

Care Quality Commission

Inspection Evidence Table

Nuffield Road Medical Centre (1-548229142)

Inspection date: 30 September 2021

Date of data download: 15 September 2021

Overall rating: Good

At our previous inspection in August 2019 we rated the practice as Requires Improvement overall. We identified issues relating to the management of risks, inadequate infection control audits and a lack of processes in place for the recruitment of staff. At this inspection we found that improvements had been made, risk assessments were in place and systems had been strengthened in the management of recruitment. We have now rated the practice as good overall.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

At our previous inspection we rated the practice as requires improvement for providing safe services. The practice was unable to demonstrate they had effective systems and processes in place to ensure patients were kept safe, risks were managed appropriately and the safe management of prescription stationery.

At this inspection, we have rated the practice Good for providing safe services as improvements had been made in all areas of previous non-compliance.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	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 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

Safeguarding	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff we spoke with were aware of who they needed to go to if they had safeguarding concerns. • There were comprehensive policies and procedures for safeguarding children and vulnerable adults. These were reviewed and updated to reflect any changes and were accessible to staff. • Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. • At the previous inspection, we found minutes of meetings lacked sufficient details. At this inspection evidence was provided of regular meetings with multi-disciplinary teams, however the majority of the minutes were handwritten and difficult to read. To gain an understanding of what was discussed, patients individual care records had to be reviewed for the latest update as information from meetings was recorded within the consultation records. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We looked at a range of staff files including clinical and non-clinical staff. There was evidence of checks undertaken as part of the recruitment process such as references and proof of identity. • At the previous inspection we found the practice were unable to provide evidence to confirm staff vaccination status was in line with the relevant guidance. At this inspection, on reviewing a sample of staff files, we found the relevant vaccination status was in place. • There was an induction programme on appointment of new staff and we found the appropriate checks had been completed including DBS checks for all staff. 	

Safety systems and records	Y/N/Partial
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There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: February 2021	Y
There was a record of equipment calibration. Date of last calibration: April 2021	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
A fire risk assessment had been completed. Date of completion: March 2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the previous inspection we found the process for the calibration of equipment was unclear. At this inspection, the practice provided evidence that demonstrated equipment calibration and portable appliance testing had taken place. During the last fire risk assessment a range of actions had been identified. These included: ensuring fire exits were kept clear and stair gates were removed. We found these actions had been completed. Fire safety policies were in place and evidence was provided of a completed fire risk assessment. Since the last inspection, the practice had ensured there was clear signage to identify where oxygen was stored. All staff had completed fire safety training. Fire marshals had undertaken additional training for the role. Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: December 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw risk assessments in place in relation to health and safety and the premises, however we found some actions had not been completed. For example: the next inspection of the mains gas supply was due in November 2020. We were told that due to the COVID-19 pandemic this had been difficult to organise. A risk assessment for Legionella (a bacteria found in water) had been completed by an external contractor in May 2021. One of the actions was to implement a monitoring control process for measuring water temperatures. This had not been acted on. The last water temperature recorded was in May 2021. There were comprehensive risk assessments in place for the storage of hazardous substances. Training records showed health and safety training had been completed by all staff. 	

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: July 2021	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: <ul style="list-style-type: none">• During the last inspection, we found some of the infection control processes required strengthening. At this inspection we found improvements had been made. For example: Due to the COVID-19 pandemic, the practice had increased the frequency of cleaning and ensured there was adequate personal protective equipment available to minimise the spread of infection.• Evidence provided showed the last infection control audit had taken place in July 2021. The practice had achieved an overall score of 94%. One of the main areas highlighted for action was for some areas to be redecorated. A plan was being implemented to identify the work that was required.• Policies, procedures and audit templates were in place for infection prevention and control and accessible for all staff. A range of risk assessments had been completed, which included waste disposal and the management of sharps.• All staff had completed infection control and prevention training relevant to their role• We observed the general environment to be clean and tidy with the layout and facilities of the premises changed in line with COVID-19 guidance for infection prevention and control.• Records confirmed the regular cleaning of the environment including clinical rooms and equipment used for patients care and treatment.	

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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had received training on managing a medical emergency including identifying signs and symptoms of sepsis. • Staff had access to equipment and medicines to deal with medical emergencies (including suspected sepsis). This included medical oxygen and a defibrillator which were regularly checked to ensure they were fit for use. • The provider told us that during the COVID-19 pandemic they had been able to manage staff absences effectively. 	

