

# Care Quality Commission

## Inspection Evidence Table

### Shelley Manor & Holdenhurst Medical Centre (1-542762663)

Inspection date: 27 September 2021

Date of data download: 31 August 2021

## Overall rating: Good

Following the inspection undertaken on the 4 November 2020, the practice was rated as requires improvement. This was because:

Safeguarding processes required improvements to assure all staff understood the procedures and the need to refer to other agencies when needed.

There was not an effective system in place to learn and make improvements when things went wrong. Reviews and investigations of significant events were not always meaningful and did not include all relevant people.

At this October 2021 inspection, we found these issues had been corrected and built upon to provide a safe practice for its patients and staff. We found improved systems and process were now embedded within the practice and provided a strong foundation for ongoing development.

Improved links with the wider community services, such as the Enhanced Care Team, demonstrated a drive to increase the level of overall care to vulnerable and hard to reach patients.

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

## Safe

## Rating: good

Following the inspection undertaken on the 4 November 2020, the practice was rated as requires improvement. This was because:

Safeguarding processes required improvements to assure all staff understood the procedures and the need to refer to other agencies when needed.

There was not an effective system in place to learn and make improvements when things went wrong.

Reviews and investigations of significant events were not always meaningful and did not include all relevant people.

During this inspection, on 27 September 2021 we found these issues had been addressed.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Since the previous inspection the practice had reviewed its policies for adult and child safeguarding. This ensured it contained the most up to date information relevant to the practice and to ensure staff were aware of this information.</li> <li>• Both the practices safeguarding adults' and children's policy and procedures clearly identified who the safeguarding lead was and how to report concerns. Every member of staff we spoke with, knew who the current safeguarding lead was.</li> <li>• There were regular safeguarding meetings within the practice and with external agencies. We could see from meeting minutes examples of where sharing of information to staff had helped ensure that they maintained regular awareness of current safeguarding concerns and learning from these to ensure patient safety.</li> <li>• The practice had an established process in place to inform the out of hours service of any relevant safeguarding information.</li> </ul>	

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.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person.	Yes
There was a record of equipment calibration. Date of last calibration: March 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: July 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: July 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2021	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff were trained in health and safety procedures such as, the use of spill kits for cleaning of blood.</li> <li>• Health and safety policies and procedures were available to staff, and they understood their responsibilities in the event of an incident.</li> </ul>	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• During the last inspection we found the practice had not updated its infection prevention control (IPC) policy to reflect who the named IPC lead was. At this inspection, we found the IPC policy was up to date with the appropriate level of information.</li> <li>• A comprehensive IPC audit had been undertaken which identified issues that required action. An additional action plan was created, and action taken to address the areas identified as needing attention. For example, flooring in the advanced nurse practitioners' room had been replaced to ensure compliance to current standards.</li> <li>• However effective oversight of a third-party cleaning company was not well managed. Visual observations of the practice demonstrated that the premises and equipment were clean. The practice was unable to evidence how they assured themselves that the cleaning undertaken by a third-party contractor was completed to an acceptable standard. Whilst the responsible individuals at the practice undertook regular checks of the premises there was currently no formal audit of work was used to assess the standard of cleanliness completed by the contractor.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes

## 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
Referrals to specialist services were documented, contained the required information 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• 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.</li><li>• All staff had received training in how and when to use the ‘red flag’ symptoms. This is the flag used to indicate an acutely unwell patients that required urgent attention.</li></ul>	

## 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)	0.65	0.70	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)	8.7%	10.5%	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)	5.67	5.58	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	108.1‰	100.9‰	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)	0.87	0.60	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	10.6‰	7.2‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

