

# Care Quality Commission

## Inspection Evidence Table

### Dr V C Tiguti & Partners (1-580430186)

Inspection date: 18 December 2019

Date of data download: 13 December 2019

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

### Safe

### Rating: Requires improvement

We rated the practice as requires improvement in safe because:

- Used sharp's boxes had not been collected within three months after first use, even if not full.
- When the manufacture's maximum temperature range had been exceeded in fridges used to store vaccines, the practice had not followed the processes detailed in their cold chain policy to ensure that vaccines were safe to administer.
- A risk assessment had not been completed to mitigate potential risks for the storage of prescription stationery in a printer at the branch practice.
- When changes were made to procedures as a result of a significant event, the standard operating procedure for dispensing of medicines had not been updated.

### 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.	Partial
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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was able to describe to us how proxy on-line registrations, accessible to parents, supported the safe registration of patients under 11 years old. Following our inspection, the practice forwarded their online policy to us.</li> <li>The practice held regular meetings with community midwives and the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to protect vulnerable adults and children at risk of harm. Changes in the management of the local health visiting service meant that regular face to face meetings between health visitors and the practice no longer took place. The practice called health visitors and school nurses when they needed to discuss a concern, for example when children frequently failed to attend childhood immunisations.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We reviewed the records of four members of staff employed by the practice. We found that recruitment checks had been carried out in line with legal requirements.</li> <li>There were systems in place to immunise staff in line with PHE guidance. We saw that three members of staff had failed to acquire immunity to hepatitis B following immunisation and five members of staff were in the process of receiving immunisations for hepatitis B. There was general guidance advising staff on measures to take to mitigate potential risks to themselves and patients.</li> </ul>	

<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: 12 July 2019 at both the main and branch practices.	Yes
There was a record of equipment calibration. Date of last calibration: 19 July 2019 at both the main and branch practices.	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial

There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: Main practice: 10 April 2019 Branch practice: January 2019	Yes
There was a log of fire drills. Date of last drill: Main practice: 30 October 2019 Branch practice: 24 October 2019	Yes
There was a record of fire alarm checks. Date of last check: Main practice: 11 December 2019 Branch practice: 18 December 2019	Yes
There was a record of fire training for staff. Date of last training: Various dates	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: Main practice: 30 April 2019 Branch Practice: 17 January 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We saw there was a mercury blood pressure machine at the main practice. A risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed. Following our inspection, the practice forwarded to us evidence that the blood pressure machine had been removed from the practice by an appropriate service.</li> </ul>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Yes
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Examples of risk assessments completed at the main practice:	
Premises risk assessment:	25 October 2019
Five-year electrical testing of fixed wires:	30 June 2016
Gas boiler service:	6 December 2019
Legionella risk assessment:	18 September 2019
Emergency lighting inspection:	14 September 2018
Examples of risk assessments completed at the branch practice:	

Gas boiler certificate:	valid until April 2020
Legionella risk assessment:	1 November 2017
Asbestos survey:	12 November 2015
Five-year electrical testing of fixed wires:	valid until 17 January 2020

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were not fully 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: Main practice: 24 July 2019 97% compliance Branch practice: 30 August 2017 95% compliance	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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw evidence that clinical waste was disposed of by an appropriate company. However, we found two sharps' containers were undated and one sharp's container was dated 12 April 2019. This meant that systems for ensuring collection of sharp's boxes within three months after first use, even if not full, were not operating effectively.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<ul style="list-style-type: none"> <li>A protocol was in place to support clinicians and reception staff in the identification and management of patients with possible sepsis.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<ul style="list-style-type: none"> <li>• We found there was detailed summarizations of patients' notes.</li> <li>• Systems were in place to ensure that test results were reviewed and acted on the day they were received.</li> </ul>	

## Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation however, they were not always effective.

