

# Care Quality Commission

## Inspection Evidence Table

### Dr A Cashyap and Partners (1-542420697)

Inspection date: 23 October 2019

Date of data download: 25 October 2019

## Overall rating: Good

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

## Safe

## Rating: Requires improvement

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

- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.
- The system for acting on safety alerts was insufficient.

### Safety systems and processes

**In most areas, 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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Partial
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social	Y

Safeguarding	Y/N/Partial
workers to support and protect adults and children at risk of significant harm.	
<p>Explanation of any answers and additional evidence:</p> <p>All the staff we spoke with demonstrated they understood the relevant safeguarding processes and their responsibilities. Staff had completed adult and child safeguarding training to the appropriate level before the intercollegiate guidance on safeguarding competencies was published in August 2018 (adult safeguarding) and January 2019 (child safeguarding). (Intercollegiate guidance is any document published by or on behalf of the various participating professional membership bodies for healthcare staff including GPs and nurses). Following publication of the guidance, GPs, nurses and non-clinical staff at the practice were required to complete higher levels of safeguarding training.</p> <p>During our inspection, we found there was no documented process or written policy in place on how staff responded when child patients at the practice were not taken to scheduled secondary care appointments by their parents or guardians. These are referred to as 'was not brought' children. ('Was not brought' is a term used to refer to children who were not taken to clinic appointments. As children, it is not their responsibility to attend an appointment, but a parental responsibility to take them). Despite this, we found that staff at the practice were mostly consistent in their response to such patients and acted on any identified concerns. The practice took immediate action and following our inspection, they provided us with evidence that a new policy and protocol was in place. Although not yet a comprehensive policy, it provided basic details of how the practice identified and responded to instances of 'was not brought' children and how any risks to children were clinically assessed.</p> <p>We found there was no formal, established method for the practice to communicate with the Out of Hours service and inform them of any relevant safeguarding information. Despite this, the practice had a system in place to identify regular users of the Out of Hours service and take the appropriate action when required to ensure there were no risks to patients. The practice took immediate action and following our inspection, they provided us with evidence that a new policy and protocol was in place. This detailed how the practice communicated and shared important patient information with the Out of Hours service, including safeguarding concerns. The policy also detailed how patient information received from any Out of Hours or urgent care service was managed, recorded and responded to by the practice to ensure the appropriate action was taken as necessary.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection, the practice demonstrated that all but four direct patient contact staff (GPs, nursing staff and receptionists) had either received the required vaccinations for their roles, provided a positive antibody test, or provided evidence of a history of infection where this was permissible. For two non-clinical staff members there were no appropriate records of their tetanus/polio/diphtheria status and for a further two non-clinical staff, this was the case for their diphtheria status. The practice took immediate action and following our inspection, they provided us with evidence that demonstrated those staff had received the required vaccinations.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: July 2019.	Y
There was a record of equipment calibration. Date of last calibration: August 2019 for most equipment.	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: October 2019.	Y
There was a log of fire drills. Date of last drill: June 2019.	Y
There was a record of fire alarm checks. Date of last check: Weekly test records were completed throughout 2019 and there was an alarm service and inspection in May 2019.	Y
There was a record of fire training for staff. Date of last training: Between May and October 2019.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: October 2018.	Y
Actions from fire risk assessment were identified and completed.	Y

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: October 2019.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2019.	Y
<p>Explanation of any answers and additional evidence:</p> <p>A Legionella risk assessment was completed in October 2015. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). In adherence with the assessment's recommendations, the practice completed regular water temperature checks. These showed hot water temperatures at the practice were regularly below the required levels and no action had been taken to investigate or rectify this.</p>	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: September 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: We saw the practice was visibly clean and tidy. There were appropriate processes in place for the management of sharps (needles) and clinical waste. Hand wash facilities, including hand sanitiser were available throughout the practice. Regular and comprehensive infection control audits were completed. Staff had completed infection control training and the staff we spoke with were knowledgeable about infection control processes relevant to their roles.	