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.	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 changes to a patient's medicines including changes made by other services.	Yes
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
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	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> <ul style="list-style-type: none"> <li>• We undertook a remote review of a sample of patients clinical records in relation to the use of medicines including high risk medicines and found that there were clear and effective systems in place to for monitoring patient's health and that these were completed in the required timeframes in order to keep patients safe.</li> <li>• The practice had a prescribing team. They worked as part of the general practice team to improve value and patient outcomes from medicines prescribed. They consulted with and treated patients directly. This included providing help to manage long-term conditions, advice for those on multiple medicines and better access to health checks. Their role was pivotal to improving the quality of care and ensuring patient safety.</li> <li>• Regular medicine safety searches were carried out to ensure patients were being prescribed the best medicines for their health.</li> <li>• Patients on high risk medicines were regularly monitored. High risk medicines were managed and reduced as necessary to ensure patients' ongoing good health.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>The structured medication reviews performed by the pharmacists were detailed and thorough using a template to accurately record all necessary information. The pharmacists ensured any necessary physical checks had been completed, as well as checked the monitoring was up to date. The pharmacist had checked patients were able to use their equipment well, for example, checking inhaler technique for a patient with asthma and discussed medication side effects. They had also provided advice on when to take medication to reduce side effects.</li> </ul>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	Six
Number of events that required action:	Six
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our previous inspection in November 2020, the practice was not able to demonstrate how learning from significant events were discussed with and disseminated to the whole team. At this inspection we found the practice had invested in a system that captured all significant events. This included the details of any investigations, lessons learned and learning shared. Feedback from staff and meeting minutes demonstrated how this change was being embedded at the practice.</li> <li>We looked at six significant event records and found appropriate actions had been taken, additionally there was evidence of learning disseminated from these events to staff. Therefore, we were assured practice's team had been made aware of the learning from these incidents.</li> </ul>	

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

Event	Specific action taken
A pain medicine Dihydrocodeine was issued twice.	The error was identified by the prescribing team. It was marked in error and the medicine stopped. The secretarial team and prescribing team were informed and reminded to be extra vigilant. The incident was discussed at whole team meeting
Cancer two week wait, a missed task.	The referrals team were updated and now are running weekly searches to spot two week wait patients. An additional red



	flagging system was implemented on patient records when on a two week wait for referrals. All staff were informed of the new red flag system in use.
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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: <ul style="list-style-type: none"> <li>The practice had a good protocol in place for managing, recording and acting on safety alerts. We saw examples of actions taken on recent Medicines and Healthcare products Regulatory Agency Alerts (MHRA) for example, regarding sodium valproate.</li> </ul>	

## Effective

## Rating: Good

At our last inspection we rated effective as Requires Improvement. This was because the practice's follow up system to improve quality outcomes for patients, in particular for cervical cancer screening and patients with long term conditions was not always effective. The provider did not have a system or policy in place to ensure all children that did not attend their appointment following referral to secondary care or for immunisations were appropriately monitored and these occurrences had been followed up.

At this inspection we found new and improved systems had been developed to maintain quality outcomes for the patients. Policies surrounding children that did not attend appointments had been reviewed and updated.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice's policies, procedures and clinical guidelines had been reviewed and updated as appropriate. Staff had access to these via an electronic record system.</li></ul>	

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.

- The practice checked on all older patients discharged from hospital. It ensured their care plans and prescriptions had been 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.
- The practice worked with an enhanced care team which was aligned to care homes within its catchment area. This service provided additional support for older people. For example, a direct phone line for the care home that enabled to speak with the enhanced care team if they had concerns about their patients. This also included same day visiting service for housebound patients or those too unwell to attend the surgery.

## 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 specialist 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 demonstrated how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Longer appointments and home visits were available when needed or on request. Appointments for the review of long-term conditions were up to extended in duration and were tailored to suit individual patient needs.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

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	86.6%	76.4%	76.6%	Tending towards variation (positive)

RCP questions. (01/04/2019 to 31/03/2020) (QOF)				
PCA* rate (number of PCAs).	32.8% (480)	14.6%	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)	92.1%	90.3%	89.4%	No statistical variation
PCA rate (number of PCAs).	16.0% (86)	14.5%	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)	61.6%	80.1%	82.0%	Significant Variation (negative)
PCA* rate (number of PCAs).	2.7% (14)	6.6%	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)	60.4%	68.1%	66.9%	No statistical variation
PCA rate (number of PCAs).	20.7% (187)	20.2%	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)	49.2%	71.2%	72.4%	Significant Variation (negative)
PCA rate (number of PCAs).	4.7% (108)	8.8%	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)	83.0%	91.8%	91.8%	Variation (negative)
PCA rate (number of PCAs).	2.7% (9)	5.7%	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)	62.6%	75.5%	75.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	21.1% (191)	13.2%	10.4%	N/A

