

Care Quality Commission

Inspection Evidence Table

Briton Street GP Surgery (1-4057869524)

Inspection date: 15 July 2021

Date of data download: 25 June 2021

Overall rating: Good

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

Safe

Rating: Requires Improvement

At our previous inspection in 2019 we rated the practice as inadequate for providing safe services because:

- There were not adequate systems and processes to manage medical emergencies.
- Processes to monitor high risk medicines did not provide assurance that safety was routinely maintained.

At this inspection we have rated the practice as requires improvement for providing safe services because:

- We saw that systems had improved around the practice's process for managing medical emergencies.
- We saw evidence of systems to support monitoring for some high-risk medicines however we found that not all monitoring of medicines was up to date at the time of our inspection. During our inspection, the provider took action in response to the issues we identified.
- Remote searches of the practice clinical system also highlighted potential missed diagnoses of patients with diabetes and chronic kidney disease.
- Although medication reviews had been completed, they were not always structured formal medication reviews and we found evidence of some patients who were prescribed combinations of medicines which were not advised.

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|--|----------------|
| There was a lead member of staff for safeguarding processes and procedures. | Y ¹ |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |

| Safeguarding | Y/N/Partial |
|---|----------------------|
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| Staff who acted as chaperones were trained for their role. | Y ² |
| 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. | Partial ³ |
| Explanation of any answers and additional evidence: | |
| <ol style="list-style-type: none"> 1. The practice lead GP supported by a non-clinical lead supervisor for safeguarding concerns who held regular internal meetings about all patients with safeguarding concerns. Staff within the practice were aware they could go to the non-clinical lead or to the safeguarding lead with concerns about patients. 2. There was evidence of staff completing chaperone training. The practice's chaperone policy did not direct to where chaperones should stand in relation to the procedure they were observing but staff were able to describe where they would stand. 3. Multi-agency meetings to support and protect adults and children at risk of significant harm had been postponed during the pandemic and had not reconvened at the time of the inspection. The practice advised they were planning to reinstate these meetings when COVID-19 restrictions were lifted. Practice staff informed us that they would liaise with any external healthcare colleagues should issues arise. The practice had a system of regularly reviewing patients with safeguarding concerns and documenting any discussions on the patient record to ensure that other health and social care professionals would be able to see the discussions and actions planned for these individuals. | |

| Recruitment systems | Y/N/Partial |
|---|--------------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Y |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |
| Explanation of any answers and additional evidence: | |

| 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: 24/03/2021 | Y |
| There was a record of equipment calibration. Date of last calibration: 23/02/2021 | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| A fire risk assessment had been completed. Date of completion: 25 th March 2021 | Y |
| Actions from fire risk assessment were identified and completed. | Y |
| Explanation of any answers and additional evidence: | |

| Health and safety | Y/N/Partial |
|---|--------------------|
| Premises/security risk assessment had been carried out. Date of last assessment: March 2021 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2021 | Y |
| 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. | Y |
| Staff had received effective training on infection prevention and control. | Partial ¹ |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2021 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| There was a system to notify Public Health England of suspected notifiable diseases. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| Explanation of any answers and additional evidence: | |
| <p>We saw evidence of training for most staff however we were not able to see training for a locum nurse in relation to infection prevention and control. We were told this was due to an issue with the bluestream training platform. There was no evidence that the locum nurse had completed infection control training upon starting employment with the practice.</p> | |

Risks to patients

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

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

| | Y/N/Partial |
|--|----------------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Partial ¹ |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | N ² |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. There was a system for managing pathology results however we found evidence that some results which required action had not been dealt with in a timely manner. The registered manager took remedial action to address this. 2. We found evidence of one incident where correspondence had not been sent to the appropriate clinician to deal with. We saw a significant event had been created for this and learning had been documented and shared with the team. We carried out a clinical review of patients on medicines and found evidence of: <ul style="list-style-type: none"> • 19 patients whose pathology results indicated potential diabetes • 10 patients whose pathology results indicated potential CKD <p>The practice immediately reviewed the findings and took the necessary actions to ensure safety and follow ups were arranged where appropriate. We saw evidence that patients had been apologised to where necessary.</p> <p>The practice has a process for managing 2 week wait referrals. Records we sampled showed 2 week wait referrals being done in accordance with NICE suspected cancer guidance and that there was a system for the practice to monitor that patients had been seen within the 2 week timeframe.</p> | |

