

Care Quality Commission

Inspection Evidence Table

Bexley Medical Group (1-552705177)

Inspection date: 12 November 2019 and 27 November 2019

Date of data download: 04 November 2019

Overall rating: Good

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

Safe

Rating: Requires improvement

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

- The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However some health and safety systems did not operate effectively; particularly in relation to some aspects of fire safety, infection prevention and control, dealing with medical emergencies, and managing prescription stationery.
- The practice had partial arrangements in place to ensure staff vaccinations were completed in accordance with published guidance.
- Appropriate standards of cleanliness and hygiene were met but the service had not assessed risks associated with infection control at all their practice sites
- There were adequate systems to assess, monitor and manage risks to patient safety, but some arrangements for dealing with medical emergencies were in need of review.
- The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, the management of prescription stationery was in need of further review.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, some health and safety systems did not operate effectively.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes

Safeguarding	Y/N/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
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial ¹
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence:	
<p>1. We found that a staff immunisation policy was now in place to include Hepatitis B, Measles, Mumps and Rubella (MMR). The policy was completed August 2019, with a review date set as August 2024. The practice also had a policy to offer the annual influenza vaccine to all staff annually. They informed us that some staff had the flu vaccinations in the practice and others at their own GPs.</p> <p>We found that the practice's policy and arrangements in relation to staff vaccinations were in need of update, as they did not ensure everyone who had direct contact with patients, including reception staff, were up to date with their routine immunisations: tetanus, polio, diphtheria and MMR.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: King Harold's Way – 20/08/2019 Hurst Place Surgery – 15/08/2019 Erith Health Centre – 15/08/2019</p>	Yes
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: King Harold's Way – 22/08/2019 Hurst Place Surgery – 14/08/2019 Erith Health Centre – 22/08/2019</p>	Yes
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	Yes
<p>There was a fire procedure.</p>	Yes
<p>There was a record of fire extinguisher checks.</p> <p>King Harold's Way – 23/04/19 Hurst Place Surgery – 29/03/2019 At Erith Health Centre, we saw records of these checks maintained that indicated they were completed weekly by the facilities support officer.</p>	Yes
<p>There was a log of fire drills.</p> <p>Date of last drill: King Harold's Way – 10/08/2018 Hurst Place Surgery – 29/08/2018 Erith Health Centre – July 2018</p>	Yes
<p>There was a record of fire alarm checks.</p> <p>Date of last check: tested weekly and King Harold's Way – 31/07/2018 Hurst Place Surgery - 29/03/2019 Erith Health Centre – 04/01/2019</p>	Yes
<p>There was a record of fire training for staff.</p> <p>Date of last training: various dates</p>	Yes
<p>There were fire marshals.</p>	Partial ²
<p>A fire risk assessment had been completed.</p> <p>Date of completion: King Harold's Way – 09/05/2019 Hurst Place Surgery – 04/09/2018 Erith Health Centre – 09/03/2018</p>	Yes
<p>Actions from fire risk assessment were identified and completed.</p>	Partial ³
<p>Explanation of any answers and additional evidence: 2,3. The most recent fire risk assessment of King Harold's way advised that an additional member of staff</p>	

