

# Care Quality Commission

## Inspection Evidence Table

### The Crown Surgery (1-549594021)

Inspection date: 14 October 2019

Date of data download: 11 October 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 took account of patients accessing any online services.	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: The practice had a nurse led safeguarding system. Patients who were or who could be at risk were identified on the system. The practice had improved their safeguarding system and included a review of children that were not brought for appointments in either the practice or secondary care. The safeguarding lead had developed a spreadsheet which included all	

Safeguarding	Y/N/Partial
safeguarding reports and follow up information.	
The practice had changed its previous policy of only having DBS checks in place for clinical staff with risk assessments for non-clinical staff. All staff had DBS checks and all staff who provided chaperone support had been trained. The practice had considered offering chaperone training to non-clinical staff and planned to implement next year.	

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 and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: Staff registrations were checked at regular intervals and staff were required to bring in proof of re-registration.	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: March 2019	Yes
There was a record of equipment calibration. Date of last calibration: November 2018	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 30/09/2019	Yes
There was a log of fire drills. Date of last drill: 27/06/2019	Yes
There was a record of fire alarm checks. Date of last check: 9/10/2019	Yes
There was a record of fire training for staff. Date of last training: All staff completed fire training at various dates throughout the year.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: January 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The practice planned to increase the number of fire marshals it had trained to ensure cover for annual leave. We saw that the training log for fire training was up to date and that staff were expected to complete all mandatory training annually.	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: July 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2018 and rebooked for October 2019	Yes
Explanation of any answers and additional evidence: There was also documented evidence that suitable checks had been made on gas safety, hardwiring and emergency lighting. A specific water test for the water borne bacteria legionella was also carried out annually.	

## 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: June 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
Explanation of any answers and additional evidence: We made a best practice recommendation in our January 2019 inspection "to review and update the cleaning schedule". The practice had taken a whole team approach to this and included the cleaning staff and sought support from an external infection prevention and control (IPC) audit soon after our January 2019 inspection. They acted on that IPC audit and developed a refurbishment plan, reorganised key areas and decluttered clinical rooms. The practice had developed a comprehensive IPC policy and there was a detailed action plan to follow up on areas identified from the IPC audit. The practice had refurbished the practice, refined the cleaning schedule with a clear checklist procedure and completed a second IPC audit by June 2019. At this inspection we found the practice was clean and tidy with an appropriate IPC policy, risk assessment and action plan in place. The practice had plans to carry out spot IPC audits at regular intervals throughout the year which would include handwashing.	

## 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	Yes

impact on safety.	
<p>Explanation of any answers and additional evidence: There were laminated aide memoirs for sepsis in all GP rooms and all staff had received dedicated training. They clinical staff used an electronic tool which identified any sepsis indicators and generated a flag warning on the screen which ensured any identified patients were escalated through the system. We saw that a patient who had described warning signs was assessed by the practice flagged appropriately and had been admitted to a local hospital for treatment.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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

## 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)	0.78	0.98	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	9.0%	10.2%	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)	5.84	5.60	5.63	No statistical variation
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)	2.27	2.11	2.08	No statistical variation

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.	Yes
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	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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.	Yes
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.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
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: The practice had improved their printer security for blank prescriptions. However, they had not restricted access to these as much as they could have.</p> <p>The practice had emergency medicines in place however, some were in the doctors' bags, whilst others were with the emergency equipment. This made it more difficult for staff to locate any item in an emergency as it was not clear which medicines were stored where. We asked the practice to revisit this and confirm arrangements. Immediately after inspection the practice confirmed that they would review this urgently.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
Explanation of any answers and other comments on dispensary services: We found that the dispensary had comprehensive standard operating procedures in place (SOPs) for every aspect of the work carried out. However, three of the SOPs required rewording for clarity, for example the intervals medicines were checked for date of expiry.	

## 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:	16
Number of events that required action:	16
Explanation of any answers and additional evidence: The practice had developed their root cause analysis process and review process since our inspection in January 2019. All incidents were appropriately investigated to ensure that all possible contributory factors were identified and that learning elements were shared widely. The practice shared the events at the first available monthly clinical meeting and in more detail at a dedicated significant event meeting which took place quarterly. The actions identified from the significant event meeting were recorded as being reviewed at the following significant event meeting to ensure that any suggested changes were practicable and to review how they worked or if further changes were required.	

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

Event	Specific action taken
Storage of emergency equipment.	The practice had stored their emergency equipment in two areas and not one central area. They conducted a red button alarm test to satisfy themselves that this would work effectively. However, following the test they realised that not all of the emergency equipment required had been taken to the test site. The practice treated the test result as a significant event and reviewed their process. All emergency equipment was then stored in a portable wheeled box in a central area.
A GP had printed out letters to two separate patients and had inadvertently picked them up as one and put them into an envelope to one patient.	The mistake was not realised until after the post had been delivered to one of the patients. The GP immediately rang the patient who had their confidentiality breached and an apology offered. The practice carried out a full review of the workflow process and had considered additional recruitment. All staff encouraged to check printed letters have not got stuck together before sending out.

