

Care Quality Commission

Inspection Evidence Table

Hilltops Medical Centre (1-566368759)

Inspection date: 3 August 2021

Date of data download: 27 July 2021

Overall rating: Good

Following a previous focused inspection on 15 October 2019, the practice was rated requires improvement overall and with a rating of requires improvement for providing safe and well led services and a rating of good for providing effective services and for all population groups.

We then carried out a remote review of Hilltops Medical Centre on 9 December 2020. This was undertaken to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in Regulation 12 safe care and treatment as set out in a requirement notice following our inspection in October 2019.

At our remote review on 9 December 2020, we rated the practice as requires improvement overall because:

- There had been insufficient action taken to seek assurance on staff immunity status to reduce the risks to patients and staff.
- A systematic approach to the management and review of medicines safety alerts was lacking.
- The system in place for the management of significant events and complaints to ensure a consistent approach required strengthening.
- Results from the GP National Patient Survey showed patient satisfaction and experience scores were below local and national averages.

At our inspection on 3 August 2021, we found the practice had made improvements and were able to demonstrate:

- A comprehensive system was in place to ensure all staffing groups had a record of the necessary vaccinations in line with national guidance.
- A systematic approach was in place for the safe and effective management of medicines safety alerts.
- The process in place for managing significant events and complaints had improved.
- Whilst data showed patient satisfaction remained lower than local and national averages, the latest results from the 2021 GP National Patient Survey showed patient satisfaction and experience scores had improved when compared with the 2020 data.

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

Safe

Rating: Good

The practice was previously rated as requires improvement for providing safe services because:

- Not all staff members had a record of their vaccinations and immunity status.
- We found some gaps in the system in place to record significant events.
- The system in place to record and respond to safety alerts required strengthening.

During this inspection we found:

- The practice had a comprehensive system in place to ensure a record of all staff members vaccinations and immunity status was maintained.
- The system in place to record and action significant events had improved and was effective.
- The practice had developed a clear system to respond to relevant safety alerts.

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| There was a lead member of staff for safeguarding processes and procedures. | Y |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| Staff who acted as chaperones were trained for their role. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence: Staff had access to safeguarding e-learning modules and all of the staff we spoke with demonstrated an awareness of managing safeguarding concerns. Both clinical and non-clinical staff members had completed safeguarding adults and children training to the appropriate level for their role. | |

| Recruitment systems | Y/N/Partial |
|-------------------------------------------------------------------------------------------------------------|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Y |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had reviewed and updated their staff recruitment and induction procedures. There was a clear system in place to ensure all staff had the necessary recruitment checks in place including DBS checks.</p> <p>The practice had taken steps to ensure both clinical and non-clinical staff members had up-to-date records of vaccinations in line with national guidance.</p> | |

| 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: 23/06/2021 | Y |
| There was a record of equipment calibration. Date of last calibration: 04/12/2020 | 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: 23/06/2021 | Y |
| Actions from fire risk assessment were identified and completed. | Y |

| Health and safety | Y/N/Partial |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 08/07/2021 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 08/07/2021 | Y |
| Explanation of any answers and additional evidence: A Legionella risk assessment was in place and water temperature checks were carried out. | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| There was an infection risk assessment and policy. | Y |
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: | 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: An external contractor collected clinical waste from the practice on a regular basis. | |

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 |

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

| | Y/N/Partial |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

| Indicator | Practice | CCG average | England average | England comparison |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA) | 0.67 | 0.69 | 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) | 10.2% | 10.8% | 10.2% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA) | 5.25 | 5.53 | 5.37 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA) | 95.4‰ | 98.7‰ | 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) | 0.67 | 0.79 | 0.66 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA) | 5.9‰ | 6.9‰ | 6.7‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|---------------------------------------------------------------------------------------------------------------------------------------|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |

| Medicines management | Y/N/Partial |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Y |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | 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. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | 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> <p>From the sample of clinical records we reviewed, we found the practice had a comprehensive system in place for monitoring patients receiving high risk medicines and medicines which required monitoring. A system of clinical coding and alerts enabled the practice to easily and accurately identify patients that were due the required checks prior to medicines being re-authorised and issued.</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: | 38 |
| Number of events that required action: | 15 |
| Explanation of any answers and additional evidence: The practice had recently introduced a new online system to complete and update significant event reporting forms. At the time of our inspection, the practice was in the process of embedding this new way of working into their day to day working. All significant events were discussed and reviewed during weekly practice multi-disciplinary team meetings. The practice had introduced a quarterly review of significant events in order to ensure all actions and follow up activity was completed and the practice identified key trends and themes from significant events. Staff had a good understanding of their role and responsibilities when identifying, recording and acting on significant events. | |