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
Referrals to specialist services were documented, contained the required information 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A GP specialist advisor to the Care Quality Commission (CQC) accessed the clinical patient records system to carry out searches of patient records. We found no concerns with the standard of clinical record keeping during our remote searches. • We found workflow was completed in a timely way during our search of the clinical system and no delay in the actioning of test results. The duty doctor looked at the results at the beginning and end of the day and dealt with any abnormal results. • There were systems in place for monitoring two week wait referrals so that they could be followed up. • Mutli-disciplinary team meetings were being held regularly to share information with other agencies to ensure patients received the appropriate care. 	

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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.76	0.74	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	12.8%	12.2%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	5.44	5.26	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	129.3‰	118.0‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.94	0.68	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	10.1‰	5.8‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines 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.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
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> <ul style="list-style-type: none"> During the inspection process, a review was carried out of the clinical system by a GP specialist advisor to the Care Quality Commission (CQC) who undertook searches to identify patients on high-risk medicines that required routine monitoring due to the potential risk of harm from taking them. We found the monitoring of patients on other high-risk medicine was effective and in line with national guidance. There was clinical oversight for all requests to medicine changes and a clear process was in place to demonstrate what actions had been taken. Emergency medicines and vaccines were appropriately stored, however we found the monitoring systems needed strengthening as there was out of date adrenaline within the emergency stock. At the last inspection we found blank prescription stationery was not kept securely. At this inspection the practice had implemented a system to ensure all blank prescriptions were kept in a locked cabinet with a recording process in place to identify when prescriptions were removed for use within the practice. 	

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:	9
Number of events that required action:	9
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff were encouraged to report all significant events and incidents. One of the GP partners and salaried doctors were the lead for significant events and reviewed each one and risk rated them. A monthly practice meeting was held to discuss the events and share learning. Minutes of the meetings were sent to all staff. 	

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

Event	Specific action taken
Prescription issued for antibiotics, patient allergic to ingredients	<ul style="list-style-type: none"> Clinical records were reviewed which confirmed that the patient was allergic. The findings were discussed with the GP and learning was shared. A prescription was issued for an alternative medicine.
Information about one patient added onto record of another patient in error.	<ul style="list-style-type: none"> On investigation it was found both patients had the same date of birth. Discussed with the team and error was corrected.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had clinical meetings on a weekly basis for sharing information and to discuss safety alerts and actions that had been taken. We looked at a range of safety alerts and found these had been actioned appropriately. For example, we reviewed the actions the practice had taken for medicines which placed unborn children at risk if taken by mothers when pregnant. We identified 11 patients on these medicines 	

when we carried out a remote search of the clinical system. We found no concerns on reviewing a random sample of patients records.

Effective

Rating: Requires Improvement

At the previous inspection we rated the practice as requires improvement for providing effective services. We found there was no structured approach for effective quality assurance systems and clinical oversight. At this inspection we have continued to rate the practice as requires improvement for providing effective services as childhood immunisations and screening targets were below national averages.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">Medication reviews were being carried out and on reviewing a sample of patients records we found them to be in line with recommended guidance.Searches of the clinical system showed the appropriate monitoring was in place for patients with long term conditions. For example: We carried out a remote search of the clinical system to identify patients with the potential of having being missed for diabetes. A total of 13 patients were identified from the search. We reviewed a random sample of five patients and found they had been appropriately coded and were having yearly checks or further tests were being arranged.We saw care plans to drive forward patient care in areas such as learning disability reviews were in place.The practice used a range of clinical templates to support the management of patients' conditions, which linked in with the latest clinical guidance.One of the care practitioners employed by the practice regularly visited patients in the care homes to monitor their health conditions.	

Older people

Population group rating: Good

Findings

- Clinical staff spoken with provided some examples of how they delivered effective care to older patients such as referring to social prescribers and working alongside the multi-disciplinary team such as the district nurses.
- 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 medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.