Appropriate and safe use of medicines

| 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) | 0.39 | 0.59 | 0.70 | Variation (positive) |
| 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) | 16.7% | 10.0% | 10.2% | Tending towards variation (negative) |
| 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) (NHSBSA) | 4.26 | 4.73 | 5.37 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA) | 176.6‰ | 88.7‰ | 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) (NHSBSA) | 0.26 | 0.86 | 0.66 | Variation (positive) |

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

Any additional evidence or comments

The practice were higher than average prescribers for some antibiotics. The clinical lead had reviewed this and had found this was due to trainee doctors who had been used to prescribing these in hospital settings. The trainee doctors were trained on the local formulary and a process was put in place to ensure all antibiotic prescribing was reviewed by the clinical lead. Records that we reviewed showed that prescriptions for these medicines had been issued by trainee doctors, the extended access service and following advice of a hospital consultant.

| Medicines management | Y/N/Partial |
|---|----------------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Partial ¹ |
| 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 ² |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Partial ³ |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | 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. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | N/A |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> At the time of our inspection there was no formal process for supervision, however management informed us that there were informal conversations to support clinicians however these were not documented. Staff we spoke with were comfortable to speak with management or the lead clinician to support with their decisions. The practice had a process for safely handling requests for repeat prescriptions however we were told that formal structured medicine reviews were not in place at the time of our inspection. | |

| Medicines management | Y/N/Partial |
|---|-------------|
| <p>We found that medication reviews had been done however we found evidence of patients being prescribed combinations of medicines which had been advised against in safety alerts. For example, we found evidence of patients who had been prescribed clopidogrel and omeprazole together.</p> <p>3. We found examples of monitoring for some high-risk medicines, however we found evidence that some monitoring was overdue for certain medicines. For example;</p> <ul style="list-style-type: none"> • 11 patients prescribed medicines for lowering patients' blood pressure had not had appropriate monitoring as expected by NICE guidance. <p>The registered manager told us they had reviewed these patients immediately and reviewed medicines which were prescribed.</p> | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Y |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | 6 |
| Number of events that required action: | 6 |
| Explanation of any answers and additional evidence: | |

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|-------------------|--|
| Delay in referral | Practice implemented a system to check on patient referrals to ensure that they are received by secondary care. Also updated hospital information to ensure they had current contacts for departments. |
| Medicine error | Support given to trainee doctors to ensure they prescribe the correct formulations of products. |

| Safety alerts | Y/N/Partial |
|---|----------------------|
| There was a system for recording and acting on safety alerts. | Partial ¹ |
| Staff understood how to deal with alerts. | Y |

Explanation of any answers and additional evidence:

We found a process was in place to record and action appropriate safety alerts which had been implemented since July 2020. It was not clear if there were any processes in place before this and if historical safety alerts had been acted on. We found evidence of patients who were prescribed combinations of medicines who had not been reviewed in line with previous safety alerts.

Effective

Rating: Good

At the previous inspection in 2019 we rated the practice as requires improvement for providing effective services because:

- Quality Outcomes Framework (QOF) data was below local and national averages for patients with long term conditions meaning the practice was performing lower in certain areas for treating patients receiving treatment for long term conditions.
- Uptake of childhood immunisations was consistently below the minimum 90%.

At this inspection we have rated the practice as good for providing effective services because:

- The practice was able to demonstrate improvements in the management of patients with long term conditions.
- Unverified data provided by the practice showed improvement in three of the four childhood vaccinations which were previously below the 90% average.

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">• Adjustments had been made to support patients, for example, longer appointments were offered to patients with complex needs.• The practice had access to Language Line and interpreters and had devised leaflets in multiple languages to ensure relevant guidance and information was available to patients whose first language was not English.• All staff, including administration, had undergone training on a range of illnesses for them to be aware of including sepsis awareness. | |

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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 medicine 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

- There was evidence of improvement in areas of QOF for example COPD outcomes had improved from 71% in 2019 to 100% in 2020. Following the inspection, the practice provided us with up to date unverified data for QOF in August 2021 which showed improvements for diabetes and hypertension.
- We saw evidence that medication reviews were done for patients receiving regular medicines however these were not structured annual reviews. The registered manager told us that the practice was in talks with the Primary Care Networks (PCN) for the possibility of pharmacist support to undertake these in the future.
- 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.
- Staff, including administration staff, had completed training on a number of conditions including atrial fibrillation, cancer, diabetes and epilepsy.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- 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 | 84.5% | 76.9% | 76.6% | No statistical variation |