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

| Event | Specific action taken |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient's medicine dosage not updated following discharge from hospital. | A new system was implemented to ensure medication changes in discharge summaries were highlighted and cross referenced when prescribing. |
| Consultation notes added to the incorrect patient record. | A new process of routinely cross-checking at least two lines of information when booking and carrying out patient consultations was introduced. |

| Safety alerts | Y/N/Partial |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence: Following our previous inspection, the practice had introduced a systematic approach to ensure relevant safety alerts were effectively managed and acted on. Safety alerts were discussed and actions reviewed during weekly practice multi-disciplinary team meetings. We saw examples of actions taken on recent alerts for example, regarding sodium valproate. | |

Effective

Rating: Good

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: Clinicians had access to a wide range of clinical templates in line with national guidelines. This information was used to monitor and improve patient care. Senior staff engaged with the local Clinical Commissioning Group (CCG), GP Federation and Primary Care Network (PCN) and used local guidelines. The practice demonstrated how this information was used to plan and review care in order to meet identified needs. (PCNs were introduced across England in 2019 with the aim to create integrated community based health services). | |

Older people

Population group rating: Good

| Findings |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• 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.• Structured annual medicines reviews for older patients were undertaken.• 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 GPs worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- 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) (QOF) | 78.7% | 78.3% | 76.6% | No statistical variation |
| PCA* rate (number of PCAs). | 3.6% (36) | 15.8% | 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) | 70.9% | 87.8% | 89.4% | Variation (negative) |
| PCA rate (number of PCAs). | 6.2% (13) | 17.4% | 12.7% | N/A |

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

| Long-term conditions | Practice | CCG average | England average | England comparison |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-----------------|--------------------------------------|
| The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF) | 83.8% | 78.9% | 82.0% | No statistical variation |
| PCA* rate (number of PCAs). | 8.4% (25) | 6.8% | 5.2% | N/A |
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | 69.3% | 65.6% | 66.9% | No statistical variation |
| PCA rate (number of PCAs). | 15.1% (106) | 17.4% | 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) | 82.4% | 68.3% | 72.4% | Tending towards variation (positive) |
| PCA rate (number of PCAs). | 14.1% (259) | 8.6% | 7.1% | N/A |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF) | 92.0% | 93.8% | 91.8% | No statistical variation |
| PCA rate (number of PCAs). | 2.9% (6) | 3.8% | 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) | 81.0% | 72.8% | 75.9% | No statistical variation |
| PCA rate (number of PCAs). | 10.3% (72) | 14.0% | 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 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The practice held regular meetings to monitor their performance in relation to QOF. During our inspection, we discussed the lower than average performance for 2019/2020 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. The practice told us during this time they did not have a nurse that was trained to carry out COPD reviews and the temporary nurse that was employed had been off work for some time. The practice now uses an online decision support tool to assist with COPD and asthma reviews. The practice now has one practice nurse who is currently in the process of completing training in COPD and their second practice nurse is returning from maternity leave which will create more capacity for COPD checks. It was noted that the PCA rate for COPD reviews was significantly lower than local and national averages.</p> |

Findings

- The practice had met the minimum 90% for five of five childhood immunisation uptake indicators. The practice had met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for three of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England) | 178 | 184 | 96.7% | 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) | 179 | 189 | 94.7% | 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) | 181 | 189 | 95.8% | Met 95% WHO based target |
| 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) | 180 | 189 | 95.2% | Met 95% WHO based target |

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|-------|-----------------|
| 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) | 192 | 211 | 91.0% | Met 90% minimum |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|-------|-----------------|

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

Any additional evidence or comments

In an attempt to increase attendance rates, the practice had plans to implement childhood immunisation clinics to enable parents to choose a suitable time on pre-planned dates for their child's immunisation.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- The practice had introduced a telephone triage system to improve access and ensure patients were assessed by the most appropriate clinician.

