

Care Quality Commission

Inspection Evidence Table

Dr M Aslam's Practice (1-495180256)

Inspection date: 24 June 2021

Date of data download: 14 June 2021

Overall rating: Good

We completed a focused inspection on 12 November 2019. We inspected the key questions effective and well-led, and rated both as requires improvement, due to:

- Performance data was lower for patients with long term conditions and those with poor mental health, and exception reporting was high for some areas.
- Governance systems were not effective. Improvements were required in relation to quality improvement activity, performance monitoring, recruitment processes, learning from complaints and identification of risks.

We did not inspect the key questions safe, caring and responsive, and these carried over their previous good rating from their previous inspection in January 2015. During the November 2019 inspection the provider was rated as requires improvement overall.

We completed this inspection on 24 June 2021. This inspection was a focused inspection, for the key questions safe, effective and well-led. In line with our current methodology, we did not inspect the key questions caring and responsive, which again carried over their good rating from our 2015 inspection.

At this inspection we found:

- Performance data had improved.
- Overall governance systems had been reviewed and strengthened although this was an ongoing process.
- There was a practice commitment to continuous improvement.

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

Safe

Rating: Requires improvement

This key question was not inspected during our November 2019 inspection, however due to a change in process was included during this focused inspection. We found that systems around medicines management, those relating to staff vaccination, monitoring of status of professional registrations and handling of incoming test results required further improvement.

Therefore we rated the provider as requires improvement for providing safe care and treatment.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, some required strengthening.

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.	Partial ¹
Partners and staff were trained to appropriate levels for their role.	Yes ¹
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
<p>¹ Although the policies had been reviewed, they had not taken into account the change in intercollegiate guidance for the safeguarding of children. The change meant that non-clinical staff who, within their role, have contact (however small) with children and young people, parents/carers or adults who may pose a risk to children, should complete as a minimum, level two safeguarding children training. The practice was transitioning over to a new system for all policies and procedures which automatically updated them with any update. Some of the non-clinical staff had not completed their level 2 safeguarding children training, however the practice sent us evidence following the inspection which assured us that the remaining staff now have the appropriate level of training.</p>	

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.	No ¹
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial ²
Explanation of any answers and additional evidence: ¹ Staff recruitment files did not evidence that the practice had checked that staff were vaccinated in line with current PHE guidance. Following the inspection the practice told us that their system had been reviewed to include this. ² The practice told us that clinical staff registration was checked on recruitment and then yearly. However, they did not formally document this, therefore they could not provide assurance that this was done. Following the inspection they told us that they had reviewed the process and would be completing periodic recorded spot checks.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: June 2021	Yes
There was a record of equipment calibration. Date of last calibration: 19 August 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 ¹
A fire risk assessment had been completed. Date of completion: 12 February 2021	Yes
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence: ¹ The fire procedure took into account those patients and staff who may have a visual or auditory impairment as well as wheelchair users.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 24 June 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10 April 2020	Yes
Explanation of any answers and additional evidence:	

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:	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
Explanation of any answers and additional evidence:	

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
Explanation of any answers and additional evidence:	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. Although, systems related to handling tests results required strengthening.

	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.	Partial ¹
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>¹ When we accessed the provider's clinical system we found there were over 200 outstanding pathology results. We alerted the provider to this and found throughout the day that this number reduced significantly as the provider took immediate action. The provider sent further evidence at a later date which assured us that action had been taken to deal with outstanding pathology results. We reviewed the protocol for monitoring of diagnostic tests; there was no mention of buddying or annual leave arrangements. The provider told us that they would be reviewing the system relating to test results to ensure that this did not occur again.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, some systems required review of their effectiveness and strengthening.