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	85.4%	76.5%	76.6%	Tending towards variation (positive)

RCP questions. (01/04/2019 to 31/03/2020) (QOF)				
PCA* rate (number of PCAs).	14.1% (146)	11.3%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	90.2%	90.7%	89.4%	No statistical variation
PCA rate (number of PCAs).	13.3% (39)	14.4%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	85.7%	80.8%	82.0%	No statistical variation
PCA* rate (number of PCAs).	6.3% (16)	6.8%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	77.8%	69.8%	66.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	20.7% (131)	17.2%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	64.6%	71.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	5.9% (63)	8.6%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	92.0%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	13.5% (31)	5.1%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	71.7%	72.1%	75.9%	No statistical variation
PCA rate (number of PCAs).	12.7% (80)	13.0%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had not met the minimum 90% for four of five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	123	130	94.6%	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) (01/04/2019 to 31/03/2020) (NHS England)	126	148	85.1%	Below 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) (01/04/2019 to 31/03/2020) (NHS England)	123	148	83.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	127	148	85.8%	Below 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	133	170	78.2%	Below 80% uptake
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice had employed an extra nurse to support the nursing team and offer more appointment availability for children's immunisations. Regular invitations were sent out to encourage patients to attend and time was made to support patients' who had concerns by offering education and advice.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice uptake for cervical screening was below the national screening programme target of 80%. Patients were encouraged to attend appointments and flexibility in appointment availability was offered to encourage patients to attend.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including 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 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). (Snapshot date: 31/03/2021) (Public Health England)	62.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	60.8%	68.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	60.5%	63.6%	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	91.3%	92.7%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	75.8%	62.2%	54.2%	No statistical variation
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Any additional evidence or comments

The practice were aware that the cervical screening uptake was below average. They told us they have tried to engage with the local population. The Clinical Commissioning Group had had implemented a project with the practice to improve uptake of patients who failed to respond to invitations. The project commenced during 2020 and was continued throughout the COVID-19 pandemic. Data provided by the practice showed improvements in the number of patients attending their appointments. For example: Between August to November 2020 a total of 112 patients were seen for cervical screening. The practice has continued with the project to encourage more patients to attend.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

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

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	66.1%	81.8%	85.4%	Tending towards variation (negative)
PCA* rate (number of PCAs).	15.9% (24)	18.9%	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	81.9%	82.0%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.6% (15)	9.3%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

At the previous inspection we found the practice's performance for mental health indicators were below the CCG and England averages. At this inspection, we found a slight improvement in the data. The practice told us that during the COVID-19 pandemic patients' with mental health needs were prioritised and more reviews were offered.

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	England average
Overall QOF score (out of maximum 559)	543.6	533.9
Overall QOF score (as a percentage of maximum)	97.2%	95.5%
Overall QOF PCA reporting (all domains)	8.9%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	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

The practice had completed a range of audits throughout the year. For example: An audit of non-steroidal anti-inflammatory drugs (NSAIDs) was completed for patients aged 65 years and over to reduce the number of patients prescribed these specific medicines without gastro protection. The audit identified

4.6% of patients on these medicines had not been prescribed gastro protection medicines. Each patient was reviewed and a second audit was completed after six months and there was a reduction to 0.6%. The outcome of the audit was discussed as part of the clinical governance meeting and continuous reviews were planned by the clinical pharmacists.

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.	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
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> A system was in place to monitor and review staff training and we saw a high levels of completion rates for training specified as mandatory by the provider. This included level three safeguarding training for clinical staff. A training matrix was in place which was monitored by the management team to ensure all staff were up to date with their training needs. Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding and responding to an emergency. There was evidence of staff appraisals and staff reported they were encouraged and given opportunities to develop. All staff received an annual review Clinical leads carried out regular reviews of consultations and prescribing to ensure they were clear, appropriate and contained the relevant information. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
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
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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 and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Regular meetings were being held with community teams to ensure palliative care patients received the support and care they needed. The practice had a programme of quality improvement to ensure clinical registers were up to date and patients received the appropriate reviews and monitoring. The practice had been allocated social prescribers through their Primary Care Network. Social prescribers help patients by offering support and signposting to local support groups. The practice had been certified as a Parkrun practice. This was an initiative which enable GPs and practice staff to socially prescribe physical activity by referring patients to take part in a park run to support their health and wellbeing. 	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Well-led

Rating: Good

At the previous inspection we rated the practice as requires improvement for providing well led services as governance processes needed strengthening and risks had not been proactively identified and managed. At this inspection we have rated the practice as good for providing well led services as governance procedures had been embedded, risk assessments had been implemented and acted on and the leadership team demonstrated skills to delivery quality care.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Leaders understood the challenges impacting on the delivery of the service which included access to appointments and the impact of the COVID-19 pandemic. They had taken action to improve patients experience which included an increase in the number of clinics to ensure patients received regular reviews.• There was a business development plan in place and work in progress to address the areas for improvement.• Staff told us that leaders were approachable and supportive and staff engagement was encouraged.	