should be trained to fire marshal standard. This recommendation has not yet been addressed by the practice.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Legionella risk assessments had been completed on the sites as follows Kind Harold's Way – 21/8/18 (next assessment is due in 21/08/2020) Hurst Place – 21/8/18 (next assessment is due in 21/08/2020) Erith Health Centre – 02/10/2017 (next assessment was due in 02/10/2019).	Yes ⁴
Explanation of any answers and additional evidence: 4. We saw evidence that a Legionella risk assessment had been arranged for 11/12/19 at Erith Health Centre.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met but the service had not assessed risks associated with infection control at all their practice sites.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes ⁵
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: King Harold's Way – 25/01/2018 Hurst Place Surgery – not available Erith Health Centre – not available	Partial ⁶
The practice had acted on any issues identified in infection prevention and control audits.	Partial ⁷
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: 5. The practice had updated their infection prevention and control (IPC) policy since our last inspection. 6. The practice nurse explained that IPC arrangements had historically been led by their nurse practitioner and was focussed on the King Harold's Way site. They are now in the process of making arrangements with their local clinical commissioning group (CCG) Health Protection team to get their IPC lead enrolled on a course that will support them in carrying out their role. 7. The most recent IPC audit completed at the King Harold site identified a few issues which remain unaddressed: textured woodchip wallpaper (unsuitable surface as difficult to keep clean) in rooms 4 and 6, textured woodchip wallpaper in the corridor leading to the clinic rooms, carpet along corridor by room 4, and damaged tiled flooring in the waiting room.	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety, but some arrangements for dealing with medical emergencies were in need of review.

	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.	Partial ⁸
Clinicians knew how to identify and manage patients with severe infections including	Yes

sepsis.	
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
Explanation of any answers and additional evidence: 8. Some medicines recommended for treating medical emergencies were not stocked: Furosemide / oral Bumetamide (for Left ventricular failure) and Diclofenac (for pain relief). The practice stocked an alternative (but suitable) medicine to Dexamethasone (for treating croup in children).	

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.	Partial ⁹
Explanation of any answers and additional evidence: 9. At our first inspection visit, we found that the practice did not act on instructions made by the hospital in the cases of two patients prescribed medicines that needed additional monitoring: one patient was lost to hospital follow up and still continued to be prescribed the medicine without further secondary care input, and with another patient the hospital instructed the medicine be stopped in letter correspondence, but this letter was not seen by a GP and the medicine continued to be prescribed. The lead GP acted immediately to address these issues as soon as they were brought to their attention.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, the management of prescription stationery was in need of further review.

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)	0.71	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)	8.2%	9.9%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	5.89	6.30	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.20	1.69	2.08	Tending towards variation (positive)

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 ¹⁰
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial ¹¹
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes ¹²
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.	Not applicable
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>10. The management of prescription stationery was not in line with published guidance, such as the NHS Prescription guidelines – Management and control of prescription forms. We found that prescription stationery received was not recorded, prescription stationery usage was not auditable, and keys were not restricted to the prescription stationery storage area.</p> <p>11. Recent PGDs were in date, but not all practitioners working under it have signed as such from the sample reviewed: Meningitis B and Rotavirus.</p> <p>12. We found that medicines management arrangements were in place and had been reconsidered since a recent Coroner's inquest was published into the death of a patient in the practice. We reviewed a range of patients prescribed various high risk medicines and we found that they were appropriately managed, except for two patients in the sample we reviewed (sample size - 18 patients). We found the gaps in the appropriate care and treatment of these two patients echoed themes highlighted in the Coroner's report, in that there was a lack of secondary care input in the prescribing of the medicine, and the practice had not appropriately followed the hospital instructions regarding the prescribing of the medicine. Although the provider took immediate actions to ensure these two patients were safe as soon as we highlighted the gaps, we decided at the end our first visit as part of this inspection that a second visit would be necessary to review a larger sample of records of patients prescribed medicines that require more careful monitoring. At our second visit we reviewed the records of a third of all their patients prescribed high risk medicines. We found that appropriate monitoring and clinical review arrangements were in place for these patients, either in the practice or at the hospital. If the patient was jointly under hospital care, their records indicated this.</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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes ¹³
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 6 months:	11
Number of events that required action:	11
Explanation of any answers and additional evidence: 13. Reception team meeting was held in August 2019, where significant event process was discussed by the assistant managers.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Another patient's notes given to a patient in error	<ul style="list-style-type: none"> • Patient given the incorrect information reported the error to the practice. • The practice took full details of the error from the reporting patient • Report made, and advice sought, from the CCG • The practice that received the wrong patient's notes shredded the information immediately. • Matter reported to the Information Commissioner's Office (ICO) and the outcome of the data breach was that no further action was required • Event discussed, and actions reviewed at supervisors' meeting. • Event discussed with the practice team and protocol for ensuring correct information is shared reiterated.
An email sent to the practice requesting that arrangements be made for a patient to have a mental health review was forwarded to an administrator but not properly reviewed and actioned until the following morning.	<ul style="list-style-type: none"> • A significant event review meeting was held and attended by an assistant manager and the members of staff concerned. • The process and protocol for actioning requests was reiterated.