| | | | | |
|--|----------|-------|-------|--------------------------------------|
| RCP questions. (01/04/2019 to 31/03/2020) (QOF) | | | | |
| PCA* rate (number of PCAs). | 1.7% (1) | 5.7% | 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) (QOF) | 100.0% | 89.7% | 89.4% | Tending towards variation (positive) |
| PCA rate (number of PCAs). | 0.0% (0) | 9.3% | 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) | 75.8% | 82.5% | 82.0% | No statistical variation |
| PCA* rate (number of PCAs). | 0.0% (0) | 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) (QOF) | 51.3% | 67.7% | 66.9% | Tending towards variation (negative) |
| PCA rate (number of PCAs). | 1.9% (3) | 10.4% | 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) | 52.7% | 73.2% | 72.4% | Variation (negative) |
| PCA rate (number of PCAs). | 2.4% (6) | 4.6% | 7.1% | N/A |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF) | 88.9% | 93.6% | 91.8% | No statistical variation |
| PCA rate (number of PCAs). | 0.0% (0) | 3.4% | 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) | 47.4% | 73.5% | 75.9% | Significant Variation (negative) |
| PCA rate (number of PCAs). | 1.9% (3) | 6.9% | 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

We reviewed QOF with the registered manager who was aware of the lower results reported.

The practice acknowledged the low results for blood pressure reviews for patients which were overdue and thought this was due to a lack of nurses at the surgery. Following the inspection, the practice told us they had employed locum nurses to support the practice to assist with these appointments and offered a number of clinics through the week. The practice implemented systems to contact patients who were due monitoring and encourage patients to attend the surgery. We saw unverified data for patients aged 70 or under with hypertension in whom the last blood pressure reading was 140/90mmHg or less where the practice were achieving 82.2% (PCA rate 3.3% - 8 patients) which higher than the local and national averages.

The practice reported difficulties accessing the community diabetes team to refer patients for support to. The practice reported that this relationship had improved and they were reviewing QOF performance following this. Following the inspection we saw unverified data for diabetic patients with diabetes, without moderate/severe frailty in whom the last blood pressure reading was 140/90mmHg or less and where the practice were achieving 84.9% (PCA rate 4.5% - 7 patients) which is higher than the local and national averages.

Findings

- The practice has not met the minimum 90% for four of five childhood immunisation uptake indicators, however the unverified data we reviewed for 2020/2021 results showed improvements and four out of five indicators were now at the required 90%.
- 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) | 20 | 21 | 95.2% | Met 95% WHO based target |
| 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) | 16 | 18 | 88.9% | 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) | 15 | 18 | 83.3% | 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) | 16 | 18 | 88.9% | 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) | 16 | 20 | 80.0% | 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 practice were aware of the childhood immunisation levels being below average. The practice had attempted to improve uptake rates by recalling all children who were due to have immunisations by contacting parents. The practice had also employed a locum nurse to offer appointments for childhood vaccinations.

We saw unverified data from April 2020 to March 2021 which showed:

- 95.2% 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)
- 95.5% of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster)
- 90.9% 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)
- 90.9% of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)

- 83.3% of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)

The unverified data showed improvement in three of the four vaccinations which were previously below the 90% average.

The population of children at the practice are low. The 2021 data we reviewed for children aged 5 who have received immunisation for measles, mumps and rubella was 15 patients out of a possible 18.

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: 31/12/2020) (Public Health England) | 60.4% | 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) | 71.2% | 62.2% | 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) | 44.4% | 50.4% | 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) | 100.0% | 92.1% | 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) | 60.0% | 53.4% | 54.2% | No statistical variation |

Any additional evidence or comments

The practice was aware that cervical screening was low and told us this was due to the COVID-19 pandemic and previous management issues which had been rectified within the practice.

The practice attempted to increase cervical screening uptake rates and had implemented a system to contact all patients with appointments the day before to remind them of the appointment and reduce non-attendances. The practice had offered appointments for cervical screening throughout the pandemic to promote uptake. The locum nurse offered appointments for ladies to attend the surgery with any questions or concerns before having cervical screening to try and promote uptake.

Following the inspection, the practice told us that they had employed locum nurses to offer smear clinics throughout the week to improve uptake rates. The practice implemented systems to contact patients who were due monitoring and encourage patients to attend the surgery. The practice had identified that there were incorrect coding for patients which was updated.

