

Care Quality Commission

Inspection Evidence Table

Giffard Drive Surgery (1-549743288)

Inspection date: 10 October 2019

Date of data download: 01 October 2019

Overall rating: Good

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

Effective

Rating: Good

We have rated the practice as good for providing effective services. (The practice was previously rated as outstanding for providing effective services). The practice reviewed and recalled patients for care and treatment in line with guidance and followed evidence-based guidelines. We identified governance concerns relating to care plan reviews and sharing of information, and rated the population group families, children and young people as requires improvement due to their childhood immunisation uptake rates being significantly below the minimum 90% standard.

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

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>	0.82	0.83	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.
- The practice followed up on older patients discharged from hospital. It ensured that their prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- We looked at a sample of care plans which had been recorded on the practice computer system. We noted the practice did not routinely share these with external stakeholders, such as the out of hours GP or ambulance services. The practice told us patient records could be accessed by some external stakeholders such as the local federation and local hospice team. We did note that “do not resuscitate” orders were shared with external agencies. We were also unable to ascertain if a formal review process, for updating and reviewing care plans, was in place to ensure the information contained in them was up to date.

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>	82.6%	80.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	7.9% (45)	9.2%	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>	81.3%	79.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.6% (43)	7.8%	9.8%	N/A
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>	82.9%	83.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	8.5% (48)	10.8%	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>	72.1%	73.2%	76.0%	No statistical variation
Exception rate (number of exceptions).	4.1% (25)	4.0%	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>	93.5%	92.2%	89.7%	No statistical variation
Exception rate (number of exceptions).	12.7% (20)	10.3%	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)	82.6%	81.5%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.3% (62)	3.1%	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)	94.1%	93.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.0% (15)	5.9%	6.7%	N/A

Families, children and young people

Population group rating: Requires improvement

Findings

We rated the population group families, children and young people as requires improvement as the uptake rates for childhood immunisations was significantly below the minimum 90% target. It was too early to identify if the new nursing team had been effective at improving this.

- The practice had not met the minimum 90% target for three of the four childhood immunisation uptake indicators and was 0.2% below the 90% minimum for one indicator. The practice had a system in place to recall children for vaccinations and the nursing team was responsible for following up any children who did not attend.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	88	98	89.8%	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)	97	124	78.2%	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)	97	124	78.2%	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)	95	124	76.6%	Below 80% uptake

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice had had a reduced nursing workforce over the preceding 12 months and had successfully recruited a full complement of nursing staff into post in recent weeks, including a nurse manager. The nurse manager had been in post for three weeks at the time of the inspection and was planning to review the system for recalls and invitations for children to attend for immunisation, to determine if any changes or improvements were required. The practice regularly reviewed a list of children who did not attend for immunisation and these were followed up by the nursing team.

The practice showed us their unverified data and payment statements for childhood immunisations for the periods April 2019 to June 2019 and July 2019 to September 2019.

The figures demonstrated the practice had met the minimum 90% target for children aged two receiving immunisations according the appropriate schedule.

After the inspection (November 2019), the practice received official data confirming they had achieved the 90% minimum target for child immunisations.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Telephone consultations and e-consult were available for working age patients who could not attend the surgery. There was also a variety of extended hours options for outside core working hours, so patients could access GP services at a time that was convenient to them.
- The practice provided a tier two gynaecology service to all eligible female patients within the clinical commissioning group. (A two tier service is a service which allows patients to have access to specialist services through their GP). The service was commissioned to undertake four sessions per week. It was a GP led service (one of the GPs had a specialist interest in gynaecology and had undertaken additional training to become the lead for this service).

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) <small>(Public Health England)</small>	74.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) <small>(PHE)</small>	74.0%	73.1%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2017 to 31/03/2018) <small>(PHE)</small>	60.0%	62.2%	57.3%	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) <small>(PHE)</small>	88.7%	77.0%	69.3%	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) <small>(PHE)</small>	39.6%	43.5%	51.9%	No statistical variation

Any additional evidence or comments

The practice had recognised their uptake rates for cervical cancer screening were lower than local and national averages and had undertaken a review of their recall processes and systems.

In February 2018, the practice signed up to a local incentive scheme to improve cervical screening uptake rates. They identified an action plan which included the following actions:

- Patients were contacted by telephone if they had not responded to recall letters.
- Alerts were added to the practice computer system so clinicians could offer opportunistic screening when patients attended for other appointments.
- Reception staff offered appointments to eligible patients when they contacted the practice for another appointment.
- New patients registering with the practice were invited to attend for screening if they were identified as being overdue.
- Eligible patients on the learning disability register were offered cervical screening as part of their annual health check.
- Nepali speaking members of practice staff assisted to contact eligible patients from the Nepali community to invite them to attend.
- Information posters and leaflets in the patient waiting room, clinical rooms and patient toilets to promote awareness.

