

# Care Quality Commission

## Inspection Evidence Table

### Dr Shakarchi's Practice (1-3879357223)

Inspection date: 12 September 2019

Date of data download: 4 September 2019

## Overall rating: Good

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

## Safe

## Rating: Good

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>We saw that GPs and the practice nurse were trained to safeguarding children level 3. The practice was aware of the latest Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (January 2019) guidance and were reviewing the level of training for all staff in line with the guidance. For example, non-clinical staff to be trained, where appropriate, to level 2.</li></ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses) was checked and regularly monitored.	Yes

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: 16.08.2019	Yes
There was a record of equipment calibration. Date of last calibration: 19.06.2019	Yes
There were risk assessments for any storage of hazardous substances for example, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire alarm maintenance checks. Date of last check: 16.08.2019	Yes
There was a record of fire extinguisher checks. Date of last check: 16.08.2019	Yes
There was a log of fire drills. Date of last drill: 15.07.2019	Yes
There was a record of fire alarm checks. Date of last check: 09.09.2019	Yes
There was a record of fire training for staff. Date of last training: Variable as on-line training (all within 12 months)	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 18.10.2018	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice operated from premises with another GP practice. All decisions and actions regarding building maintenance and facilities management was shared between both practices.</li> <li>At our previous inspection the practice could not demonstrate that the storage of some consumables identified in the Control of Substances Hazardous to Health (COSHH) risk assessment were in line with recommendations. At this inspection we found that the practice had acted upon our findings. There was a COSHH risk assessment in place and all consumables identified as a COSHH risk were appropriately stored.</li> <li>We saw evidence of a valid gas safety certificate (01.07.2019) and an electrical installation condition report (16.08.2019).</li> </ul>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 16.09.2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11.07.2019	Yes

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 22.08.2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection we found concerns in relation to the management of infection prevention and control (IPC). We found that the practice had not carried out a recent IPC audit, we observed high and low-level dust in some consultation rooms, including where minor surgery was undertaken and there was inadequate segregation of cleaning equipment, which posed a risk of cross-contamination. At this inspection the practice demonstrated that they had acted upon all these findings.</li> <li>We saw that appropriate standards of cleanliness and hygiene were maintained.</li> <li>We saw that the practice had undertaken their own IPC audit on 4 June 2019 and a formal IPC audit had been undertaken by the Commissioning Support Unit IPC team on 22 August 2019. At the time of our inspection the practice had just received the IPC report and time-scaled action plan and were addressing the actions required.</li> <li>At our previous inspection we found that the practice was not systematically monitoring and recording the hot and cold-water temperatures and we found some temperatures recorded were out of the recommended ranges. At this inspection we found that there was a schedule to monitor and record water temperatures on a monthly basis. However, some recorded temperatures were still outside the recommended ranges. The practice was aware of this and an additional Legionella risk assessment had been undertaken in August 2019, which recommended remedial work to bring the temperatures in line with guidance. The practice told us that the remedial work was scheduled to be undertaken.</li> <li>The newly recruited practice nurse had been nominated as the IPC lead. At the time of the inspection they had not undertaken training for the lead role that included specific IPC knowledge in line with the Hygiene Code which identified specific primary care IPC responsibilities for this role such as how to mitigate the risk of healthcare acquired infection.</li> <li>At our previous inspection we observed that clinical staff did not have access to all the appropriate colour-coded sharps containers required for the range of medicines administered at the service. At this inspection we found that all appropriate sharps containers were available.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>At our previous inspection the practice could not demonstrate that non-clinical staff had received guidance on actions to be taken if they encountered a deteriorating or acutely unwell patient, including sepsis awareness. At this inspection we saw evidence that all non-clinical staff had undertaken formal sepsis awareness training and staff we spoke with confirmed this. We saw sepsis awareness posters were displayed around the practice.</li><li>The practice had a formal sepsis protocol in place which it had been unable to demonstrate at our last inspection. We saw that sepsis had been discussed in a recent practice meeting.</li></ul>	

## 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection the practice could not demonstrate a system in place to safety-net two-week wait referrals. At this inspection the practice demonstrated a documented system to ensure a patient had received an appointment, had attended the appointment and the practice had received an outcome.</li> <li>At our previous inspection the practice could not demonstrate a failsafe system to ensure a result had been received for cervical screening sample sent for pathology. At this inspection the practice demonstrated a system to monitor samples sent and results received.</li> </ul>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.63	0.52	0.87	Tending towards variation (positive)
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)	9.8%	9.9%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	7.99	5.80	5.63	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.53	1.26	2.08	No statistical variation