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

### Any additional evidence or comments

- Following our November 2020 inspection this population group was rated as requires improvement because of the high exception reporting data which was above the local and national averages. Since then, exception reporting has been replaced by Personalised Care Adjustments (PCAs). Data for this inspection continued to show high PCA rates for some areas of long-term condition monitoring. Patients were only accepted after a process of not responding to invitations or being on the maximum medicine available, the practice had undertaken additional incentives and communications to encourage patients to attend. It also recognised that during the COVID-19 pandemic some patients were hesitant to attend the practice.
- We reviewed unverified data for 2020/21, which showed an improvement in monitoring of patients' health. Such as for patients with COPD where the practice had achieved 95% for patients who had had a review by a healthcare professional during the first six months of the reporting year (2021/22). The practice had exceeded the 90% target before the end of the reporting year.
- We also saw an improvement in unverified data for 2020/21 in patients with high blood pressure. The practice's target was 90% of patients to have their blood pressure measured. The current data showed they were at 83% and also on course to meet their target.
- Following our 2020 inspection the practice had identified that a software issue had been incorrectly coding patients which led to incorrect and higher than usual exception reporting. They had addressed this issue and the correct coding had been applied which meant fewer patients were removed from the required monitoring.
- The COVID-19 pandemic had severely impacted on the number of patients needed to attend a face to face appointment, for example, to carry out monitoring of their health such as blood pressure readings. Staff told us significant numbers of patients were reluctant to attend the practice during this time due to infection concerns or because they had been shielding. They told us, many patients had utilised at home blood pressure monitoring systems and were able to submit readings to the practice via the electronic system. This enabled their blood pressure to continue to be reviewed and monitored by clinicians without having the need for patients to attend the practice.
- The practice had taken action to improve their use of data and monitoring of patient outcomes, including the implementation of systems to optimise workflow and the use of pathways and advanced reporting to improve understanding of the data.

**Findings**

- The practice was just below the minimum 90% for five of the five childhood immunisation uptake indicators. The practice were close to achieving the target and had plans to continue to encourage uptake following the national COVID-19 pandemic.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up on 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)	225	253	88.9%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	213	242	88.0%	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)	214	242	88.4%	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)	216	242	89.3%	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)	229	256	89.5%	Below 90% minimum

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

#### Any additional evidence or comments

- Child immunisation rates were just the below average in all areas. The practice had acted to improve these rates, for example, by identifying outstanding immunisations and sending additional letters and making telephone contact. They also requested face to face appointments with parents declining to immunise their children, so they could ensure, and informed choice was being made.
- The practice had reviewed its policy surrounding non-attendance for children that do not come to their appointments. This built on a previous version and was shared with clinical and non-clinical staff.

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

Population group rating: Good

### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including 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)	64.8%	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)	57.4%	74.1%	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)	54.9%	68.4%	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)	90.3%	93.0%	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)	50.9%	57.2%	54.2%	No statistical variation

### Any additional evidence or comments

- Practice leads demonstrated a good understanding of the issues impacting on cancer screening. This included a high turnover of patients. The practice routinely monitored screening uptake and had reviewed this as part of its quality assurance processes. Action taken to address poor uptake included contacting eligible patients. Reluctance of patients to attend the screening appointment throughout the COVID-19 pandemic had a notable impact on target figures. The practice was proactive in working on the cervical smear recall system to ensure where a patient did not attend for an appointment they had been followed up by their GP.



- The practice also identified that there was a percentage of their patient population who struggled to read large portions of text such as the booklet provided on cervical screening. As such the practice had sourced an easy read version of the booklet which contained pictorial representation of the information including the procedure which was offered to patients.

### 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.
- The practice reviewed young patients at local residential homes.
- The practice had recently registered 31 people who have been evacuated from Afghanistan. They offered a personalised GP care for emergency needs and facilitated a smooth registration and provided an ongoing support.