The nursing team and capacity had been reduced in the preceding 12 months and the practice had successfully recruited additional nurses into the team, including a nurse manager. Cervical screening was being reviewed by the nurse manager to identify any further actions that could be implemented to increase uptake rates. All the nurses who undertook cervical screening had been appropriately trained and received timely updates. Individual nurses monitored their sample taking processes and reviewed inadequate sample rates. Patients who did not attend for colposcopy were also followed up by the practice.

The practice showed us their data trends (sourced by the practice from NHS England) which demonstrated a 2% improvement over time (from 72.9% in December 2016 to 74.9% in October 2018).

The practice showed us their unverified data from the quality and outcomes framework (QOF) achievement which demonstrated they had achieved an uptake of over 80% for eligible women receiving suitable screening. (This data is not directly comparable with Public Health England data in the table above). We noted the exception reporting data for the QOF cervical screening was 2.7% for 2017/18 which was lower than local and national averages.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- In 2018/19 the practice achieved 66% uptake for a health check for patients with a learning disability. The practice had information leaflets in easy read and picture formats to explain what happens during a health check. They encouraged patients to book longer appointments and invited patients in during times when the practice was quieter, including evenings and weekends.
- The practice was accredited as a military veteran friendly practice.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes, where appropriate.
- The practice recognised the effect of isolation with vulnerable patients and made Christmas boxes to deliver to patients who were alone, with no family. Staff donated gifts to contribute to the boxes and these were hand delivered by practice staff in the days before Christmas. The practice had received many thank you letters and cards from grateful patients.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- 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.
- The practice was registered as a dementia friendly practice and all staff had received dementia training.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.2%	91.8%	89.5%	No statistical variation
Exception rate (number of exceptions).	7.1% (4)	10.8%	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)	94.4%	89.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.6% (2)	9.0%	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)	87.2%	83.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	9.6% (5)	4.9%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	553.8	547.6	537.5
Overall QOF score (as a percentage of maximum)	99.1%	98.0%	96.2%
Overall QOF exception reporting (all domains)	4.2%	4.4%	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 clinical audits or other improvement activity in past two years:

Receiving results for endometrial pipelle biopsy

This audit was undertaken to review the timescale for receipt of histology results following an endometrial pipelle biopsy (a sample of tissue taken from within the lining of the uterus to determine if there are any abnormal cells which require follow up or referral. It is different from a cervical cytology screen, where a sample of tissue is taken from the cervix).

The clinician undertaking the audit, established that all results should be sent back to the practice within two weeks of the sample being sent for analysis.

A search of patients was carried out between February 2012 and September 2018 which identified 15 patients who had a record of such a test being carried out.

Of these, 20% of the results had been received by the practice within two weeks. The average number of days was 23. One sample was insufficient to test and the remainder had results that did not require an urgent onward referral. (GP follow up was required for best practice so patients understood their results and had a discussion around risk factors and future risks and to allay any patient anxiety).

Possible reasons for the delay in receiving the results included issues with the pathology department (technical, equipment, staffing), inadequate clinical information on the request form and inadequate sampling.

Learning actions and recommended outcomes included lower suspicion for endometrial cancer and earlier referral for biopsy and implement a system for reviewing histology results and follow up if not received by 14 days. At the time of the inspection, there had been no second cycle of audit to verify if improvements had been made.

Prediabetes referrals to national diabetes prevention programme

This audit was undertaken to review the number of patients diagnosed with their first episode of prediabetes who were referred to the national diabetes prevention programme (NDPP).

The author identified how patients making changes to their lifestyle through the NDPP had statistically improved outcomes to those on alternative pathways, such as commencing medication.

A search of patients was carried out between January 2018 and January 2019 which identified 148 patients:

- 14% were referred to NDPP
- 31% declined the offer
- 53% were not recorded

The results demonstrated a low uptake of referrals to NDPP, in comparison with national audits, which identified some more deprived areas had increased uptake of NDPP at 49%.

Possible reasons for the low referrals included language barriers, mobility/travel issues, time consuming, commitment/low motivation.

Learning actions and recommended outcomes included reviewing accessibility to the programme and flexibility of the offered sessions. Language barriers and patient knowledge and understanding were also recommended to be reviewed and promoted.

