-learning facility and twice-yearly protected learning sessions (Clinical Commissioning Group target days). We saw there were gaps where essential staff training was not completed, or completion by some staff was more than three years ago. This mostly affected non-clinical staff and one GP. At the time of our inspection, the practice had recently introduced a monitoring system to assist in identifying gaps in completion of staff training and take the appropriate action to resolve this.</p> <p>At the time of our inspection, all but two staff had received an appraisal in the last 12 months. Both these staff were scheduled to receive an appraisal shortly after our inspection.</p> <p>The healthcare assistant (HCA) at the practice was employed after April 2015. The Care Certificate didn't form part of their induction. Senior staff we spoke with said they would research this and arrange for the healthcare assistant to complete the Care Certificate at the earliest opportunity.</p>	

## 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 three monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	N
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>From our conversations with staff, we found there were no formal, scheduled multidisciplinary or palliative care meetings at the practice. We found that although the practice approach was informal and unstructured, staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence that multidisciplinary team liaison and communication to discuss the needs of complex patients, including those with end of life care needs was comprehensive, and took place regularly. These patients' care plans were routinely reviewed and updated. Staff we spoke with told us that a structured and formal palliative care meeting was scheduled for September 2019 and would continue from that date.</p>	

## 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, tackling obesity.	Y

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>	95.9%	94.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (4)	0.6%	0.8%	N/A

### 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
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: We saw the process for seeking consent was adhered to and examples of documented informed patient consent for recent procedures completed at the practice were available.	

## 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
Explanation of any answers and additional evidence: At the time of our inspection, changes to the partnership and staff team were imminent. We found that appropriate succession planning was in place and this included an ongoing, coordinated transfer of responsibilities between roles, especially those at a senior level in the practice.	

### 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: A combination of day-to-day reviews between one GP partner and the deputy practice manager, ad-hoc management meetings between the GP partners and non-clinical managers and a structured monthly practice meeting were used to monitor the strategic direction of the practice throughout the year. This included developing and reviewing any evolving needs or areas of focus. Some of the main areas of strategic focus for the practice throughout 2019 were taking a proactive approach to health education, reviewing the pre-bookable appointments structure to meet the needs of a growing practice population, and investigating introducing new staff roles to the practice. There was also a focus on the significance of Primary Care Networks (PCNs) in how GP practices operate moving forwards.	



## 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.	N
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection, we found the practice did not have access to a Freedom to Speak Up Guardian and staff were not aware of any local initiatives. Senior staff we spoke with told us they'd investigate this provision following our inspection.</p> <p>At the time of our inspection, some staff had completed equality and diversity training. Most staff were yet to complete the training.</p>	

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

Source	Feedback
Staff interviews.	The staff we spoke with said there was a relaxed, informal and open culture within the practice and they had the opportunity to raise and discuss any issues directly with other staff or at meetings and felt confident in doing so and supported if they did. They told us they felt respected, valued and well supported and knew who to go to in the practice with any concerns. Staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by the practice.

## Governance arrangements

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

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

There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This was demonstrated by such things as the availability of and adherence to most practice specific policies. There was a protocol in place for how decisions were agreed and a monthly meeting at the practice for all staff to attend supported this. There was an unstructured approach to multidisciplinary working at the practice. Evidence was available to demonstrate this was comprehensive and took place regularly.</p> <p>There were named members of staff in lead roles. There were nominated GP leads for safeguarding, prescribing and patients with diabetes. We saw there was a clear staffing structure and found that except for some infection control related issues, staff understood their roles and responsibilities and those of others.</p>	

### Managing risks, issues and performance

**There were some clear and effective processes for managing risks, issues and performance. Where processes were not effective and when practicable, the practice responded to rectify this.**

	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 systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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:	
<p>During our inspection, we saw evidence to demonstrate that where the practice identified their systems, processes or protocols required improvement, action was taken to achieve this. For example, we saw that during 2019, the practice had identified issues with their cervical screening recall system, child immunisations data inputting and process for responding to abnormal patient test results. In each case, action was taken to improve. The practice implemented more comprehensive systems and processes and identified and contacted any patients affected to ensure their care and treatment was appropriate.</p> <p>We identified some concerns during our inspection. For example, those in relation to staff vaccinations, the process to follow up 'was not brought' children, and the process for reviewing patients prescribed the contraceptive pill, among others. Senior staff at the practice assured us they would act to ensure any issues were resolved in the same way as they'd demonstrated throughout 2019.</p>	

## 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 adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
We found the practice used accurate and reliable data and indicators to understand and monitor the performance of the practice. Where they identified any irregularities with data, they took action to rectify this. There was a programme of clinical and internal audit which was used to monitor quality and to make improvements.	

If the practice offered online services:

	Y/N/Partial
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
Any unusual access was identified and followed up.	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.	N
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 staff we spoke with said they were encouraged to actively participate in practice life and share their views. An open culture among staff and management supported this.	
The relevant staff we spoke with told us there was no active Patient Participation Group (PPG) at the practice. They said they wanted to re-establish a group and at the time of our inspection, one staff member was researching the best way to do this.	

We saw there were other methods available for patients to express their views and leave feedback about their experiences including a suggestions box and an online comments facility. We saw the practice reviewed all the suggestions made, including making changes to improve services and the patient experience.

The practice had an effective system in place for handling complaints and concerns. Information was available to help patients understand the complaints system. Complaints notices were displayed in the waiting area and a leaflet detailing the complaints process was available from reception. A brief introduction to the process was available on the practice's website. This didn't provide any comprehensive detail on the complaints process in place at the practice. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care or patient experience.

## 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
Explanation of any answers and additional evidence:	
In June 2019, the deputy practice manager commenced completing an advanced diploma in primary care management.	
One of the GP partners had recently developed and introduced a clinical newsletter circulated to all clinical staff at the practice. This provided relevant updates and information in a consistent and timely way. Due to the positive feedback from staff about the newsletter, plans were being considered to introduce a non-clinical version for those staff.	
The same GP partner was proactive in providing health information and education events for patients. In 2018, they hosted an education event for patients with asthma on how to best manage their condition and visited a local nursery to present on common childhood conditions. They recently hosted a patient education event on cardiovascular disease prevention with approximately 15 attendees.	
The practice was in the early stages of participating in a Primary Care Network (PCN). (A Primary Care Network is a group of practices working together to provide more coordinated and integrated healthcare to patients). As part of this, the participating practices were identifying areas of focus to assist in improving and diversifying the delivery of patient care.	

## 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.