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:	

Effective

Rating: Good

We have rated the practice as good for providing effective services because:

- 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.
- The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.
- The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- However, we have rated the practice as requires improvement for providing effective services for people experiencing poor mental health (including people with dementia) as they had high exception reporting rates for patients in this population group, and these rates were higher than the previous year.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence:	

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>	0.55	0.57	0.75	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> To tackle loneliness and giving consideration to the local Council's Ageing Well Strategy, the practice started the Home Alone Project in 2015 with the full support of their patient participation group (PPG). The project's volunteers are all patients at the practice prepared to help lonely, elderly patients. The lead PPG member and lead GP organise the scheme with the help of the practice HR administrator. The practice ensure that patients living with dementia are invited to attend their annual review, preferably with their carer. The practice arrange home visits for housebound patients living with dementia; these visits are carried out by the lead GP. The practice has a lead GP for end of life and palliative care, who attends all the cancer care review meetings locally and practice GPs have written up over eight cancer care reviews over the last 2 years. The practice uses the Co-ordinate My Care online platform to ensure that end of life patients have their care plans uploaded so that outside health care agencies (111, community palliative care nurses, paramedics) can view their up to date progress. The practice has a safeguarding lead for adults. The practice holds monthly multidisciplinary meetings with palliative care nurses and district nurses to discuss care plans for older people.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice has a member of staff with designated responsibilities for quality and performance outcomes. The staff member has responsibility for ensuring there are timely reviews arranged for people with long term conditions, including dementia, mental health problems, asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, atrial fibrillation and stroke related illness. The practice has approximately 1000 diabetic patients and has a lead staff member who oversees and monitors their care. Most of the practice's diabetic patients (over 95%) were cared for by the practice. They also monitor stable Type 1 diabetic patients who are persistent non-attenders at secondary care. There was a weekly diabetic specialist nurse for diabetic patients with complex problems. The diabetes specialist nurse liaised with local community podiatrists, the community diabetic teams and the retinal-screening programme.

- The lead clinician for diabetes and two practice nurses are trained in insulin starts, so this service is offered in the practice.
- One of the GP partners the local CCG's cardiology lead and has brought cardiology clinics and cardiology diagnostics into the local community. The practice hosted the community clinics and diagnostic tests include ECGs, 2hour ECGs, echocardiograms and 24 hr. ambulatory BP monitoring. All Bexley GPs had direct access to the cardiology community clinics.
- All the practice nurses were trained to provide COPD and asthma reviews, which included spirometry.
- There was a recall system for patients' annual clinic review, review appointments with the diabetic specialist nurse or the diabetes lead doctor at the practice. Whilst the practice had high exception reporting rates for their diabetic patients, with approximately a quarter of patients in this group not being seen for annual review to ensure their condition being appropriately monitored and controlled, they were able to demonstrate that these patients were appropriately excepted.

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>	86.6%	81.7%	79.3%	No statistical variation
Exception rate (number of exceptions).	26.7% (265)	16.3%	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>	75.9%	80.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	24.7% (245)	12.1%	9.4%	N/A

- Any additional evidence or comments**
- The provider explained the distinction between the excepted patients: 17% were informed dissent and 9% were unsuitable (as they were already under hospital care).
 - The provider was aware that their diabetes clinical performance figures needed to improve and were reviewing their recall system.

