

Care Quality Commission

Inspection Evidence Table

Suthergrey House Medical Centre (1-539513612)

Inspection date: 28 November 2019

Date of data download: 14 November 2019

Overall rating: Good

During this inspection we inspected the following key questions: Safe, Effective and Well-led domains.

- We rated the provider as good for providing safe and effective services.

We rated the population group people with long-term conditions in the effective domain as requires improvement because:

- Clinical outcomes for this population group were lower than expected compared to CCG and England averages.

We rated the provider as requires improvement for being Well-Led because:

- Overall QOF scores were lower than expected compared to the CCG and National averages. These were more evident in relation to the monitoring of people with long term conditions. While interventions made had shown improvements to clinical quality, the practice had not developed systems to continually monitor clinical data and staffing, so sustained improvements in line with CCG and England averages could be demonstrated.
- Overall exception reporting was lower than the CCG and England averages. The practice needed to implement systems to understand the impact of exception reporting (now replaced in 2019/20 with Personalised Care Adjustment (PCA)) on the overall QOF scores.
- The cervical cancer screening uptake was lower than expected compared to CCG and England averages.
- Some policy documents we saw needed a review and amendments.
- The practice had not developed systems to demonstrate the efficacy of measures implemented to try and improve patient satisfaction.

We found the following areas where the provider must improve:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We found the provider should:

- Complete the updating of the spreadsheet of safety alerts received and acted upon.
- Implement systems to understand the impact of exception reporting (now replaced in 2019/20 with Personalised Care Adjustment (PCA)) on the overall QOF scores.
- Act to achieve the 95% WHO based target for childhood immunisations.
- Act to achieve the cervical cancer screening 80% national programme coverage measure set by Public Health England.

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

Safe

Rating: Good

Safety systems and processes

The practice had 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.	Y
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.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
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 workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: The contacts listed in the safeguarding policy needed updating which the practice amended on the day of the inspection.	

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.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: The practice regularly used two locum GPs. On the day of our inspection details of infection control and fire safety training were not accessible for one of the locum GP. The practice sent records of training immediately after our inspection.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: October 2019	Y
There was a record of equipment calibration. Date of last calibration: 18 July 2019	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: January 2019	Y
There was a log of fire drills. Date of last drill: 16 June 2019	Y
There was a record of fire alarm checks. Date of last check: Weekly	Y
There was a record of fire training for staff. Date of last training: Various on a two-year cycle	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: June 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Most actions identified following the June 2019 fire risk assessment have been completed. The practice manager was progressing those that were outstanding.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: June 2019	Y
Explanation of any answers and additional evidence: The action plan following the June 2019 fire risk assessment was work in progress. We saw evidence of action being completed in accordance with the timelines stated.	

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: 19 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: The infection control policy did not include details of the designated infection control lead which the practice amended on the day of our inspection.	

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

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.83	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)	11.9%	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)	5.93	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)	0.99	1.60	2.08	Variation (positive)

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.	Y
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

Medicines management	Y/N/Partial
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 including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
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.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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>The practice did not stock defibrillation pads for use on children who are less than 8 years of age. Immediately after our inspection the practice confirmed that these had been purchased.</p>	

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.	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:	12
Number of events that required action:	2

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

Event	Specific action taken
Allergic reaction	Following a report of an allergic reaction due to antibiotic therapy, the practice had reinforced the prescribing protocol to all clinical staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Safety alerts received were reviewed during the weekly practice meetings. We reviewed two recent safety alerts and found that these had been acted upon as per the guidance. One concerned an alert related to a medicine used to treat elevated blood uric acid levels associated with health conditions such as gout. The other alert related to a potential syringe failure to treat an anaphylactic shock due to blockage of the needle. We found in both instances the practice had acted as given in the guidance.</p> <p>The practice was in the process of updating a spreadsheet of alerts received and acted upon.</p>	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.73	0.59	0.75	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their 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.
- Patients in care/residential homes that were discharged from inpatient hospital stay were offered a review of their clinical needs and medicines within 14 days of discharge.
- Older people were offered appropriate vaccinations such as flu, pneumovax and shingles.