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) (01/10/2018 to 30/09/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.92	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). (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	7.8%	8.7%	8.5%	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 (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	5.51	5.22	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	1.91	2.18	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.	Partial
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.	Not applicable
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 patients' 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.	Partial
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.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection, we made a best practice recommendation that the practice introduced a system to ensure use of prescription stationery within the practice was tracked in line with national guidance. At this inspection we found that an appropriate system was in place at the branch practice but not at the main practice. Before the end of our inspection we saw that the system had been amended and met national guidance.</li> <li>We found that locks had been fitted to printers that contained prescription stationery to ensure they were stored securely. However, prescriptions were left overnight in a printer at the branch practice. The printer was not fitted with a lock or the prescriptions were not removed and stored securely when cleaning staff attended the practice in the evenings. A risk assessment to mitigate potential risks had not been completed.</li> <li>A policy was in place regarding the required blood test monitoring for high risk medications. However, it was not always adhered to. We reviewed the records of three patients prescribed a high-risk medicine used for the treatment of rheumatoid arthritis. Clear systems were not in place to ensure the safe monitoring and the valid use of an essential shared care agreement (ESCA). We found similar issues for patients prescribed a medicine for the treatment of bipolar disorder where lithium levels with an up to date kidney and thyroid blood test were not available. Following our inspection, the practice forwarded to us evidence that the outstanding blood tests had been requested.</li> <li>Prescribing of antibiotics was comparable with local and national averages.</li> <li>Systems were in place to monitor and limit prescribing of medicines that had the potential to be misused.</li> </ul>	



**Medicines management****Y/N/Partial**

- The practice did not have the suggested emergency medicine used in the treatment of croup in children. Following our inspection, the practice forwarded to us a risk assessment to mitigate potential risks.
- We reviewed the temperature logs for fridges used to store medicines and vaccines. We found that the manufacture's maximum temperature range had been exceeded in one fridge for four days and in another fridge for six random days over a six-month period. No action had been taken to quarantine the medicines or carry out an investigation as per their cold chain protocol. We informed the practice they needed to follow their cold chain policy to determine if patients had been placed at risk.

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.	Partial
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.	Partial
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.	Not applicable
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Not applicable
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.	No
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>• The standard operating procedure for accurately checking the dispensing of medicines did not include controlled medicines. Following our inspection, the practice forwarded to us an updated policy outlining the procedures to follow. When changes were made to procedures as a result of a significant event, the standard operating procedure had not been updated. For example, following a dispensing error, learning from a significant event analysis was that dispensing staff use colour coded baskets to place medicines in. This had not reflected in the standard operating procedure.</li> <li>• The temperature logs for the dispensary fridge used to store medicines and vaccines showed that the manufacturer's maximum temperature range had been exceeded for four days in April 2019. Action to ensure the safety of these medicines had not been carried out in line with their cold chain policy. Following our inspection, the practice contacted Public Health England for advice.</li> <li>• The practice did not have the facility to print large print labels.</li> </ul>	

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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	Seven
Number of events that required action:	One
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was evidence of learning from significant events. However, systems to enable staff to discuss the learning as a whole team were not in place and a system to review trends over time was not in place. Following our inspection, the practice forwarded to us a newly implemented system whereby they would collectively record and review significant events over time.</li> </ul>	

### Example of significant events recorded and actions by the practice.

Event	Specific action taken
The wrong medicine was dispensed to a patient for four weeks.	Learning from the event was that dispensing staff should use colour coded baskets to place medicines in for double checking. The practice manager now carries out weekly spot checks to monitor the dispensing of medicines.
A patient was sent information regarding another patient.	The practice collected the letter from the patient and contacted their data protection officer for advice. They completed an Independent Commission's Office (ICO) self-assessment form to determine the level of risk. Processes were updated for sending out letters to patients and shared with administrative staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <p>We saw examples of actions taken on recent alerts for example, prescribing of sodium valproate; the recall of specific batches of adrenaline. However, an overarching record of Medicines and Healthcare products Regulatory Agency (MHRA) alerts to track actions taken by the practice over time was not in place. Following our inspection, the practice forwarded to us a newly implemented system to monitor</p>	

and track MHRA alerts.

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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

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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.34	0.78	0.74	Tending towards variation (positive)

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up older patients discharged from hospital. It ensured that their care 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.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice nurses and a health care assistant worked as elderly care facilitators to support the needs of older patients.

- The practice provided an inhouse phlebotomy service for older patients.