<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was aware that their prescribing of antibiotics for uncomplicated urinary tract infections (UTIs) was above the local and national averages. We saw that antibiotic prescribing in UTIs formed part of a prescribing incentive scheme (PIS) and was monitored by the Clinical Commissioning Group (CCG) medicine optimisation team.</li> </ul>
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Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection we found concerns in relation to the management of emergency medicines. The practice had not assessed the risk in relation to the availability of emergency medicines to manage a medical emergency when medicines were taken off site, for example, for a home visit. At this inspection the practice demonstrated the availability of additional medicines for the home visit emergency bag. We saw that these expiry dates were monitored and documented.</li> <li>At our previous inspection we reviewed some patient records and found some medicines were</li> </ul>	



Medicines management	Y/N/Partial
<p>still active on patients' medicine list after they had stopped taking the medicines. At this inspection we saw evidence that the practice had undertaken an audit of all patients on repeat medication, undertaken medication reviews and stopped repeat medicines, where appropriate. The audit was repeated after three months. The practice told us they planned to repeat the audit again in three months' time.</p> <ul style="list-style-type: none"> <li>At our previous the practice could not demonstrate a documented system to monitor, manage and record the expiry dates of medicines and oxygen. At this inspection we saw evidence that the practice had put a system in place.</li> <li>There was a dedicated medicines storage refrigerator with built-in thermometer and we saw minimum, maximum and actual temperatures had been recorded. The practice did not have a secondary thermometer in line with Public Health England (PHE) guidance. After the inspection the practice sent evidence that a secondary thermometer had been procured.</li> </ul>	

## 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	5
Number of events that required action:	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was an incident policy in place, which was accessible to staff.</li> </ul>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Incorrect patient booked an appointment with similar name.	We saw evidence that it had been discussed in a practice meeting to reiterate the process to check appropriate patient indicators, such as date of birth and address.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our previous inspection the practice could not demonstrate that patient safety alerts and outcomes were consistently discussed in clinical and/or practice meetings. At this inspection we saw patient safety alerts were a standing agenda item. The practice demonstrated their system to receive and action patient safety alerts and we saw evidence of patient searches and outcomes for recent alerts.</li> </ul>	

## 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our previous inspection the practice could not demonstrate a formal process to disseminate new clinical guidance to all clinicians. At this inspection we saw that recent guidance had been discussed in a clinical meeting. Clinical staff we spoke with told us that updates were discussed in meetings, which were minuted.</li> </ul>	

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) (NHSBSA)	0.83	0.91	0.75	No statistical variation

### Older people

### Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</li> <li>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.</li> <li>The practice carried out structured annual medication reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Influenza, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> </ul>



- All patients had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

## 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.
- Patients with multiple conditions had their needs reviewed in one appointment.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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 suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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>	74.8%	78.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	1.3% (2)	10.6%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	84.2%	75.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	2.0% (3)	9.4%	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	77.6%	78.5%	80.1%	No statistical variation

months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <sup>(QOF)</sup>				
Exception rate (number of exceptions).	1.3% (2)	10.3%	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) <sup>(QOF)</sup>	80.4%	77.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (2)	7.6%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <sup>(QOF)</sup>	100.0%	88.8%	89.7%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	12.5%	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) <sup>(QOF)</sup>	90.6%	79.4%	82.6%	Variation (positive)
Exception rate (number of exceptions).	1.6% (6)	3.8%	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) <sup>(QOF)</sup>	100.0%	87.9%	90.0%	Variation (positive)
Exception rate (number of exceptions).	4.5% (1)	6.7%	6.7%	N/A

## Families, children and young people

## Population group rating: Requires Improvement

### Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets for one and two-year olds. The practice were aware of this and had put an action plan in place.
- 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)	18	28	64.3%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	19	28	67.9%	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)	22	28	78.6%	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)	21	28	75.0%	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 was aware that their immunisation rates were below the WHO target. Since our last inspection the practice had recruited an additional administrator, who was responsible for coordinating recall and follow-up of patients. Parents and guardians were reminded ahead of appointments and followed-up if they did not attend. In addition, the practice held a Saturday clinic to enable patients to access immunisations out of core hours.

### 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.

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)	55.8%	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)	49.6%	54.1%	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)	38.7%	37.8%	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)	56.5%	59.7%	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)	50.0%	53.5%	51.9%	No statistical variation

#### Any additional evidence or comments

The practice was aware that their cervical screening outcomes were below the England average and the national target. Since our last inspection the practice had invited a representative from Jo's Cervical Screening Trust to discuss available resources and ways to encourage patient uptake with the cervical screening programme. In addition, the practice had recruited an additional administrator to coordinate recall and follow-up of patients and a healthcare assistant which had freed-up practice nurse time to focus on cervical screening.

#### People whose circumstances make them vulnerable

#### Population group rating: Good

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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.

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

Population group rating: Good

### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- 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) <small>(QOF)</small>	90.8%	81.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	3.0% (2)	9.7%	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>	97.0%	87.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.5% (1)	7.6%	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>	87.5%	84.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	33.3% (4)	7.5%	6.6%	N/A

### Any additional evidence or comments

- We saw that all staff had undertaken dementia and learning disability training.