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
<p>Explanation of any answers and additional evidence: At our inspection in January 2019 the practice had not established a system to capture all alerts. At this inspection we saw that they had developed a comprehensive spreadsheet with all required alerts linked, summarised, shared and actioned. The spreadsheet also detailed ongoing action or when repeat searches were required.</p> <p>An estates and facilities alert had been issued in relation to a specific type of printer and power source which posed a fire risk. The practice knew they had some of this equipment and checked all printers checked to see if they had an affected unit. The practice identified one unit and ensured the power source was unplugged each evening until the replacement unit was received.</p> <p>We also saw that action had been taken on recent medicine alerts for example, regarding sodium valproate. We saw that the GPs had set up a suite of searches to support the alert process.</p>	

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<p>Explanation of any answers and additional evidence: The practice used best practice guidance from both the local Clinical Commissioning Group (CCG) and the National Institute for Clinical Excellence (NICE).</p> <p>The practice planned to have an e consult process in place during November 2019 and had completed all digital and information security protocols as part of their preparation.</p>	

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>	0.20	0.95	0.75	Significant Variation (positive)

## 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</li> </ul>

plans and 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.
- The practice offer people with particular accessibility needs a supported choice to meet their communication needs, for example people with hearing impairment were offered a text service.

## 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.
- 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>	84.8%	78.8%	78.8%	No statistical variation
Exception rate (number of exceptions).	9.7% (41)	13.6%	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>	83.4%	80.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.7% (37)	10.6%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.7%	80.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	18.0% (76)	16.5%	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>	86.7%	75.2%	76.0%	Variation (positive)
Exception rate (number of exceptions).	23.4% (101)	14.1%	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>	100.0%	94.0%	89.7%	Significant Variation (positive)
Exception rate (number of exceptions).	2.8% (3)	16.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.3%	82.3%	82.6%	No statistical variation
Exception rate (number of exceptions).	9.6% (116)	5.2%	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)	92.8%	89.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.8% (10)	4.6%	6.7%	N/A

#### Any additional evidence or comments

The practice had carried out a full investigation into their high exception reporting and had raised the event as an internal significant event. The practice found that the previous lead for the long-term conditions that had high exception rates had been excepting patients too early, and that patients had received assessments after they had been excepted. The practice had changed both the lead clinician and the process to ensure that patients were not excepted before they had received a review.

### Families, children and young people

### Population group rating: Good

#### Findings

- The practice had met the minimum 90% target for four of four childhood immunisation uptake indicators. The practice had not met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators. However, the margin the practice missed the WHO target by was less than 0.5% and the practice had taken every opportunity to inform and encourage parents to bring children to the practice for immunisations.
- 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.
- 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)	63	64	98.4%	Met 95% WHO based target
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)	55	58	94.8%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	55	58	94.8%	Met 90% minimum
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)	55	58	94.8%	Met 90% minimum

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 not met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators. However, the margin the practice missed the WHO target by was less than 0.5% and the practice had taken every opportunity to inform and encourage parents to bring children to the practice for 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.
- 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)	77.9%	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) (PHE)	79.5%	74.1%	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) (PHE)	62.9%	60.8%	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) (PHE)	81.0%	72.9%	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) (PHE)	57.4%	58.0%	51.9%	No statistical variation

#### Any additional evidence or comments

The practice was aware of being slightly under target for cervical screening and had taken an opportunistic approach to encourage eligible women to attend for 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 considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

**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) (QOF)	94.4%	93.9%	89.5%	No statistical variation
Exception rate (number of exceptions).	43.8% (14)	30.0%	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)	96.0%	92.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	21.9% (7)	23.9%	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)	96.8%	78.0%	83.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	18.4% (7)	6.9%	6.6%	N/A

#### Any additional evidence or comments

The practice had carried out a full investigation into their high exception reporting and had raised the event as an internal significant event. The practice found that the previous lead for the long-term conditions that had high exception rates had been excepting patients too early, and that patients had received assessments after they had been excepted. The practice had changed both the lead clinician and the process to ensure that patients were not excepted before they had received a review.

#### 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)	542.3	547.5	537.5
Overall QOF score (as a percentage of maximum)	97.0%	97.9%	96.2%
Overall QOF exception reporting (all domains)	5.3%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive 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

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

The practice had carried out a wide range of audits for both clinical and non-clinical activity. For example, the practice had conducted an audit on a medicine to support diabetic patients with type II diabetes. The practice had 113 eligible patients of whom 15 were already on the medicine the practice would encourage all eligible patients to take. All eligible patients were written to and the proposed changes to their medicine explained. At a follow up audit two months later there were 111 eligible patients and 102 (91%) of them were then taking the required medicine. A follow up audit conducted one month later showed that the 91% of patients on the preferred medicine had remained on it.