	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>	90.2%	82.7%	81.3%	Variation (positive)
Exception rate (number of exceptions).	24.5% (243)	14.5%	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>	79.8%	74.5%	75.9%	No statistical variation
Exception rate (number of exceptions).	15.8% (148)	8.9%	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>	95.6%	90.3%	89.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	19.2% (59)	11.8%	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>	82.9%	83.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.1% (187)	5.9%	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>	84.7%	89.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	6.1% (14)	6.5%	5.9%	N/A

Any additional evidence or comments
<ul style="list-style-type: none"> Two healthcare assistants (HCAs) carried out the reviews for people with learning disabilities, supported by an administrator to ensure any remaining patients in the group were followed up. Patients requiring review were all invited three times, and the practice was now using a mixture of text and phone calls as well. However, we observed that the practice had particularly high exception reporting rates for some groups of patients with long term conditions, including those with diabetes, asthma and COPD, which are also higher than the previous year.

Families, children and young people

Population group rating: Good

Findings

- The practice has met the minimum 90% target for all four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the four childhood immunisation uptake indicators.
- The practice offered the six-week baby check and post-natal checks in a single appointment booking so that they were able to identify any issues at an early stage.
- The lead GP and a practice manager met with the health visitors and school nurses monthly to discuss safeguarding concerns.
- The practice had identified the need to reflect young people's views and engage with them so that they could address local needs such as teenage pregnancies, sexual health provisions and mental health issues, increasingly frequent among the young. A receptionist and a HCA have recently been appointed as Young Persons' Champions, with particular responsibilities for supporting young people to feel comfortable expressing their concerns.

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)	215	235	91.5%	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)	204	216	94.4%	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)	202	216	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)	202	216	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>

Any additional evidence or comments

- The practice ran bi-monthly searches for patients requiring child immunisations. All newly due patients were invited. When the parent or carer of the patients could not be reached, an alert was placed on the patient's record, so that it was easier to remember to offer them an appointment or offer them the vaccinations if they attended the practice for other reasons.
- The practice had regular health visitor meetings, approximately monthly. They also met with school nurses occasionally.
- At safeguarding meetings, they have had social services involvement. The meetings have mainly focussed on discussing safeguarding concerns and any children on the child protection register.
- The practice have district and palliative care attendance at their multidisciplinary team meetings.

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 medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	75.1%	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)	77.5%	76.9%	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)	58.2%	54.5%	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)	91.5%	70.2%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	57.7%	54.1%	51.9%	No statistical variation

Any additional evidence or comments

- One of the managers had a lead responsibility for cervical screening, coordinating the results and ensuring they were appropriately dealt with.
- The practice completed audits of cervical screening.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice had a register of patients with Learning Disabilities (LD) and offered them annual reviews. They have recently started an HCA-led programme to visit patients with LD at home as the Did Not Attend (DNA) rate for reviews at the surgery was very high.
- The practice recognised the homelessness and poverty problems in the local area, and they supported their patients affected by these problems by referring them to the social prescribing scheme/ Community Connect.
- The practice recognised the vulnerabilities potentially experienced by people with caring responsibilities. The practice had arrangements to identify and refer carers. The practice seeks to support carers by providing information and local authority resources and contact points. Staff were trained to identify patients with caring responsibilities and to engage with them to ensure that they are supported and that this information is entered onto their notes so staff providing them with care and treatment are aware and able to better support them. The practice's support for carers was advertised on practice notice boards.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The practice had a register of patients with mental health problems and they are invited for an annual review. For those that are unable to attend, home visits are arranged.
- Where concerns are identified with patients in this group, the practice referred them to the local mental health team.
- The practice referred their patients who had the need to the local counselling service, MIND.
- The practice had a register of all their patients who suffer with attention deficit hyperactivity disorder (ADHD) and they are invited for an annual review, including a medication review.
- However, we noted the practice had particularly high exception reporting rates for this group of patients, which is also higher than the previous year.