## 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: During our inspection, we saw that built-in emergency buttons were available on the phones and a panic alarm system was installed in clinical rooms throughout the practice. The staff we spoke with said temporary staff, including agency nurses and temporary locum GPs were	

rarely, if ever used at the practice, although a suitable induction process was in place for these staff if required.

We saw that all staff had access to a level of sepsis training appropriate to their roles. We found that one of the nurses had received external training on sepsis and had cascaded the learning to other staff during a protected learning session. The staff we spoke with demonstrated a good understanding of the condition and their role in identifying patients with presumed sepsis and ensuring their urgent clinical review.

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.76	0.83	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)	11.3%	9.5%	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)	5.71	5.89	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)	1.93	1.60	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.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines	Y

Medicines management	Y/N/Partial
including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a system in place to monitor the use of blank prescription forms, which were not always securely stored. Prescription stationery was logged on arrival at the practice and securely stored before being allocated to individual clinicians. This process was also documented. We saw that once allocated, blank prescription stationery was left unsecured in printers when the clinical rooms were unoccupied, including overnight. The practice took immediate action and following our inspection they ordered locks for all 18 printers that may store blank prescription stationery.</p> <p>During our inspection, we found there was no adhered to process in place for the monitoring of uncollected patient prescriptions. Patients who did not collect their prescriptions were not routinely contacted and there was no subsequent clinical review of those patients. The practice took immediate action and following our inspection they provided evidence that demonstrated they had removed and clinically reviewed all uncollected prescriptions more than three months old. No patients were deemed to be at risk or needed contacting. A new process was implemented for the monthly review of uncollected prescriptions by a GP who would authorise their cancellation and record this. Patients would be contacted based on any identified risk to them from not collecting their prescriptions.</p> <p>We found there was no process in place for the practice to monitor and record the collection of patient prescriptions for controlled drugs. Consequently, the system for monitoring the compliance of patients taking these medicines was not comprehensive. The practice took immediate action and following our inspection they provided evidence that demonstrated a new process had been implemented. This included the clear identification of prescriptions for controlled drugs and a register to record the details of when they're collected and who by.</p>	

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

**The practice learned and made improvements when things went wrong. The system for acting on safety alerts was insufficient.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	16
Number of events that required action:	16
Explanation of any answers and additional evidence: There was an effective system in place for reporting and recording incidents and significant events. The staff we spoke with were clear on the reporting process used at the practice and we found that lessons learnt were shared to make sure action was taken to improve safety in the practice.	

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

Event	Specific action taken
An empty sample bottle was sent to the laboratory for testing and a negative result was returned.	Staff identified that a negative result was returned on an empty sample and notified the laboratory. The patient was retested. Staff were reminded to check samples are complete before sending them for testing.
A GP prescribed a patient their medicine at a higher dose than requested on the secondary care letter.	The patient was informed of the error and the prescription was updated with the correct dose. Staff were reminded to double check the secondary care letters and call the patient to discuss the issue if there's any doubt about the request.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: We saw a partial process was in place and adhered to for the receipt of safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The process included the logging of all alerts and their distribution to relevant staff at the practice. We found there was no adhered to process for documenting that relevant staff received the alerts and understood any actions required from them. There was no process for the monitoring and review of actions taken in response to the alerts and they were not routinely discussed at clinical meetings. There was no process for flags or alerts to be routinely entered on patients' records when they may be affected by the requirements of a recent safety alert.	



We looked at the practice's response to five safety alerts and saw evidence that appropriate actions were taken in response to three of those alerts. This included one regarding sodium valproate (a medicine primarily used in the treatment of epilepsy). For two of the alerts, the appropriate action was not taken. We saw that for one type of antidepressant medicine, six patients were prescribed above the maximum dose required by the relevant alert. For a cholesterol lowering statin medicine co-administered with a medicine used to treat high blood pressure, there were 10 patients prescribed above the maximum dose required by the relevant safety alert.