### 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. The practice provided 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 had been 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 developing dementia had been identified and offered an assessment to detect possible signs of dementia. When dementia had been suspected there was an appropriate referral for diagnosis.
- Patients experiencing poor mental health, including those living with 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) <small>(QOF)</small>	91.1%	87.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	21.1% (90)	17.8%	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) <small>(QOF)</small>	84.2%	83.7%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.5% (10)	7.4%	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
<ul style="list-style-type: none"> <li>The practice was aware of the high exception reporting rates for mental health indicators. At our previous two inspections we identified this to be an area for improvement. The practice had made improvements in this area and these rates were now only marginally above average for one of the two indicators for personalised care adjustment percentages. The practice was located in an area of high prevalence of complex mental health needs linked to substance misuse.</li> <li>The practice continued to develop ways to engage this hard to reach group, for example additional sessions for clinicians to reach out to this patient group.</li> <li>A link worker was available, and their role was to focus on people with mental health concerns, including children and families, to provide support for minor level mental health concerns</li> <li>The practice identified a software issue that had automatically exempted patients sooner than it should. A new software patch was developed to ensure a third contact attempt is to be made before exempting patients.</li> </ul>

## 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)	498.7	533.9
Overall QOF score (as a percentage of maximum)	89.2%	95.5%
Overall QOF PCA reporting (all domains)	9.1%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years</p> <ul style="list-style-type: none"> <li>• A nitrofurantoin prophylaxis (this is an antibiotic medication used to treat recurrent urinary tract infections) audit had been carried out in November 2019. This audit had been undertaken following a patient presenting with shortness of breath, a cough, tiredness and weight gain. The patient was found to have an abnormal lung and kidney function and was referred onto secondary care. A search was carried out on other patients who had nitrofurantoin prophylaxis on a repeat prescription.</li> <li>• Seventeen patients were identified during the search, of these eight had lung monitoring carried out within the last six months and nine had received a kidney and lung check within the last six months.</li> <li>• Following advice two patients were prescribed another medication and three no longer had nitrofurantoin prophylaxis on repeat prescription.</li> </ul>
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## Effective staffing

**The practice was able/ unable 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.	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
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Mandatory and essential training was identified for each role within the practice and monitored by the management team. This included for permanent, bank and self-employed staff. Staff reported they received regular appraisals.</li> </ul>	

## 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>GPs attended multidisciplinary meetings and external meetings, including clinical commissioning led community care meetings and palliative care meetings.</li> <li>An enhanced care team maintained links between the practice, care homes and its patients and staff which enable for continuity of care to be maintained. Care home staff had access to a direct line for reporting concerns relating to a patient's condition.</li> </ul>	

## 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 and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Patients were referred or signposted to local initiatives that included stop smoking support and health, wellbeing and fitness services.</li> </ul>	

## 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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff demonstrated an understanding of the Mental Capacity Act (2005) and presumed capacity. They understood where a person was assessed as lacking capacity to make certain decisions, best interest decisions needed to be made.</li> </ul>	

## **Caring**

**Rating: Good**

Shelly Manor & Holdenhurst was rated Good for the provision of caring services at our last inspection in November 2020. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried through to contribute to the overall rating for the practice.

## **Responsive**

**Rating: Good**

Shelly Manor & Holdenhurst was rated Good for the provision of responsive services at the previous inspection in November 2020. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried through to contribute to the overall rating for the practice.

## **Well-led**

**Rating: Good**

At our November 2020 inspection, the practice was rated as requires improvement in this domain because leaders could not demonstrate fully how they aimed to deliver high quality, sustainable care. The practice's vision, values and strategy were not supported by all the staff and practice did not have clear or effective governance process and systems in place.

Staff stated they did not always raise concerns, or they were not always appropriately supported when they did.

At this inspection we found the practice and its staff had identified actions to enable them to address the above concerns and develop the service. We found evidence there was better involvement and motivation from all staff group across all levels. The practice's vision and values had been developed with the input from the staff to help deliver high quality, sustainable 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.	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
<ul style="list-style-type: none"> <li>• Following our previous inspection in November 2020, the practice had set up clear priorities to ensure sustainability. There was ongoing recruitment to bridge gaps within the staff team.</li> <li>• Staff told us; the leadership of the service had stabilised over recent months. Staff told us leaders were approachable and worked to involve them in the way the service was run and developed. One of the main areas of concerns previously identified had been staffing levels, and we had consistent feedback from staff the staffing situation had improved.</li> <li>• The practice had established whole team meetings to ensure communication and learning was shared effectively and acted upon by teams.</li> </ul>	