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>	97.5%	85.4%	89.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	33.6% (41)	14.0%	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>	90.3%	90.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	23.8% (29)	12.0%	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>	79.7%	77.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	21.0% (21)	8.0%	6.7%	N/A

Any additional evidence or comments

- The practice have experienced difficulties getting the patients with mental health needs to attend their review appointments.
- They provided multiple invitations, three to four attempts, for these recalls, using a variety of invitation methods as per QOF rules. They also tried to review this group of patients opportunistically.
- The provider explained that they completed a software system change during the 2018 / 2019 QOF year, which caused disruptions to their recalls and reporting.
- However, we noted the practice had particularly high exception reporting rates for this group of patients, which is also higher than the previous year.

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)	554.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	99.3%	No Data	96.4%
Overall QOF exception reporting (all domains)	10.2%	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

Body mass index (BMI) recording and Combined oral contraceptive pill (COCP): The practice carried out a review of the number of women prescribed COCP and the proportion that had a record of their BMI. The re-audit showed a significant improvement.

Direct Oral Anticoagulant (DOAC): Audit on the monitoring of creatinine clearance (to check kidney function) in patients prescribed a DOAC.

Valproate Monitoring. Audit of sodium valproate in women of child bearing age to ensure that they are complying with the regulatory framework and published guidelines.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, 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: The practice used an online training provider for their staff training.	

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 services.	Yes

For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

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

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>	93.0%	94.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (36)	0.9%	0.8%	N/A

Consent to care and treatment

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

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

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:	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

Culture

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

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

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

Source	Feedback
Staff interviews	Staff we spoke with during our inspection said that they felt happy working at the practice. They spoke of there being a family ethos and that the practice leaders were supportive of their development within their roles, and well as for other / enhanced 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:	

Managing risks, issues and performance

There were clear and effective processes for managing most risks, issues and performance. However, staff did not have oversight of some health and safety risks.

	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 ¹
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. There was a lack of oversight of some health and safety risks, which meant they were not consistently appropriately managed. Some health and safety systems did not operate effectively; particularly in relation to some aspects of fire safety, infection prevention and control, dealing with medical emergencies, and managing prescription stationery. 	

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 ²
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes ³
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 2. The practice discussed their performance at staff meetings held by the clinical and administrative teams. 3. The practice have a blood pressure (BP) machine downstairs. Patients who used the machine could ask for a clinician to review their readings. The practice also asked patients to send in their BP results if they have their own machine at home. 	

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: The practice held telephone consultations as part of their patient access services. They had plans in place to start offering online consultations from February 2020 for book on the day appointments. The practice have employed a physician associate to carry out triage of remote access contacts, and redirect enquiries to the administrative team, for advice, or to make an appointment. The physician associate is expected to start employment at the end of January 2020.	

Engagement with patients, the public, staff and external partners

The practice involved staff and patients to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: The lead GP was supportive of, and involved with, the PPG. They held regular, quarterly meetings and they maintained minutes of these meetings, which included improvement plans in response to discussions held.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

- The practice had introduced the at home project in conjunction with their PPG which provided a befriending service for patients who were socially isolated.
- The practice had introduced a system which allowed the practice to easily use text messages to encourage patients to attend for reviews, send in blood pressure results and encourage patients to attend for flu immunisations. The practice was the second surgery within the CCG to use this.
- We saw that staff were attending regularly clinical updates and staff we spoke with outlined ways in which the practice utilised the skill mix within the service and encouraged staff to upskill and take on additional responsibilities to better serve the needs of the local population. For example, the practice had enabled a member of non-clinical staff to train as a healthcare assistant. Healthcare assistants were encouraged to expand their areas of responsibility. The practice had also taken on apprentices and offered work experience placements at one of their branches. A clinical pharmacist had been taken on at the practice as part of a pilot initiative in the locality and, as result of the success of this, the practice had taken on a second clinical pharmacist.
- Previously the surgery had a low uptake of electronic prescribing. In response the practice had promoted the service extensively and encouraged patients to sign up. The practice had increase the percentage of patients to 63% which was greater than the national target of 56%.

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.