The practice took immediate action and following our inspection they provided evidence that demonstrated all the patients affected by the two safety alerts were written to and invited for an appointment. Their repeat prescriptions were amended to the appropriate dosage and alerts were placed on their records to notify staff of prescribing requirements. A new safety alerts policy was implemented which required some alerts to be received directly by GPs and others to be routinely discussed at clinical meetings on a quarterly basis. The policy included a requirement for the practice to complete safety searches every six months to ensure all patients affected by the requirements of safety alerts were identified and appropriate action was taken.

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: The practice assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. The practice had systems in place to keep all clinical staff up-to-date. Staff had access to National Institute for Health and Care Excellence (NICE) best practice guidelines and templates based on best practice guidelines. They used this information to deliver care and treatment that met patients' needs.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.36	0.59	0.75	Tending towards 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.</li> <li>As part of a local initiative, the practice was aligned to one care home and one trainee GP at the practice visited the home on a weekly basis to provide continuity of care and ensure residents'</li> </ul>

health needs were met. The trainee GP had access to support from a practice-based GP partner during each visit.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Older people had access to targeted immunisations such as the flu vaccination. The practice had 2,144 eligible patients aged over 65 years. Of those, 1,646 (77%) had received the flu vaccination at the practice in the 2018/2019 year.
- Staff could recognise the signs of abuse in older patients and knew how to escalate any concerns.

## People with long-term conditions

## Population group rating: Good

### Findings

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

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	83.8%	78.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.1% (41)	15.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	83.9%	76.6%	77.7%	No statistical variation
Exception rate (number of exceptions).	10.6% (39)	10.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	85.1%	79.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	12.5% (46)	13.2%	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>	76.1%	75.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.1% (20)	5.7%	7.6%	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>	90.1%	90.1%	89.7%	No statistical variation
Exception rate (number of exceptions).	22.0% (20)	9.1%	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) <small>(QOF)</small>	83.3%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.7% (22)	3.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>	87.6%	91.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.8% (7)	5.9%	6.7%	N/A

### Any additional evidence or comments

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

We discussed any areas of above averages exception reporting for the 2017/2018 year with senior clinical staff during our inspection. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This related to some individual categories for chronic obstructive pulmonary disease (COPD), cancer, depression and cardiovascular disease. The practice's current unverified data showed exception reporting for 2018/2019 was lower than in 2017/2018 and we found that in the cases we looked at exception reporting was clinically appropriate.

We found the practice's lower than local and national averages prescribing of hypnotics demonstrated good medical practise and adherence to national guidelines.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice met the minimum 90% target for all four childhood immunisation uptake indicators. The practice contacted the parents or guardians of children due to have childhood immunisations.
- A range of contraceptive and family planning services were available.
- There were eight-week post-natal and child health checks. Baby vaccination clinics were available at the practice.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	71	77	92.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	107	118	90.7%	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)	109	118	92.4%	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)	108	118	91.5%	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>

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

Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.</li> <li>Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had 4,627 patients eligible to receive an NHS health check. Of those, 413 had received a health check in the past 12 months.</li> <li>Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.</li> </ul>

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)	74.8%	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)	81.2%	69.9%	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)	66.6%	55.3%	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)	61.0%	75.6%	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)	64.6%	51.6%	51.9%	No statistical variation

Any additional evidence or comments
<p>There was evidence to suggest the practice encouraged its relevant patients to engage with nationally run and managed screening programmes.</p> <p>Public Health England data for the year April 2017 to March 2018 showed the practice was below the national 80% target for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period. We looked at the practice's own unverified data. This showed that at the time of our inspection, 80% (2,256) of eligible patients were screened adequately within a specified period.</p> <p>We spoke with practice staff about their efforts to achieve 80% attainment (the threshold set for the National Health Service Cervical Screening Programme to be effective). We found the practice operated a comprehensive reminder system for patients who did not attend for their cervical screening test. They demonstrated how they encouraged uptake of the screening programme, for example, by ensuring a female sample taker was available.</p>

**People whose circumstances make them vulnerable**

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>The practice held a register of patients living in vulnerable circumstances including those with a learning disability.</li> <li>End of life care was delivered in a coordinated way which considered the needs of those whose</li> </ul>

circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- GPs had completed training in mental capacity and Deprivation of Liberty Safeguards (DoLS). All the clinical staff we spoke with displayed a good understanding of the requirements in relation to mental capacity legislation.