## 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)	550.9	520.2	537.5
Overall QOF score (as a percentage of maximum)	98.5%	93.1%	96.2%
Overall QOF exception reporting (all domains)	2.2%	6.7%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our last inspection the practice could not demonstrate a formal process to identify clinical audit and there was no programme of continuous quality improvement. At this inspection the practice demonstrated they had undertaken four two-cycle prescribing audits. We saw that one had been in response to the findings of our previous inspection with regards patients on repeat medicines. We saw all audits had learning outcomes.</li> <li>The lead clinical undertook regular minor surgery audits as part of the quality assurance process for minor surgical procedures.</li> <li>We saw the clinical audit programme had been discussed at a recent clinical meeting and some audits agreed for the forthcoming year.</li> </ul>	

## 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.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes



Staff had access to regular appraisals, one to ones, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

## 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)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our last inspection the practice did not have a formal system in place to follow-up on patients who did not attend the national screening programmes, for example bowel and breast cancer. At this inspection the practice demonstrated that patients who did not attend were sent a text reminder. The clinicians told us that they discussed opportunistically with patients in consultations if they had failed to engage with the screening programme to encourage uptake.</li> </ul>	

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>	97.1%	95.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (1)	1.2%	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Clinicians had a good understanding of the Mental Capacity Act (MCA) and had received training.</li> <li>Staff were aware of the need to request consent to share records with referrals in line with General Data Protection Regulation (GDPR) principles.</li> <li>We saw that the practice included consent training as part of its core training schedule for clinical staff.</li> </ul>	

## 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had been responsive to feedback from our previous inspection and had addressed all our findings.</li> <li>Since our last inspection the practice had recruited a new practice manager and added a</li> </ul>	

healthcare assistant and additional administrator to the team.

- The partners and manager told us there was a drive to continue to improve outcomes for patients.

## 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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

## 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had duty of candour and whistleblowing policies in place, which were accessible to staff. We saw that staff had undertaken being open and whistleblowing training as part of the practice's core training schedule.</li> <li>• We saw evidence that staff had undertaken health and safety, display screen equipment (DSE) and moving and handling training as well as bullying and harassment and conflict resolution to support staff safety and well-being.</li> </ul>	

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

Source	Feedback
Staff interview	Staff told us they were happy to work at the practice and felt it was friendly, open and senior staff were approachable.

## 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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection we had concerns about reliable systems and processes to ensure good governance. This included recording and acting on significant events, disseminating new clinical guidance to all clinicians and consistently minuting meetings. At this inspection we found the practice had addressed our findings.</li> <li>The practice had a meeting structure which included a one-to-one daily catch-up meeting for staff, weekly operational meetings, monthly clinical and multidisciplinary meetings and quarterly formal safeguarding and palliative care meetings. We saw that all meetings were minuted and minutes were available for staff. The practice also engaged with practices in its locality as part of local initiatives, for example the Primary Care Network (PCN).</li> <li>The practice had nominated staff into designated lead roles, for example safeguarding, infection prevention and control and complaints.</li> <li>There were practice-specific policies including, child and adult safeguarding, infection and prevention control and significant events. There was a system for these to be regularly reviewed. All staff we spoke with knew how to access the policies.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	

- The practice demonstrated a structured approach to the management and oversight of its Quality and Outcome Framework (QOF) achievement which included a patient recall system.

## 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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

## 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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We did not speak with any patients during the inspection. However, as part of our inspection process, we asked for CQC comments cards to be completed by patients during the two weeks prior to our inspection. Five comment cards were received, all of which were positive, and described the practice as excellent, caring and helpful. One card was mixed regarding accessibility for a wheelchair user.</li> <li>• The practice pro-actively sought patient feedback through the NHS Friends and Family Test (FFT). Results for the period April 2018 to August 2019, based on 438 responses, showed that 91% of patients would be extremely likely or likely to recommend the service.</li> <li>• We reviewed the National GP Patient Survey for the period 1 January 2019 to 31 March 2019. We saw that 459 surveys had been sent out and 91 were returned, which was a response rate of 19.8% and 2.23% of the practice population. The outcomes in relation to the practice being caring were comparable to local and national averages and outcomes in relation to the practice being responsive were above local and national averages. We found: <ul style="list-style-type: none"> <li>➤ 97.7% of patients stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (CCG average 92%; national average 95.5%).</li> </ul> </li> </ul>	

- 82.7% of patients stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (CCG average 81.5%; national average 87.4%).
- 97% of patients responded positively to how easy it was to get through to someone at their GP practice on the phone (CCG average 81%; national average 68.3%).
- 86.9% of patients stated that they were very satisfied or fairly satisfied with their GP practice appointment times (CCG average 60.6%; national average 64.7%).

## 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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice engaged with the CCG and neighbouring practices in local current and future initiatives which included the Primary Care Network (an approach to strengthening and redesigning primary care to focus on local population needs and provide care closer to patients' homes).</li> <li>The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.</li> </ul>	

#### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.