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.81	0.70	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	7.1%	10.4%	10.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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 (01/10/2020 to 31/03/2021) <small>(NHSBSA)</small>	6.66	5.89	5.37	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) <small>(NHSBSA)</small>	181.8‰	113.6‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) <small>(NHSBSA)</small>	0.83	0.77	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>	13.2‰	6.9‰	6.7‰	Variation (negative)

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
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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial ¹
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.	Partial ¹
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

Medicines management	Y/N/Partial
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial ²
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.	No ³
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>¹ We completed a series of high level clinical system searches and found that, some patients were able to request repeat prescriptions without the prescriber checking that the necessary monitoring tests had been completed and that the medication dosage was appropriate. We reviewed the records of 15 patients prescribed four different medicines which all require monitoring tests to be completed on a regular basis. We found that for 12 of the 15 patients, records showed that monitoring was out of date. 12 of the 15 did not evidence that the prescriber had checked whether monitoring was up to date prior to issuing a repeat prescription. The impact of continued prescribing without the patient receiving the appropriate monitoring, or the prescriber checking the levels, is that some medicines can impact on the functioning of other systems in the body, such as kidney function, and if testing shows changes then the medication dosage may need altering.</p> <p>Following the inspection, the practice told us that they had recruited an in house pharmacist and that they and the clinical team, were working to review patients in line with current medicines guidance. We received evidence that gave us assurance this was taking place.</p> <p>For another medication, searches showed that a specific calculation had not been completed to check that the patient was on the correct medicine dosage. The search told us that out of 141 patients, 114 may not have had this level calculated. We reviewed three patient records in detail and found that the specific calculation was not documented in the record of any of the three patient's records. We calculated the dosage and found that all three were on the correct dosage, therefore there was no harm to the patients whose records we viewed. However, it was not clear if the calculation had been completed for the other 111 patients but not documented in the record, or whether this had not been completed at all. The impact of non calculation is that potentially patients might be receiving higher than recommended doses of the medication in relation to their renal function. The practice looked into the issue after the inspection, they revisited each patient's record manually and ran the template embedded within the clinical system to complete and record the calculation. The practice also spoke with the helpdesk for the template provider to resolve the administrative side of the issue, to help mitigate the issue from reoccurring. They provided us with assurance that this had been completed and that the calculations had been completed for all relevant patients.</p> <p>For some medicines that were subject to a shared care agreement, it was not clear on the record if the prescriber had checked monitoring tests were satisfactory or that appropriate action had been taken if the tests indicated an issue. There were 14 patients prescribed Warfarin, we reviewed five records in detail and found that four out of the five did not have a recent International normalised ratio (INR) recorded in the patient record. For those four patients there wasn't clear evidence in the records that</p>	

Medicines management	Y/N/Partial
<p>the prescriber had checked that the monitoring was up to date prior to issuing the repeat prescription. The checking of INR monitors the effectiveness of the medicine for that patient, therefore if this not completed or checked then the dosage level may be ineffective. Following our inspection the practice told us that they had rerun the searches completed by CQC and were working through each patient to update the blood test results. They told us the searches would subsequently be run fortnightly to monitor progress.</p> <p>² Prescribing of medication for uncomplicated urinary tract infections was slightly higher than averages. The practice told us that they met regularly with the local medicines management team to discuss the practice performance. They told us that they were able to contact the team for advice and support.</p> <p>³ The practice held a small amount of emergency medicines, there were no risk assessments in place for those that were not held. The practice told us that they would be completing risk assessments for those medicines not held.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
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:	11
Number of events that required action:	11
<p>Explanation of any answers and additional evidence:</p> <p>A significant events log was kept and a review of incidents took place to see if a similar incident had reoccurred, or whether mitigating measures had been successful.</p>	

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

Event	Specific action taken
<p>Patient called the practice and was offered a call back. Call back did not occur and the patient was admitted to hospital.</p>	<p>The incident was discussed with staff. The patient was contacted. Reception staff were advised to tell patients that if they have not received a call back (when expected) by 4pm to ring the practice again. Clinical staff were reminded to check before they finish work that all required tasks or actions had been completed.</p> <p>Staff were also reminded to check that the correct contact details were on record.</p> <p>The actions had a review date.</p>
<p>A ceased opiod was accidentally put on an acute prescription from a repeat, however was noted by the signing GP,</p>	<p>The incident was discussed with the relevant member of staff.</p> <p>The practice protocols were changed to state that non-clinical staff are never to issue certain medicines on acute</p>

therefore amended prior to harm occurring.	prescriptions (although the prescription will always be signed by an authorised prescriber). Staff were reminded if they were unsure of something to always ask. An audit was completed to check how many other prescriptions were issued from an acute prescription by the relevant member of staff and the above action was the outcome. The actions had a review date.
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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: We saw examples of actions taken on alerts, which satisfied us that there was a system in place.	