The practice provided us with up to date unverified data which showed that the uptake rate for smears within the practice in August 2021 was 81.8% and therefore above the 80% target rate. Some patients had reported they did not want to attend the surgery for cervical screening due to COVID 19.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice had devised a bereavement support leaflet signposting bereaved individuals to specialist services and support in the local area.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- The practice used to hold Gold Standards Framework meetings to discuss patients on the palliative care register, but these had not happened for the last 18 months as a result of the COVID-19 pandemic. We saw evidence of patients care being discussed with other healthcare professionals when necessary.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. We saw evidence of patients having discussions about their wishes and preferred place of care documented within patient records.
- The practice had access to RESPECT forms to support patients with end of life care planning.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Patients were signposted to other services for support (e.g. IAPT for counselling/psychotherapy). The practice website included links to resources to support patients.
- We saw evidence of patients who were regularly reviewed who were experiencing poor mental health. We saw that the practice worked with other agencies to improve patient's mental health outcomes.
- 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 awareness training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|---|-----------|-------------|-----------------|--------------------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 61.5% | 84.3% | 85.4% | No statistical variation |
| PCA* rate (number of PCAs). | 18.8% (3) | 11.3% | 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> | 100.0% | 83.8% | 81.4% | Tending towards variation (positive) |
| PCA rate (number of PCAs). | 0.0% (0) | 8.1% | 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 |
|-------------------------------------|
| |

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

| Indicator | Practice | England average |
|--|----------|-----------------|
| Overall QOF score (out of maximum 559) | 464.9 | 533.9 |
| Overall QOF score (as a percentage of maximum) | 83.2% | 95.5% |
| Overall QOF PCA reporting (all domains) | 4% | 5.9% |

| | Y/N/Partial |
|--|-------------|
| Clinicians took part in national and local quality improvement initiatives. | Y |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Y |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Y |

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

1. The practice had completed a two cycle audit of prescribing for cellulitis. The second cycle identified that 100% of patients had been prescribed medicines appropriately in line with local prescribing guidance. Evidence was seen to show that all the GPs had confirmed that they had read the local antibiotic prescribing guidelines.
2. The practice completed other quality improvement activities including a two cycle audit on osteoporosis. This looked at improving prescribing of calcium and Vitamin D to patients at risk of osteoporosis.

Effective staffing

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

| | Y/N/Partial |
|---|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Partial |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| Explanation of any answers and additional evidence: | |
| <p>The practice did not employ any prescribing clinical staff. The PCN pharmacist prescribing was supervised by the PCN. Practice management and staff we spoke with described informal means of support for staff, such as staff calling and asking for help when needed and management having an 'open door policy'. Everyone we spoke with described this as positive and effective.</p> | |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| Explanation of any answers and additional evidence: | |
| <p>The practice used to hold monthly multi-disciplinary team and meetings and monthly Clinical Lead meetings, attended by health visitors, primary care network staff and the social prescriber, as well as guest speakers from the community to discuss their roles and the support they could offer. However, these were not occurring at the time of the inspection due to the COVID-19 pandemic. Due to this,</p> | |

information was shared with other healthcare professionals via MS teams, email or phone call where necessary. The practice had means of contacting relevant external health professionals, for example contacting district nurses via referral forms and the palliative care specialist at the hospice via phone. We saw evidence within patient records of communication with district nurses and palliative care input (for example to organise anticipatory drugs for patients at end of life).

Helping patients to live healthier lives

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

| | Y/N/Partial |
|--|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Y |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Y |
| Patients had access to appropriate health assessments and checks. | Y |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Y |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had access to a social prescriber and a care navigator who could signpost patients to services (e.g. benefits advice). • The practice had an inhouse PCN physiotherapist who could support patients with musculoskeletal problems. • The practice could signpost patients to other services for support such as IAPT for counselling or psychotherapy. The practice website included links to resources to support patients. | |

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Y |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Y |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Y |
| Explanation of any answers and additional evidence: Staff were aware of mental capacity guidance and Gillick competencies and had received training in this area. Evidence was seen during the records review of patients' mental capacity being assessed and documented when making DNACPR decisions. | |

Well-led

Rating: Good

At the previous inspection in 2019 the practice was rated as requires improvement for providing well-led services because:

- The practice received a breach of regulation 17 due to the system for managing test results did not provide assurance that patients were always protected.
- There was limited evidence to demonstrate a systematic programme to monitor quality or a holistic understanding of performance.

At this inspection we rated the practice as good for well led because:

- A system had been implemented to manage test results and so the previous breach of regulation 17 was now met.
- A new management structure had been implemented at the surgery, which included new systems and processes to monitor quality and performance.