## 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 prioritise 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice staff had a clear vision and set of values which staff understood and explained how they incorporated these into their work.</li> <li>• The practice was continuing to develop and update their strategy. The demands of the pandemic meant that some aspects of the strategy had been paused to allow the practice to remain agile to the changing patient needs during the pandemic.</li> </ul>	



## Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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 candor.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Both clinical and non-clinical staff told us they felt the culture had improved since our last inspection. They felt they could raise concerns and have them heard and acted on in a fair and transparent manner.</li> <li>The practice staff had a clear vision and set of values which staff understood and explained how they incorporated these into their work.</li> </ul>	

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

Source	Feedback
Staff feedback forms	<p>The overall theme from staff feedback forms collected was positive. Staff stated they enjoyed working for the practice. Staff spoke of a more visible management and approachable senior team. An increase in staff meetings has led to staff feeling more involved in the day to day issues facing the practice.</p> <p>Challenges did remain in finding enough staff to cover an increasingly busy practice. However, staff felt leaders were aware of the challenges facing staffing and were acting to improve this.</p>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>At our previous inspection in November 2020 we found there was limited opportunity for staff to access policies and procedures as well as some policies were out of date. At this inspection we found policies and procedures were up to date and accessible to all staff via a newly introduced digital system. This meant staff could be assured the information they accessed was current and reflected the practices operational requirements.</li> <li>There was a system in place for investigating, reviewing and learning from complaints and significant events. We found evidence of learning had been disseminated to all staff to provide assurances these events would not be repeated or to improve safety for patients.</li> <li>The practice introduced a whole team meeting to be held four times a year. Where staff are unable to attend minutes and any actions were distributed via email and stored on the shared drive archive for all staff to read.</li> </ul>	

## 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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
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:	
<ul style="list-style-type: none"> <li>• We saw evidence that systems and processes for managing risk, issues and performance were maintained. We could see how this was embedded into the practices overarching governance process. Digital records such as recruitment, staff training and health and safety were consistently updated.</li> <li>• The pharmacy team had systems to receive and act on any medical safety alerts.</li> <li>• There was an effective system to review and manage patients on high risk medicines</li> </ul>	

### **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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

### **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.	Yes
Performance information was used to hold staff and management to account.	Yes
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:	
<ul style="list-style-type: none"> <li>Coding on the computer-based system for some patient groups had been incorrectly added resulting in higher than actual personalised care adjustment numbers. The practice had adjusted this error and as a result a more accurate and improving picture was emerging.</li> <li>Current data for cervical screening and childhood immunisations were below the national and local averages. The practice had ongoing campaigns to encourage patients to attend and increase these figures. Due to the current COVID-19 pandemic and the associated burdens on GP practices we have taken this into consideration.</li> </ul>	

## 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.	Yes
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
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	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:	
<ul style="list-style-type: none"> <li>Staff reported the pandemic meant there had been difficult times and challenges for them, as a team in recent months. Staff reported feeling the situation was more stable and found the leadership team to be visible and supportive.</li> <li>The practice invited all patients to complete surveys of their experience using the service. Patients were able to complete online feedback. Survey results were shared with staff and discussed at quality assurance meetings. The practice also reviewed feedback from NHS Choices at team meetings and identified learning which was then cascaded to the team.</li> </ul>	

#### Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>Prior to the pandemic, meetings had been held with members of the patient participation group. The group reviewed patient feedback and contributed to discussions about how to make improvements. The group were also involved in planning for and attending events relating COVIDd-19 vaccination clinics. Feedback from the group included that patients had felt able to contribute and they felt listened to.</li> </ul>

#### 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:	
<ul style="list-style-type: none"> <li>Learning and improvement had a strong focus within the service and formed an integral part of the quality assurance processes. There was a culture of learning when things went wrong, and all staff understood the processes for this.</li> </ul>	
Examples of continuous learning and improvement	
<ul style="list-style-type: none"> <li>The integration of the enhanced care team to provide community links with care homes and its patients allowed for a prompt response for patient concerns from care home staff. It also allowed the patients GP to personalise care to individuals to help improve health and quality of life.</li> <li>Feedback from patients and staff about difficulties accessing the service by phone led to a new phone system being installed. The new system allowed the better monitoring of phone call traffic</li> </ul>	

in and out of the service. This means the practice could see where to better allocate staffing to manage busy periods.

#### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

#### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **\*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.