People with long-term conditions

Population group rating: Requires improvement

- We rated the population group people with long-term conditions in the effective domain as requires improvement because:
Clinical outcomes for this population group were lower than expected compared to CCG and England averages.

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute illness.
- The practice shared 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.

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>	63.9%	79.6%	79.3%	Variation (negative)
Exception rate (number of exceptions).	2.9% (15)	13.0%	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>	52.9%	75.9%	78.1%	Significant Variation (negative)
Exception rate (number of exceptions).	5.6% (29)	10.3%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	75.6%	81.7%	81.3%	No statistical variation
Exception rate (number of exceptions).	9.0% (47)	11.8%	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>	71.4%	75.9%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.9% (16)	5.9%	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>	96.8%	91.3%	89.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	15.5% (23)	10.1%	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) (QOF)	74.2%	82.6%	83.0%	Variation (negative)
Exception rate (number of exceptions).	2.7% (37)	3.7%	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) (QOF)	88.0%	91.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	2.5% (4)	4.9%	5.9%	N/A

Any additional evidence or comments

We reviewed the lower than expected comparisons for monitoring patients with diabetes and patients with hypertension. The lead GP told us that during monitoring period in question, performance had been affected by a serious incident and other factors such as reduced GP and clinical staff availability due to absence. The practice had since recruited a dedicated diabetic nurse who was supported by a trained health care assistant. There had been increased liaison with the community diabetic team in managing diabetic patients.

In relation to coronary heart disease the practice now had a patient engagement programme to encourage lifestyle changes and compliance with monitoring.

We reviewed comparative data for the past two years and noted an increase in performance as follows:

Diabetes (IFCC-HbA1c is 64 mmol/mol or less):

31/03/2018 Practice 59.9% CCG 78.1% England 78.8%

31/03/2019 Practice 63.9% CCG 79.6% England 79.3%

Diabetes (last blood pressure reading is 140/80 mmHg or less):

31/03/2018 Practice 49.3% CCG 76.6% England 77.7%

31/03/2019 Practice 52.9% CCG 75.9% England 78.1%

Hypertension (the last blood pressure reading measured 150/90mmHg or less):

31/03/2018 Practice 64.9% CCG 82.7% England 82.6%

31/03/2019 Practice 74.2% CCG 82.6% England 83.0%

Additionally, our review during this inspection indicated that these improved performances were being maintained.

Families, children and young people

Population group rating: **Good**

Findings

- The practice has not met the minimum 90% target for 3 of four childhood immunisation uptake indicators.
- 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.
- 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)	98	115	85.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	104	112	92.9%	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)	105	112	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	102	112	91.1%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

Child Immunisation: We reviewed unverified monitoring data supplied by the practice for period ending 1 October 2019 and found that the practice had achieved the minimum 90% in all four indicators. The lead GP told us that they anticipated meeting the 95% WHO based target by the end of the financial year.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the practice.

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)	72.0%	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)	63.9%	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)	53.1%	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)	22.7%	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)	38.6%	51.6%	51.9%	No statistical variation

Any additional evidence or comments

The practice was aware of the lower than expected uptake rate for cervical cancer screening. The practice had reinforced their recall and reminder systems as well as opportunistically reminding patients during their attendance at the practice for other health matters.

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. The practice was a recent recipient of The Purple Star award which recognised the delivery of high quality reasonably adjusted services to adults with learning disabilities across Hertfordshire, in line with the requirements of the Equality Act 2010.
- 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 demonstrated that they had a system to identify people who misused substances. The practice worked collaboratively with the local services to provide support for those that needed help in managing their alcohol and substance misuse.
- The practice reviewed young patients at a local residential home.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services that included referrals to Improving access to psychological therapies (IAPT) services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	85.6%	93.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.5%	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>	80.8%	92.3%	90.2%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	6.6%	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>	85.0%	88.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.0% (6)	5.2%	6.7%	N/A