Vision and strategy

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

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

Explanation of any answers and additional evidence:

- The practice had a clear vision which was shared with staff through regular meetings and updates.
- Staff told us the aim was to deliver high quality care and promote good outcomes for patients.
- Since the last inspection, the practice had prioritised the work that was required to ensure improvements were made to both quality and sustainability. Action plans were in place to monitor the priorities and progress against delivery of the practice strategy.

Culture

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

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

Explanation of any answers and additional evidence:

- There was emphasis on staff wellbeing, and this was demonstrated through discussions with staff and evidence of appraisals.
- Staff had been given the opportunity to feedback on working at the practice through an inhouse survey. The survey also asked staff about working during the COVID-19 pandemic. For example: If the practice had done enough to ensure staff safety. Evidence provided showed 94% of staff agreed that they felt safe at work during the pandemic.
- There was a policy for whistle blowing and Freedom to Speak Up guardian which allowed staff to understand the process and refer any concerns.
- Practice meetings took place which provided an opportunity for staff to discuss issues.
- Staff said they were confident to raise any concerns and felt they would be listened to.

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

Source	Feedback
Staff	Staff told us that there was a team environment at the practice and both management and GPs were very approachable and supportive.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Since the previous inspection the practice had implemented effective governance arrangements. During this inspection, we found formal systems were in place to monitor the quality of services provided. The practice had implemented regular governance meetings to ensure quality indicators were reviewed, risks were identified and there was a structured approach to support the governance arrangements.• The management of risks had been strengthened with regular reviews completed to ensure risks were mitigated.• Policies and procedures were available on an electronic system which were accessible to all staff. Discussions with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing. We looked at a sample of policies and saw they had been reviewed and were up to date for example, the governance policy.• Discussions with staff and evidence reviewed from clinical records demonstrated patients care and treatment was delivered with effective governance structures and systems and with clinical oversight. On reviewing a random sample of patients' records we found patients care and treatment was delivered in line with recommended guidance.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	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:	
<ul style="list-style-type: none">• The practice had a range of risk assessments in place, for example, health and safety, and legionella. There was a programme of clinical auditing in place to monitor quality and implement	

improvements. The programme was regularly reviewed and updated to ensure there was a formal analysis of quality and sustainability at the practice.

- A major incident plan had been implemented and staff were aware of what actions were required in the event of a major incident.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • All patients that requested to see a GP were first given a telephone appointment. Following the telephone review, the GP would make a clinical decision if a face to face appointment was required. • All patients who attended the practice were asked a range of questions to ensure they had no symptoms in relation to COVID-19. Temperatures were taken, face masks were available if patients arrived without one and hand sanitizer was in place throughout the building. • Patients who were considered vulnerable had alerts on their clinical records to identify them. • Infection control processes had been strengthened and extra cleaning schedules had been implemented to ensure cleaning was carried out at frequent intervals. Clinical staff were given extra time between patients to clean their consultation rooms. • The business continuity plan had been updated with the COVID-19 guidelines and Public Health information process for reporting positive cases. • One of the consultation rooms had been designated as an area for potential COVID-19 patients who arrived at the practice. • COVID-19 risk assessments had been completed for each member of staff. Staff that were identified as higher risk were supported to work remotely. Due to the size of the building where the practice was situated, vulnerable staff had the facilities to work socially distanced from their colleagues. 	

- A standard operating procedure was in place to ensure all staff were aware of the procedures to follow during the pandemic.

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were systems in place to monitor performance, for example regular clinical governance meetings. • Weekly clinical meetings were held to discuss patient care and monitor performance. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
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
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were policies in place to support staff with utilising digital services securely and effectively. This included the process and procedures for telephone, email and video consultations. • Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy. 	

- Training records showed all staff had completed information governance training and had signed confidentiality agreements as part of their contract.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice told us they had started a patient participation group (PPG) earlier this year. Minutes of the latest meeting were provided which showed a range of topics had been discussed. • A text message had been sent to all patients to invite them to join the PPG. The practice told us they had approximately 40 patients who had requested further information on how to become a member of the group. An awareness evening was being planned in October 2021 to provide further information to patients who had expressed an interest. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Systems and processes had been put in place to manage the risks and issues identified at our previous inspection. • The practice is a teaching practice for GP registrars and medical students. • Clinical meetings were being held each month for all clinical staff to share information and learning. • Time was allocated for staff to complete mandatory training. A quarterly learning afternoon was being planned to share learning across the practice. 	

Examples of continuous learning and improvement

- The practice encouraged staff to further develop their roles. For example: One of the nurses had recently completed their prescribing course.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -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.
- *PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.