Effective

Rating: Good

At our inspection in November 2019, we rated this practice requires improvement for providing effective care for patients because:

- Although there was some quality improvement activity occurring there was limited evidence that it was used to improve the service.
- The practice had no staff records, including training records, relating to a healthcare assistant that they outsourced from another provider.

We rated patients with a long-term condition and people experiencing poor mental health as requires improvement because:

- Performance relating to the level of cholesterol measured in patients with diabetes was lower than local and national averages and had been since 2015.
- Performance for mental health indicators was lower than local and national averages and had been since 2015.

During this inspection we found that training records for all staff were kept. Performance had improved for the areas measured by quality and outcomes framework (QOF). Some of these areas measured had changed since our previous inspection. There was quality improvement activity linked to performance, incidents and feedback occurring that involved all staff to some extent.

We therefore rated this practice as good for providing effective care and treatment.

Effective needs assessment, care and treatment

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

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

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual 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 and Pharmacists 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.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.9%	76.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	3.8% (22)	6.7%	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) <small>(QOF)</small>	90.9%*	91.3%	89.4%	No statistical variation
PCA rate (number of PCAs).	3.8% (7)	7.9%	12.7%	N/A

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) <small>(QOF)</small>	84.0%	79.6%	82.0%	No statistical variation
PCA rate (number of PCAs).	4.1% (7)	3.7%	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) <small>(QOF)</small>	62.4%	66.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	4.2% (17)	9.2%	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) <small>(QOF)</small>	75.1%	71.1%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.2% (39)	4.4%	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) <small>(QOF)</small>	91.6%	92.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	9.8% (9)	3.3%	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) <small>(QoF)</small>	79.6%	75.8%	75.9%	No statistical variation
PCA rate (number of PCAs).	4.2% (17)	7.5%	10.4%	N/A

Any additional evidence or comments

At our last inspection we identified that for a diabetes indicator relating to managing cholesterol levels, performance had been lower than average since 2015. This indicator is no longer used therefore we cannot compare with previous data. Diabetes care generally, according to the indicator currently used, was in line with national and local averages.

We also identified during that inspection, that 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, was lower than average. Performance in this area had improved from 78.6% (year 2018/2019) to 90.9% (year 2019/2020) and is in line with national and local averages.

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for four of five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the five childhood immunisation uptake indicators. Where children did not attend for an immunisation, the practice nurse called the child's parent/carer and discussed with them the importance of immunisation, inviting them to participate with the programme and offering them an appointment at the surgery. Concerns regarding vaccinations and possible side effects were discussed and parents reassured. Following this call any refusal from the parent/carer would be recorded in the clinical system and a letter from the child's parent/carer stating the reason for refusal added into the child's records. Concerns regarding vaccinations and possible side effects are discussed and parents reassured.
- 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)	80	86	93.0%	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)	87	94	92.6%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	87	94	92.6%	Met 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)	87	94	92.6%	Met 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)	77	88	87.5%*	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

*The percentage of children receiving was lower than the 90% Public Health England target. We saw evidence that the practice had a plan in place to improve performance for this indicator.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Eligible patients to have the meningitis vaccine, attending the practice for other issues were opportunistically offered the vaccination.
- 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 (although this had been paused during the COVID-19 pandemic) 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: 31/12/2020) (Public Health England)	58.9%*	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)	55.6%	64.2%	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)	47.5%	60.6%	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)	94.0%	90.5%	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)	35.7%	54.7%	54.2%	No statistical variation

Any additional evidence or comments

*The performance for cervical screening was below the 70% uptake rate. Performance had slightly improved from 2017 to 2020. The practice was aware of lower performance and discussed this in meetings and how they were going to improve this.