Monitoring care and treatment

The practice had a 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)	495.3	Not available	539.2
Overall QOF score (as a percentage of maximum)	88.6%	97.2%	96.4%
Overall QOF exception reporting (all domains)	3.4%	9.3%	10%

	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

- In August 2019, the practice reviewed young patients that were given antihistamines and nasal sprays for mild to moderate hay fever on prescription and had taken steps to switch their treatment to suitable alternatives as per the NHS England's guidance on conditions for which over the counter items should not be routinely prescribed. The practice advised they intended to re audit the effectiveness of the interventions in the months following our inspection.
- In April 2019 the practice undertook an audit of children with uncontrolled eczema that would benefit from a referral for food allergy testing. As a result, eight children were identified for referral to the paediatric allergy clinic. A re audit was scheduled for completion in a year's time.
- Following an annual prescribing audit, the practice had identified three key action points to improve prescribing efficiency in line with national and CCG guidelines.

Any additional evidence or comments

- We noted that the overall QOF scores were lower than expected compared to the CCG and national averages. These were more evident in relation to the monitoring of people with long term conditions. We also noted that the overall exception reporting (exception reporting allows practices to exclude eligible patients from monitoring based on valid criteria) was lower than the CCG and England averages. The lead GP indicated that it was practice policy not to exclude patients unless necessary. Considerations made as part of our inspection suggested that the practice may benefit from a review of exception reporting (now replaced in 2019/20 with Personalised Care Adjustment (PCA)) to understand its impact on the overall QOF scores.
- The lead GP told us that during monitoring period in question, performance had been affected by a serious incident and other factors such as reduced GP and clinical staff availability due to absence.

These had since been rectified and performance improved.

We reviewed comparative QOF data for the past two years and noted an increased performance as follows:

Indicator	Practice	CCG average	England average
2017/18, Overall QOF score (out of maximum 559)	347.3	539.9	537.5
2018/19, Overall QOF score (out of maximum 559)	495.3	Not available	539.2

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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

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)	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

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.2%	94.7%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (9)	0.8%	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

Well-led

Rating:

Requires Improvement

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

- Overall QOF scores were lower than expected compared to the CCG and National averages. These were more evident in relation to the monitoring of people with long term conditions. While interventions made had shown improvements to clinical quality, the practice needed to introduce systems to continually monitor clinical data and staffing so sustained improvements in line with CCG and England averages could be demonstrated.
- Overall exception reporting was lower than the CCG and England averages. The practice needed to implement systems to understand the impact of exception reporting (now replaced in 2019/20 with Personalised Care Adjustment (PCA)) on the overall QOF scores.
- The cervical cancer screening uptake was lower than expected compared to CCG and England averages
- Some policy documents we reviewed needed amendments.
- The practice had not developed systems to demonstrate the efficacy of measures implemented to try and improve patient satisfaction.

We found the following areas where the provider must improve:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	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: There was an open and inclusive leadership style and collaborative teamwork. We were advised by the lead GP that the practice had faced many challenges in the two years preceding our inspection. These included a serious incident, change of the practice manager, reduced reception staffing, changes to the secretarial team and reduced GP availability due to absence, all which had placed additional pressures on the practice team. Leaders spoke openly about these challenges and demonstrated a clear desire to provide high quality evidence-based care with appropriately qualified and trained staff. It is important to note the circumstances that led to lower than expected performance in relation to clinical outcomes as well as practice management. The practice had implemented several measures that included team building, staff recruitment and upskilling of staff. The lead GP told us that practice staffing has returned to full complement. During our inspection we noted that the impact of these changes was taking effect but formal arrangements to demonstrate improvement were needed.	

Vision and strategy

The practice had a vision and strategy to provide 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 aspired to deliver safe effective and responsive services in a timely manner. Staff we spoke with understood their individual role in delivering the practices vision and values.	

Culture

The practice had a culture which drove high quality sustainable.

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

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

Source	Feedback
Staff	Staff we spoke with told us that they were supported to carry out their roles. They were encouraged to develop, and they felt respected, supported and valued.