The practice had conducted an audit on patients being treated for gout. At the first audit in January 2019 the practice found that 17% of patients on the required medication had received an appropriate blood test to support their treatment. Patients who had not received a blood test were encouraged to attend for one and at the second audit four months later 43% of patients had received the appropriate blood test. The practice planned to re-audit every three months until they had blood results for all patients on the gout treatment medicine. The blood test would then become part of every patients' annual review.

#### **Any additional evidence or comments**

At our inspection in January 2019 the practice did not have a forward audit plan. However, at our inspection in October 2019 the practice had a forward audit plan, and a clear process for audit and re-audit for practice wide topics and that the learning was shared widely through appropriate clinical and staff meetings.

## 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.	N/A
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence: The practice had clearly identified training they considered mandatory for staff and this was on a dedicated list as an aide memoir in staff accessible areas of the practice. We saw that a spreadsheet was maintained for staff training which identified that all staff were up to date with all mandatory training.</p> <p>The practice had an annual cycle for appraisals and planned to change this during the next year to make it more manageable and include key staff with lead roles at the practice.</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)	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	Yes

services.	
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other 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, which included mental health campaigns.	Yes

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>	96.0%	94.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (6)	0.5%	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
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: Although the practice had ceased offering minor surgery they carried out joint injections and immunisations. The practice had updated and reviewed its consent policy to take account of best practice guidelines in these areas.	

## Well-led

## Rating: Good

### Leadership capacity and capability

At our inspection in January 2019 the practice was found in breach of Regulation 17 Good Governance; specifically, there was no oversight of all safety alerts and action taken in response to these. Appropriate action had not been taken in response to the safety alert on blank plug sockets, which required these to be removed. Appropriate action had not been taken in response to the safety alert on blind stops.

There were limited systems and processes that enabled the registered person to evaluate and improve their practice in respect of processing of information obtained throughout the governance process. In particular: there was no suitable mechanism to ensure that all clinical staff were involved in practice meetings or able to give or receive feedback for the purposes of continually evaluating and improving services. The practice did not share the learning from significant event and complaint reviews with the whole staff team. There was limited evidence of a comprehensive programme of quality improvement. The practice had not ensured the competence of staff employed in advanced roles by audit of their clinical decision making.

At our inspection in October 2019 we found that the practice had met all of the requirements within the requirement notice and had removed all blank plug sockets. They had removed blind cords from all clinical rooms and replaced these with poles. The practice had a clear plan to remove all blind cords from all rooms within the practice over the year.

The practice had set up clinical meetings on a monthly basis and ensured that the meeting changed day to facilitate the attendance of part time staff. Minutes were available in both hard copy and on the shared drive at the practice. Minutes were also e-mailed to staff.

At this inspection we found that significant events and complaints were thoroughly investigated and learning from both types of event shared widely through both clinical and staff meetings.

At this inspection we found that the practice had set up a planned programme of quality improvement which included a forward audit plan.

We saw that the practice had included staff in formal reviews of their advanced roles with supervision and audit of their clinical decision making.

### 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: The practice had revised their succession plan and had adjusted their skill mix to meet the challenges they had at the time of inspection.	

## 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
Explanation of any answers and additional evidence: The practice had sought support from the local supporting change in general practice team and had a new vision and strategy under development. Staff were included in the changes and an away day was planned for later in the year to finalise these plans.	

## 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: We saw that the practice staff had used the internal whistleblowing procedures and that the practice had addressed the concerns raised appropriately. The practice had support from another practice in their Primary Care Network (PCN) on a reciprocal basis to ensure that staff could speak out safely if they needed to.	

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

Source	Feedback
Staff	Staff we spoke with told us that they felt listened to and supported by the practice leadership team. Staff told us that they could raise issues with the leadership team safely.

## 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
Explanation of any answers and additional evidence: The practice had identified and clarified key lead roles within the practice. Staff were clear about these changes and knew who to go to for advice and	

support.

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic 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

### 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

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	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

Feedback from Patient Participation Group.

Feedback
Unfortunately, members of the PPG were not available at the time of this inspection. However, we had spoken with members of the PPG at our inspection in January 2019; and they were positive about their relationship with the practice.

Any additional evidence
We spoke with four patients who were at the practice on the day of inspection and they commented that they could get appointments, were offered online access but most had chosen not to use it. All of the patients we spoke with told us that they found the care at the practice good or very good.

## 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: The practice had reviewed its governance processes and updated these which enabled them to learn and 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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