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 reviewed young patients at local residential homes.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- At our inspection in November 2019 we found that the number of patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses, who had an agreed documented care plan in their record and whose alcohol consumption had been recorded was much lower than average. During this inspection, we found that data for agreed care plans had improved from 10.5% to 89.1%. Recording of alcohol consumption is no longer an indicator used, therefore we were unable to review the practice performance for this.
- Where reviews had taken place, we found that 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had close links with the local Dementia specialist nurse. The practice supplied a clinic room for the Dementia specialist nurse to run a weekly clinic, for patients of all local practices not just their own.
- The lead GP and the Dementia Specialist nurse had ongoing discussions about patients, shared knowledge and best practice, to improve the care offered to patients. The lead GP and the Dementia specialist nurse completed joint reviews of patients that were difficult to engage.

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>	89.1%	79.0%	85.4%	No statistical variation
PCA rate (number of PCAs).	9.8% (10)	11.6%	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>	92.1%	81.4%	81.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	1.1% (1)	7.4%	8.0%	N/A

Any additional evidence or comments

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)	527.7	533.9
Overall QOF score (as a percentage of maximum)	94.4%	95.5%
Overall QOF PCA reporting (all domains)	4.2%	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

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice had a range of topics which they discussed in clinical meetings including cervical screening, and diabetes. They reviewed current performance and what was required to maintain and/or improve performance including challenges to improved performance. A number of audits had been completed such as an end of life care audit and one relating to non-steroidal anti-inflammatory drugs (NSAIDs). The NSAID audit focused on nonselective NSAID issued in the last 6 months without co-prescription of a Proton Pump Inhibitor (PPI) and for patients in the gastrointestinal risk group (and no NSAID risk assessment in the last six months). They identified 36 patients within the criteria who had not been co-prescribed an ulcer healing medication. The practice plan going forward was to run the audit on a six monthly cycle to see if there had been an improvement in the number of patients within this category. The practice felt that by implementing use of a monitoring and risk assessment clinical tool at the practice, they now had a comprehensive system in place to prompt the clinical team to take the necessary actions and interventions appropriate to the management and safe prescribing of patients who are prescribed NSAIDs.

Any additional evidence or comments

At our previous inspection in November 2019, we found that although some quality improvement activity was taking place there was not an effective system to use information to drive improvement. During this inspection, we found that there was a system in place for quality improvement. Quality improvement activity was discussed within the various practice meetings.

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.	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: At our previous inspection in November 2019, we found that the practice outsourced a health care assistant from another provider. The practice did not maintain a record relating to this member of staff, although the practice was involved in assessing competency. During this inspection we found that where staff had been recruited by the practice, appropriate training and competency records were held.	

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:	

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:	

Any additional evidence or comments

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:	
The practice had completed an advance care planning and DNACPR audit in June 2021. They found that when DNACPR status forms were completed that a preferred place of care and preferred place of death review was also completed. The audit also showed the practice that they were interacting with community matrons, district nurse, care home staff and the palliative care teams as part of the review of patient care.	

Well-led

Rating: Good

At our inspection in November 2019, we rated the practice as requires improvement for providing well-led care because:

- The systems in place for overseeing the quality of care provided were not effective. In particular some patients with long-term conditions or those who were experiencing poor mental health.
- The systems in place for reviewing, investigating and acting on patient feedback, including complaints, were not consistent. There was limited analysis of themes and trends of patient feedback.
- Governance and clinical oversight required strengthening. There was a lack of quality improvement activity and performance management.