## 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, such as the Integrated Local Care Team (ILCT), a team that included health and social 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. We saw examples of courses completed by practice nurses to support them in this role.
- 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.4%	81.3%	79.3%	Tending towards variation (positive)
Exception rate (number of exceptions).	21.6% (74)	14.5%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.5%	81.3%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.7% (16)	10.3%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on	80.8%	84.5%	81.3%	No statistical

the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>				variation
Exception rate (number of exceptions).	8.5% (29)	13.1%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	75.1%	77.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.6% (6)	10.4%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.1%	90.4%	89.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.5% (9)	11.6%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.5%	84.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.0% (38)	4.9%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.2%	91.1%	91.1%	No statistical variation
Exception rate (number of exceptions).	2.2% (4)	4.5%	5.9%	N/A

#### Any additional evidence or comments

The exception reporting rate for patients with diabetes, whose last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months, was 21.6%. This was above the local and national averages. We discussed this with one of the GP partners. They were not aware that the exception reporting was high. They told us that all patients that failed to attend for their health reviews were contacted three times to encourage them

to attend before they were exception reported.

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- The practice had met the minimum 90% target for all four childhood immunisation uptake indicators.
- All children were offered on the day appointments.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and liaised with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception. The practice offered insertion of coils and contraceptive implants.
- 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)	43	46	93.5%	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)	42	46	91.3%	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)	43	46	93.5%	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)	43	46	93.5%	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

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including new patient checks. 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.
- The practice offered evening and weekend appointments through the GP federation.

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). (31/03/2019 to 30/06/2019) (Public Health England)	80.8%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	77.7%	76.0%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	69.8%	62.5%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	65.8%	69.9%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	65.9%	58.9%	53.8%	No statistical variation

#### Any additional evidence or comments

- The practice had exceeded the 80% target for cervical cancer 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. We saw that 25 out of 33 patients with a learning disability had received a health assessment so far this year.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held regular meetings with the palliative care team and the ILCT.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- There was a system in place to identify vulnerable patients registered with the practice. A register of vulnerable patients was maintained. Nurses were allocated vulnerable patients from this list to monitor their care and treatment. This was reviewed by the practice manager monthly.
- Staff had completed 'Prevent' training to safeguard vulnerable people from being radicalised to support terrorism or become terrorists themselves.
- Vulnerable patients over 65 years old with more than three long-term conditions were offered 20-minute appointments.

- The practice demonstrated that they had a system to identify people who misused substances. Patients who misused substances were referred to a local service.

**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. The practice issued daily prescriptions, two days over the weekend, to mitigate potential risks.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice signposted patients with dementia to a neighbouring dementia friends club.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	89.6%	89.4%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	15.4%	12.3%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	91.6%	90.2%	Variation (positive)
Exception rate (number of exceptions).	4.0% (1)	11.4%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.7%	82.5%	83.6%	No statistical variation
Exception rate (number of exceptions).	5.0% (2)	9.4%	6.7%	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)	555.1	No Data	539.2
Overall QOF score (as a percentage of maximum)	99.3%	No Data	96.4%
Overall QOF exception reporting (all domains)	5.6%	No Data	No Data

	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 an audit of patients diagnosed with sepsis to ensure that the correct codes were added to their records. Twelve patients had been coded with a diagnosis of sepsis. The audit showed that five of these patients had been coded correctly, three patients had died as a result of sepsis and four patients had been incorrectly coded because sepsis had not been confirmed. Improvements made included removing the sepsis coding from the records of the four patients incorrectly coded and adding alerts to the records of patients with confirmed sepsis. Procedures were amended so that a code for sepsis was only added to patient records after hospital discharge letters had been received confirming the diagnosis.
- An audit had been carried out to explore the actions taken when children on the practice's safeguarding list failed to attend hospital or GP appointments, adherence to their policy of following up this group of patients and ensuring alerts were added to their records with 'what to do' actions. Fifteen children were on the safeguarding list. The audit showed that none of the children had missed a hospital or GP appointment however, one child had failed to attend for an immunisation. Ten of these patients did not have an alert on their records with 'what to do' actions. Changes made following the audit was to update records to include appropriate 'what to do' actions if a child failed to attend for their appointment.