A second cycle of the audit was due to be completed in January 2020.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. 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 (1)
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y (2)
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(1) The practice manager held a record of all staff training on a computer matrix. We noted there were some gaps in training the practice had categorised as mandatory, such as health and safety training. The majority of staff training had been undertaken within appropriate timescales.</p> <p>(2) The practice had recruited a health care assistant (HCA) in April 2019. Due to gaps in the nursing team, they were unable to offer suitable supervision or mentorship for the HCA to undertake the care certificate. The practice told us now they had a full nursing team, they would ensure the HCA undertook the relevant qualifications. The HCA had, in the interim, completed several e-learning modules associated with the care certificate coursework.</p> <p>One of the GPs had also completed the care certificate to understand the requirements and to offer additional support to the nursing team.</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 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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

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) (QOF)	90.8%	94.4%	95.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.3% (6)	0.5%	0.8%	N/A

Any additional evidence or comments

The practice showed us their unverified data for recording smoking status (2018/19) which demonstrated an increase to 93% for patients with a specific long term condition. Exception reporting remained below 1%.

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.	N (3)
Explanation of any answers and additional evidence: (3) The practice told us they did not monitor consent seeking processes to ensure consent had been gained in line with guidance. We saw that consent forms were used by the practice for minor surgery procedures, such as removal of skin tags and lumps and joint injections. The administration team scanned the consent forms into the patient records and referenced these against a list of patients who had had minor surgery procedures. The practice did not monitor these against consent seeking standards, to ensure consent had been gained appropriately. We also reviewed the information leaflets and information patients were given regarding various procedures, which detailed what symptoms may occur post procedure and when to seek further medical help. The practice told us they would undertake a review of their consent seeking processes within a few weeks of the inspection and would undertake this on an annual basis.	

Well-led

Rating: Requires improvement

We rated the practice as requires improvement for well led services, the previous rating was outstanding. There were some governance arrangements that required a review and some risks that had not been identified by the practice.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels, although there were some areas requiring a review.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	P (a)
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: (a) The practice was aware of several factors that influenced service delivery such as lack of capacity in the current building, increasing patient list size and increased demand for appointments. They had secured funding for building works to commence in January 2020 in an empty residence (owned by the practice) next to the existing practice building. There were some governance concerns which were highlighted to the practice on the day of the inspection, which were unknown to the leadership team. For example, no monitoring of consent seeking processes and documentation in patient records which was not in line with guidance.	

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

Culture

The practice had a culture which drove high quality sustainable care.

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

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

Source	Feedback
Staff interviews	Good team who work well together.
Staff interviews	Supportive leadership and opportunities to undertake additional training if needed.
Staff interviews	Can approach managers or GPs about anything.
Staff and practice feedback	Many staff had taken part in charity events (sponsored walks, park runs and bicycle rides) to raise money and awareness for various charities.

Governance arrangements

The practice had staff in lead roles and systems of accountability to support good governance and management. However, we found some governance arrangements were inconsistently applied.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N (b)
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	P (c)
<p>Explanation of any answers and additional evidence:</p> <p>(b) During the inspection we reviewed several key documents to inform us of the governance arrangements in place at the practice. We found some areas where the governance arrangements required additional oversight or monitoring:</p> <ul style="list-style-type: none"> We viewed four staff recruitment files and found some documentation gaps, such as an interview summary missing and no DBS risk assessment whilst waiting for a DBS check to come through. We also noted there was no documented assessment of physical or mental health status of staff, contained in the files, to identify any reasonable adjustments. The practice manager told us they had a checklist for recruitment, but did not document a checklist for individual recruitment files to ensure all the required documentation was contained. Patient group directions (PGD) required a review. We found one PGD that had not been authorised and several with varying signature dates. (PGDs enable nurses to administer medicines and vaccinations without an individual prescription. The PGD is a generic prescription and the person 'authorising' the nurse to offer a medicine under a PGD should assess if the nurse has the competency and knowledge to give that medicine). We were shown the monitoring log for the emergency medicines stocked within the practice. The checking processes had not identified one medicine was outside its expiry date. The practice replaced the item on the day of the inspection and the nurse manager told us they would ensure all staff, who had a responsibility for checking stock, reviewed the expiry dates. <p>After the inspection (December 2019) the practice sent us an example DBS risk assessment which was due to be implemented into their recruitment processes. They also provided us with additional information on the inclusion of reasonable adjustments (where necessary) to their workforce and told us they would improve the recruitment processes to ensure these documents were included in future recruitment files.</p> <p>(c) The practice did not routinely share care plans with third party providers, such as the out of hours GP service or the ambulance service. Care plans are useful to third party stakeholders if they are contacted outside the practice core opening hours to offer care and support to patients. The practice told us several key stakeholders (including the local hospice and integrated care teams) had access to patient records via the locally used computer system. The practice also told us they were looking at encouraging more patients to sign up to the summary care record (the summary care record is the national system for consenting patients to have their primary care records accessed by authorised health care professionals to support their care and treatment). They told us they would commence with patients at the highest risk including many on the care plans we reviewed.</p>	