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>	93.1%	90.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	12.1% (4)	7.8%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	93.5%	89.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.1% (2)	6.8%	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>	98.3%	84.9%	83.0%	Variation (positive)
Exception rate (number of exceptions).	6.5% (4)	4.6%	6.6%	N/A

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	555.2	539.9	537.5
Overall QOF score (as a percentage of maximum)	99.3%	96.6%	96.2%
Overall QOF exception reporting (all domains)	5.3%	5.2%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

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

The practice completed an audit to check patients prescribed direct oral anticoagulants (DOACs are used to help prevent stroke in patients with atrial fibrillation) had the appropriate monitoring checks completed at the recommended timescales in line with local guidelines. The initial audit showed the practice was not meeting the 90% target in the two categories where patients should have up to date monitoring. The practice took action and updated the relevant clinical staff to ensure improvement in these areas. At the time of the second (repeat) audit, the practice met the 90% target in one category and improved the result in the second category. The practice identified actions to further improve the results.

An audit was completed to ensure patients with type-one diabetes and meeting set criteria, were prescribed a cholesterol lowering medicine to assist in the prevention of cardiovascular disease in these patients. The initial audit showed the practice was not meeting the required target for those patients meeting the criteria prescribed the medicine or being prescribed a clinically effective dose. The practice took action and by the second (repeat) audit had increased the number of relevant patients prescribed the medicine and those on a clinically effective dose. Further work was planned to ensure guidelines were fully met.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included role-specific training and updating for relevant staff, the use of an e-learning facility and protected learning sessions including Clinical Commissioning Group target days.</p> <p>At the time of our inspection, all but six staff (all non-clinical) had received an appraisal in the last 12 months. All these staff were scheduled to receive an appraisal in October or November 2019.</p> <p>The healthcare assistant (HCA) at the practice was employed before April 2015 and as such their induction didn't include completion of the Care Certificate. We saw they completed HCA training in June 2018 and other role-specific training including smoking cessation and spirometry.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings to discuss the needs of complex patients, including those with end of life care needs, took place monthly. These patients' care plans were routinely reviewed and updated.	

## Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.4%	94.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.7% (16)	0.6%	0.8%	N/A

## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: We saw the process for seeking consent was well adhered to and examples of documented informed patient consent for recent procedures completed at the practice were available.	

## Well-led

Rating: Good

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At the time of our inspection, the provider partnership was stable and staff turnaround was minimal. There were no planned changes to the partnership, so no succession planning was necessary. During our inspection, staff we spoke with understood the challenges faced by the practice and demonstrated how they responded to them. In response to increased patient demand, the practice introduced a workflow management system in April 2019. This included a team of staff in dedicated roles managing the workflow of incoming documentation and correspondence to reduce the administrative tasks of the GPs and allow more of their time to be focused on their clinical roles. In response to increased demands on primary care, the practice had joined a recently created Primary Care Network (PCN) and was embracing new ways of working as part of this wider network, including employing clinical pharmacists through the PCN. Many of the services provided through the PCN were accommodated at the practice.	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice leadership had recently discussed and developed a draft five-year written strategic plan. This included areas of focus and development around the effective use of resources and technology in the delivery of services. A weekly practice/partners meeting was used to monitor the strategic direction of the practice throughout the year, including any evolving needs or areas of focus. Some of the main areas of strategic focus for the practice throughout 2019 were managing the increasing demands on the practice and the significance of Primary Care Networks (PCNs) in how GP practices operate moving forwards.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection, we found the practice did not have access to a Freedom to Speak Up Guardian and staff were not aware of any local initiatives. Senior staff we spoke with told us they'd investigate this provision following our inspection.</p> <p>At the time of our inspection, some staff had completed equality and diversity training. Most staff were yet to complete the training.</p>	