## 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.	Not applicable
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We reviewed the records of one of the practice nurses and found that they had completed recent training in immunisations and cervical screening.</li> <li>Practice nurses attended quarterly clinical supervisions groups with practice nurses from neighbouring practices.</li> </ul>	

## 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 (01/04/2018 to 31/03/2019) (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, stop smoking campaigns, tackling obesity.	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.8%	96.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	1.2% (21)	1.2%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes



## Well-led

Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Leaders were aware of the challenges to delivering their service. For example, staffing of two practices and staff well-being, partnership succession planning and the development of two local housing estates increasing demand for their services.</li><li>• Succession planning was in place to replace a leaving GP partner.</li></ul>	

### Vision and strategy

**The practice did not have a clear vision however, a strategy to provide high quality sustainable care was in place.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
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.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The GP partners told us their vision and values were to provide good care and access. Staff we spoke with were not aware of the practice vision however, they told us they aimed to provide the best possible care and meet the needs of patients.</li><li>• A five-year business plan for 2019-2024 was in place. There were strategies in place to manage risks to the service for example, changes in the GP partnership, staff sickness and increased demand for their service.</li></ul>	

## 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

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

Source	Feedback
Interviews with staff members.	Staff we spoke with on the day of our inspection told us that there was an open, transparent and caring culture within the practice and that they felt supported by the management team to carry out their roles.

## 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: <ul style="list-style-type: none"> <li>Staff held lead roles within the practice. For example, safeguarding, dispensary, information governance and nurse led QOF leads.</li> </ul>	

## Managing risks, issues and performance

### There were 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was evidence of completion of risk assessments in most areas. However, we found that a risk assessment had not been completed for the presence of mercury in the practice. Following our inspection, the practice forwarded to us evidence that the mercury had been safely removed from the practice.</li> <li>• Risks to the service were considered and monitored through the practice's five-year business plan.</li> <li>• A business continuity plan was in place to refer to in the event of a disruption to the service.</li> </ul>	

## 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
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We saw that there was learning and improvements made to the service following a breach of patient confidentiality.</li> <li>• All staff had completed General Data Protection Regulation training to protect patient personal and identifiable information.</li> </ul>	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Following our inspection, the practice forwarded to us a protocol for the registering of patients using their online services.</li></ul>	

## 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 (PPG).	Partial
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>A PPG had been active within the practice. However, due to increased staffing demands on the practice and patient illness within the PPG it was no longer as active as it had been. The practice manager told us that they planned to recruit new members soon.</li> <li>At our previous inspection we made a best practice recommendation to introduce regular staff meetings to support and involve staff. At this inspection we found that regular staff group meetings were held however, whole team practice meetings were not. The managers told us that this was a staff decision to hold staff group meetings within the practice.</li> </ul>	

## Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>Prior to our inspection we spoke with a member of the PPG. They told us that due to a shortage of staff within the practice the PPG had not met some quite some time. They told us that when they had meet that the practice manager attended the meetings and listened and acted on their suggestions. They told us that speakers were invited to the PPG meetings to help patients to understand current issues. For example, a speaker had attended a PPG meeting to discuss medicine optimisation and how to reduce medicine wastage. The PPG member told us that the PPG were listened to and that they felt valued.</li> </ul>

CQC comments cards	
Total comments cards received.	15
Number of CQC comments received which were positive about the service.	15
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Any additional evidence
Patients told us that staff were helpful, understanding, kind and professional. They told us that the practice provided an excellent service and that they felt listened to.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

### Examples of continuous learning and improvement

- The practice used audits to make improvements within the practice. For example, accurately coding patients with sepsis and following up children who failed to attend hospital and GP appointments.
- The health care support worker had developed an information pack to support carers of patients with dementia.
- The practice nurses had introduced health reviews for patients with chronic kidney disease.
- A system had been put in place to ensure that patients identified as vulnerable within the practice were actively followed up and reviewed by the practice nursing team.
- There was a system in place to learn from significant events and complaints. However, the practice had not completed an annual trend analysis review of these. Following our inspection, the practice forwarded to us a newly implemented system whereby they planned to collectively record and review these over time.

## 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.