During this inspection we found that overall governance systems and oversight had been strengthened. There was a structure in place which focused on learning from feedback. There were still areas that required further review however the practice was responsive and keen to embed stronger, sustainable governance systems.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: At our last inspection we found that there was no formal succession plan or named successor in place. The practice manager told us that they had a rapid turnover of staff, who were leaving to pursue roles with fewer demands. During this inspection we found that there was a succession plan in progress. The practice had recruited a number of staff from a care home that had closed. The staff brought a wealth of experience and a different perspective to the practice, which the leadership team used effectively.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes

Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: At our last inspection we found that the practice manager had a clear overview of how their different work streams and ideas of how to improve efficiencies. However, we found that monitoring was not always effective. During this inspection we found that there was a structure in place that enabled the monitoring and review of strategies in place to improve the care. Staff were enthusiastic to provide good care and keen to learn new skills to support this.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial ¹
Explanation of any answers and additional evidence: During our last inspection, we found that there was an inconsistent structure in place for complaints handling and a lack of evidence of how complaints were shared and used in quality improvement work. At this inspection we found that complaints were handled in line with NHS complaints resolution guidance and discussed within practice meetings. We saw evidence of these meetings. During our last inspection we found that not all staff have received training in equality and diversity, at this inspection we found that two clinical and two non-clinical had not received this training.	

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

Source	Feedback
Staff	Staff told us that they felt able to raise concerns and share ideas.

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.	Partial ¹
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2019, we found that where some responsibilities had been delegated, there was limited oversight from leaders, that required actions were being completed. Some members of staff had left the practice and their responsibilities had not been reallocated. During this inspection we found that staff were clear and knowledgeable about their roles and responsibilities. There was appropriate oversight from managers.</p> <p>¹ Some of the clinical governance systems to date had been based on a single handed GP, and did not always reflect buddying or leave arrangements. The management team at the practice, including the lead GP, had all had periods of absence (in some instances extended) from the practice in the early part of 2021. The local clinical commissioning group had stepped in to help find staff to support the practice. Some of the areas identified within safe as requiring strengthening, are present due to gaps or weakness within those policies and procedures. We identified these areas to the practice during our onsite inspection and in feedback following the inspection. The practice responded by informing us the actions they were taking, or had already taken, to strengthen these, which provided us with the necessary assurance.</p> <p>We recognise the difficulties that this practice experienced and it is testament to the governance structures and staffing that overall the practice has managed to continue to provide an effective service, despite the leadership not being present for parts of the year. Not only that but the practice has improved upon their performance in many areas since our last inspection.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>¹ At our last inspection in November 2019, we found that the assurance systems in place were not fully effective, as it was difficult to see where changes had been made. There was limited audit activity in</p>	

place and it was not possible to see if audit led to improved outcomes for patients. There were some systems in place to manage risk, however, we were not assured on the day of inspection, that risks raised within complaints and other feedback from patients, would be fully identified and mitigating action taken, as there was a lack of evidence that where learning had been identified, this had been shared and actioned.

During this inspection we found that the practice had implemented a system to review and monitor areas of lower performance. Where risks were identified they were managed and learnt from, in order to mitigate the chance of them occurring again. These risks were also reviewed to ensure that they had not reoccurred or to understand why, if they had.

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
Explanation of any answers and additional evidence:	

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:	

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
Explanation of any answers and additional evidence:	

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 ¹
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:	
¹ The practice told us that they wanted to increase the amount of patients within the group.	

Feedback from Patient Participation Group.

Feedback
The Patient Participation Group (PPG) only had two members at the time of our inspection. We spoke to one member who told us that regular meetings were held with the practice either on the phone, or face to face. During the meetings, complaints themes, issues relating to COVID-19, access, staffing updates and how the PPG could support the practice to improve services, were all discussed. They felt that the practice was doing all they could throughout the pandemic.

Any additional evidence

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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: At our last inspection in November 2019, we found that there was limited evidence that learning from complaints and significant events had been disseminated. During this inspection we viewed meeting minutes which evidenced that these were now discussed.	

Examples of continuous learning and improvement

Throughout our inspection and through talking to staff, it was clear that the practice encouraged staff to develop themselves and areas of interest. Staff were enthusiastic and committed to continuous improvement. They told us that managers supported them to learn new skills. Since our last inspection, the practice attitude towards feedback had shifted and it was now used as an ongoing monitoring and improvement tool.

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](#)).
- ‰ = per thousand.