Managing risks, issues and performance

The practice had systems and processes for managing risks, issues and performance, although some areas required a review.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N (d)
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.	N (d)
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
<p>Explanation of any answers and additional evidence:</p> <p>(d) The practice showed us risk assessments and other documentation relating to identifying and managing risk. During the inspection we found some areas that had not been identified or assessed:</p> <ul style="list-style-type: none"> The practice told us they did not have any formal monitoring of consent seeking processes. There was a risk that consent had not been gained in line with guidance, or documented consent was not contained in patient records. There was no process for ensuring histology (tissue sample) results for minor surgery were received and reviewed. The practice relied on patients contacting them after a suitable time period to follow up on results. If a result had not been received or was delayed, this could result in a delay of a diagnosis or essential referral for further care. Reception staff updated patient records to reflect prescriptions that had not been collected. However, there was no process to ensure that this information was taken into account at the next medicine review or that patients were followed up by a clinician when they didn't collect a prescription for a medicine that should not be stopped suddenly. The practice had not carried out a risk assessment for clinical staff who were working whilst waiting for their disclosure and barring service (DBS) check to clear. (A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). <p>The practice told us they would review these arrangements after the inspection.</p>	

Appropriate and accurate information

The practice used data and information to drive and support decision making, although the practice records did not always contain the most appropriate and accurate information.

	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.	P (e)
There were effective arrangements for identifying, managing and mitigating risks.	P (e)
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

(e) During the inspection the GP Specialist Advisor reviewed a selection of patient records and care plans available to staff on the practice computer system:

- We saw a selection of patient care plans (non-QOF related) had not been reviewed or checked to ensure the information was up to date or accurate. There was a risk the information contained in the care plans did not reflect the most up to date status of the patient and care could be offered (or retracted) based on inaccurate information.
- Records of repeat prescriptions for some high risk medications did not include details of the most recent blood test result (or a record indicating these had been reviewed following hospital blood testing). For example, we viewed practice records and searches of patients on a medicine commonly used for inflammatory conditions such as arthritis, and found 40% were overdue for their blood testing. We also found 22% of patients on a medicine for high blood pressure were also overdue their blood test monitoring, according to practice searches. The practice told us the blood test results were often accessed from the local hospital system and these were reviewed before a repeat prescription was offered. Some of the patient records we viewed did not contain this information or record that hospital blood tests had been reviewed before a clinical decision was made, which was not in line with record keeping and documentation guidance.

The practice told us they would review these arrangements after the inspection.

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.	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

Feedback from Patient Participation Group (PPG).

Feedback
<p>We spoke with seven members of the PPG who told us they worked well with the practice. They regularly fed back to the practice any areas of concern and offered suggestions to improve.</p> <p>The PPG held fundraising events and had raised £1,000 this year, to supply additional equipment such as blood pressure machines for patient use.</p> <p>The PPG had also been actively involved in planning for the new practice building and one of the members had attended practice planning committee meetings.</p>

Any additional evidence
<p>The practice involved patients in the planning and development of the new premises. The practice told us 355 positive comments were submitted to the local council to support the application for the new building. The practice received positive comments and feedback including a number of thank you cards for their support to patients.</p> <p>We received 84 comment cards during the inspection of which 83 were positive about the care received. Only one card stated a concern with the attitude of GPs.</p>

Continuous improvement and innovation

There was evidence of 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

Examples of continuous learning and improvement

The practice had been selected as a pilot site to develop and improve access to mental health care and support locally. The primary care network (PCN) had been involved in securing funding for this pilot and provide mental health workers into the practice. The practice had only just been announced as one of the pilot sites at the time of the inspection.

The practice was working towards a learning disability friendly practice accreditation.

Following the inspection, the practice sent us documentation supporting their intention to improve on the areas outlined for review. This included a list of actions undertaken and planned actions to improve.

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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