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

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

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This was demonstrated by such things as the availability of and adherence to most practice specific policies. There was a clear protocol in place for how decisions were agreed and a regular schedule of meetings at the practice for individual staff groups, multi-disciplinary teams and all staff to attend supported this.</p> <p>There were named members of staff in lead roles. There were nominated GP leads for safeguarding, medicines management/prescribing, information governance and patients with learning disabilities, dementia and end of life care needs among others. There were also nurse-led clinics for minor illness and patients with diabetes. We saw there was a clear staffing structure and found that staff understood their roles and responsibilities and those of others.</p>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>Where we identified any concerns during our inspection, the practice took action to respond or plans of action were developed to ensure any issues were resolved. For example, those in relation to staff vaccinations, how the practice managed and responded to safety alerts and uncollected patient prescriptions, the absence of a written policy on was not brought children and an established method of communication with the Out of Hours service about safeguarding concerns, among others.</p>	



## Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

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

If the practice offered online services:

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

## Engagement with patients, the public, staff and external partners

### The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The staff we spoke with said they were encouraged to actively participate in practice life and share their views. An open culture among staff and management supported this.</p> <p>We saw there were various methods available for patients to express their views and leave feedback about their experiences including a suggestions box, an online comments facility and an active Patient Participation Group. We saw the practice reviewed and responded to any suggestions made, including making changes to improve services and the patient experience.</p> <p>The Patient Participation Group (PPG), also known as Friends of Davenport House, met monthly and held their own annual general meeting (AGM). Representatives of the PPG attended the practice meeting once each year and the practice manager and PPG chairperson met regularly. In 2018, the PPG successfully achieved charitable status and its membership was approximately 25% of the practice's patient list size. All new patient registrations were automatically enrolled in the group. We saw there was information about the PPG in the waiting areas and the practice's website promoted the PPG and its work and encouraged patients to participate. The PPG produced and electronically distributed a monthly newsletter to up to 6,000 patients and held quarterly patient information events. Patients from the three practices in the local Primary Care Network were able to attend these.</p> <p>The practice had an effective system in place for handling complaints and concerns. Information was available to help patients understand the complaints system. The complaints procedure was displayed in the waiting areas and information detailing the complaints process was available from reception. The full complaints procedure was available on the practice's website. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care or patient experience.</p>	

## Continuous improvement and innovation

### There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>The practice was a GP training practice and maintained high standards for supporting its trainees. Two of the GPs were qualified GP trainers.</p> <p>The practice was in the early stages of participating in a Primary Care Network (PCN). (A Primary Care Network is a group of practices working together to provide more coordinated and integrated healthcare to patients). As part of this, the participating practices were identifying areas of focus to assist in improving and diversifying the delivery of patient care.</p> <p>At the time of our inspection, the practice was in the final phase of a process to sub-let part of their premises to an independent group of pharmacies. Although separately owned and managed, this would become an in-house pharmacy service for the practice's patients. Work to alter the premises was planned for December 2019 with an estimated opening of the pharmacy service in January 2020.</p> <p>Throughout 2018 and 2019 the practice was proactive in engaging with and delivering local pilot projects. This included a six-month polypharmacy review of vulnerable patients on 10 or more medicines. Due to its success this was being introduced across the locality. A separate 18-month tele dermatology pilot enabled high-quality medical photographs of skin lesions to be sent electronically with patients' referral letters to secondary care for specialist advice or the need for further review to be quickly identified.</p> <p>The practice hosted an in-house vasectomy clinic on behalf of the locality. This service was provided by the Herts Vasectomy Service every other Thursday with plans to move to a weekly service from November 2019.</p> <p>The practice was Research Ready (A Royal College of GPs quality assurance programme for all research-active UK GP practices) and studies completed at the practice included those on the long-term use of antidepressants and the possible genetic links relating to anxiety and depression.</p>	

### 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)	$\leq -3$
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.