Governance arrangements

There were 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: <ul style="list-style-type: none"> • Staff accessed practice specific policies and procedures on the practice intranet system. • There were designated leads for specific governance areas. For example, the nurse was the infection control lead and a GP the safeguarding lead. • There were quality improvement activities to improve outcomes for patients. • There were regular practice meetings which facilitated effective communication of any changes to the practice team. There was a process to review and act on significant events were discussed, and complaints. 	

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.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
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: All staff received an annual appraisal of their work, which included a discussion about their training needs. The practice had a variety of risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control fire safety and legionella.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	P
Performance information was used to hold staff and management to account.	P
Our inspection indicated that information was accurate, valid, reliable and timely.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Overall QOF scores were lower than expected compared to the CCG and National averages. These were more evident in relation to the monitoring of people with long term conditions, and cervical cancer screening. While interventions made have shown improvements to clinical quality, the practice needed to introduce systems to continually monitor clinical data and staffing so sustained improvements in line with CCG and England averages could be demonstrated. • Overall exception reporting was lower than the CCG and England averages. The practice needed to implement systems to understand the impact of exception reporting (now replaced in 2019/20 with Personalised Care Adjustment (PCA)) on the overall QOF scores. • Some policy documents we reviewed needed a review and amendments. 	

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, but impact of interventions made was yet to be demonstrated.

	Y/N/Partial
Patient views were acted on to improve services and culture.	P
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

Explanation of any answers and additional evidence:

- During our inspection we spoke with ten patients. All were complementary of the services provided. Three reported that getting an appointment on the day could be difficult. However, they all said they could get forward appointments.
- During our inspection we received 26 comment cards. Patient's comments were positive about the care provided. We saw comments that staff and GPs were supportive, friendly caring, and patients said they were treated with respect. Three of the comment cards noted that sometimes it was hard to get an appointment on the day.

The 2019 National GP survey gave the following results:

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2019 to 31/03/2019)	36.4%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	43.0%	71.6%	67.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	41.3%	66.7%	64.7%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	54.5%	76.5%	73.6%	Tending towards variation (negative)

In response to the 2019 National GP survey the practice told us that they had made the following improvements:

- Made access to morning appointments by telephone available from 7.45am.
- Released online pre-bookable appointments up to two weeks in advance.
- Made available on the day telephone consultations.
- Increased on the day appointments by making available daily nurse practitioner minor illness clinics in addition to GP appointments.
- Improved access by providing early morning and evening appointments four days a week and weekend and late evening appointments through the extended access hub.
- Introduced a text reminder service to reduce the number of patients that do not attend
- Encouraged patients to use online services such as the appointments system, electronic prescription service.

However, at the time of our inspection the practice had had not developed systems to demonstrate the efficacy of measures implemented to improve patient satisfaction.

Feedback from Patient Participation Group.

Feedback

We spoke with one member of the Patient Participation Group (PPG). They told us that there were currently about six members. The member indicated that the practice services were appropriate, and GPs and the practice manager had listened to them and shared practice information with them. There had been recent discussions about involving the younger practice population in the PPG which they hoped will happen soon.

The practice told us that the PPG was engaged in work related with the appointment system, car parking, and the installation of security cameras.

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement

- Attendance at meetings with stakeholders as needed such as with the Local Medical Committee (LMC), GP forum, CCG to assess and improve the health needs of the population.
- Commissioned Target events (protected learning time) to facilitate staff learning and development.
- Engagement with the primary care network (PCN) with four other practices as part of the Central Watford PCN to collaboratively provide needs-based care for the population.
- Engagement with the local community team to care for frail patients at home with the intent of avoiding unplanned hospital admissions.
- Worked collaboratively with the community chronic obstructive pulmonary disease (COPD) nurses to provide targeted care for these patients at home.
- Achieved the purple star scheme for health services to help to people with learning disabilities.
- As part of the CCG enhanced community framework realignment project the practice was now responsible for patients living in one nursing home, one residential care home, and one home for

patients with learning difficulties.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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