Leadership capacity and capability

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

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The registered manager and practice management had future plans for the service to ensure quality and sustainability.• The practice had adapted to patient demand during the COVID-19 pandemic by increasing telephone consultation support. | |

Vision and strategy

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

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

| | |
|---|---|
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| Explanation of any answers and additional evidence: | |

Culture

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

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

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

| Source | Feedback |
|------------------|---|
| Staff interviews | Staff reported that they felt supported and that the management team are accessible if there were any issues. Staff were positive about the management structure which had been implemented. |

Governance arrangements

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

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence: | |

- Practice policies and procedures were made accessible to staff and were developed with an external consultancy who provide governance support and template policies.
- The practice had a new practice management team in place who were experienced in helping to improve governance and planning. There were regular meetings between the registered manager and practice management to discuss governance issues.

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. | Partial |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence: | |
| We saw evidence of some assurance systems in place, however there were some issues found regarding clinical care of patients which the practice systems had not identified. | |

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

| | Y/N/Partial |
|---|-------------|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic. | Y |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Y |
| There were systems in place to identify and manage patients who needed a face-to-face appointment. | Y |
| The practice actively monitored the quality of access and made improvements in response to findings. | Y |

| | |
|--|---|
| There were recovery plans in place to manage backlogs of activity and delays to treatment. | Y |
| Changes had been made to infection control arrangements to protect staff and patients using the service. | Y |
| Staff were supported to work remotely where applicable. | Y |
| Explanation of any answers and additional evidence: During the pandemic the practice had reviewed guidance and local advice and made changes to the layout, infection prevention and control and the way patients were triaged and seen within the practice. There had been support from the CCG and PCN and management had made changes in a supportive way involving all staff. | |

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. | Partial |
| Performance information was used to hold staff and management to account. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |
| Explanation of any answers and additional evidence: We saw evidence of the practice monitoring performance however they were unaware of some coding issues that were found as part of our inspection. Staff rectified issues which were found immediately. | |

Governance and oversight of remote services

| | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |
| Patients were informed and consent obtained if interactions were recorded. | Y |

| | |
|--|---|
| The practice ensured patients were informed how their records were stored and managed. | Y |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Y |
| Online consultations took place in appropriate environments to ensure confidentiality. | Y |
| The practice advised patients on how to protect their online information. | Y |
| Explanation of any answers and additional evidence: | |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| Explanation of any answers and additional evidence: | |

Feedback from Patient Participation Group.

Feedback

The practice had a PPG group which was combined with the provider's nearby surgery. Although meetings had not taken place through the COVID-19 pandemic, we saw evidence of a newsletter being sent to members to keep them updated with changes and updates within the practice.

Any additional evidence

Access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

Y/N/Partial

| | |
|---|---|
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages). | Y |
| Patients were able to make appointments in a way which met their needs. | Y |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online). | Y |
| There were systems in place to support patients who face communication barriers to access treatment. | Y |
| Patients with urgent needs had their care prioritised. | Y |
| The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. | Y |
| Explanation of any answers and additional evidence: | |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020) | 53.5% | N/A | 65.2% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020) | 57.8% | 55.2% | 65.5% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020) | 58.1% | 57.2% | 63.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020) | 56.3% | 65.8% | 72.7% | No statistical variation |

Patients were able to obtain appointments at either of the providers practices to suit them. The practice offered a number of appointment types including telephone and video consultation when appropriate. They had utilized these appointments throughout the pandemic however still offered face to face appointments when this was required for patients.

Although these results are all in line with the local and national data results we have further reviewed the two indicators which were lower than the averages for this years data.

We reviewed the latest published GP patient survey data from 2021 during the inspection. In the 2021 data:

- The number of respondents found it easy to get through to this GP practice had increased to 63% in 2021 from the 53% in the 2020 data report.
- The number of patient of pateints were satisfied with the appointment they were offered had increased to 72% from 56% in the 2020 data report.

In the 2021 data patients were also consistently higher than local and national averages when responding about the choice of appointments offered, the receptionists being helpful and feeling that their needs were met during their last appointment in general practice.

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Y |
| Learning was shared effectively and used to make improvements. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • Monthly practice meetings were held during protected learning time sessions to update staff on any developments, discuss any potential learning from significant events, staffing updates and role responsibilities. | |

Examples of continuous learning and improvement

- The practice had undergone significant change in management whilst also dealing with the changes brought on from the pandemic. Staff told us that throughout this time, improvements and changes they had gone through were implemented sensitively and with thought for the way in which it affected patients and staff.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
-
- ‰ = per thousand.