| 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: 01/03/2021) (Public Health England) | 74.1% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 71.5% | 70.2% | 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) | 61.6% | 59.2% | 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) | 97.7% | 90.6% | 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) | 54.0% | 57.3% | 54.2% | No statistical variation |

Any additional evidence or comments

The practice had plans over the coming months to implement and promote cervical screening clinics in an attempt to reduce non-attendance to appointments and enable patients to book appointments online for cervical screening. The practice told us their QOF cervical screening score for 2020/21 as of 31 March 2021 was 79.96% achievement. The practice was continuing to run regular searches and contact relevant patients to encourage them to attend screening for cervical cancer.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

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

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------|-----------------|--------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | 74.3% | 80.3% | 85.4% | No statistical variation |
| PCA* rate (number of PCAs). | 18.7% (17) | 27.2% | 16.6% | N/A |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | 79.3% | 80.3% | 81.4% | No statistical variation |
| PCA rate (number of PCAs). | 4.3% (6) | 11.6% | 8.0% | N/A |

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

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) | 542.5 | 533.9 |
| Overall QOF score (as a percentage of maximum) | 97% | 95.5% |
| Overall QOF PCA reporting (all domains) | 6.3% | 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 |

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

The practice used information about care and treatment to make improvements. For example, the practice had undertaken a quality improvement project on the management of patients with a long term condition. Data from the initial audit showed the process of arranging multiple patient appointments throughout the year for different conditions was not the most effective way of managing these patients. The practice changed the system and adopted a more proactive approach which included the development of one stop clinics for patients to attend an extended appointment with a multidisciplinary team. The practice

undertook repeated audits to monitor performance and the results showed a general improvement in their performance.

Effective staffing

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

| | Y/N/Partial |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| Explanation of any answers and additional evidence: The practice had a programme of learning and development and staff members attended local Clinical Commissioning Group (CCG) led training days which were held on a regular basis. The practice held regular educational sessions and staff regularly met with peers within the locality. The practice was an accredited teaching and training practice and the team included a number of GP trainers, tutors, appraisers and assessors. A healthcare assistant was undertaking nurse training and a member of the administration team was being supported with mental health nurse training at the Open University. | |
| The practice had a comprehensive system in place to ensure all staff received appraisals and undertook mandatory and additional training online on a regular basis. | |

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 |

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 |

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: Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Clinicians had completed training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. The practice recorded consent and monitored the process for seeking consent appropriately. | |

Well-led

Rating: Good

The practice was previously rated as requires improvement for providing well-led services because:

- Some systems needed strengthening to ensure risks were minimised where possible. In particular, those relating to the management of safety alerts.
- Whilst logs of complaints and significant events were reviewed, there were gaps in the records that suggested a lack of consistency.
- Risks regarding staff immunity status were present for some staff.

During this inspection we found:

- The practice had a comprehensive system in place to ensure a record of all staff members vaccinations and immunity status was maintained.
- The system in place to record and action significant events and complaints had improved and was effective.
- The practice had developed a clear system to respond to relevant safety alerts.

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: A new business partner joined the practice in February 2021 and introduced a new deputy practice manager who was employed by the practice. The practice had taken significant steps to address challenges to quality and make improvements across all systems and processes. The practice had successfully recruited additional GPs who were set to join the practice in September 2021. | |

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 |

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 |

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

| Source | Feedback |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Staff interviews | All of the staff we spoke with told us that the governance arrangements had improved and the new management team had introduced clear systems and processes. |

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: | |

The practice had introduced a new digital platform for storing and managing their policies and protocols and the new system was working well. The practice had reviewed and updated all practice policies and all of these documents were easily accessible to all staff members. The governance arrangements in place enabled the practice to monitor records and complete reviews and updates as and when required.

Managing risks, issues and performance

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

| | Y/N/Partial |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Y |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence: Following our previous review in December 2020, the practice had taken steps to make the required improvements. The practice had reviewed and improved the systems in place for managing risks and performance. Records were easily accessible and the practice had a comprehensive system in place to monitor risks. | |

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 |

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

| | Y/N/Partial |
|----------------------------------------------------------------------------------------------------|-------------|
| Staff used data to monitor and improve performance. | Y |
| Performance information was used to hold staff and management to account. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |

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 |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Team meetings were held on a regular basis and minutes and actions from these meetings were followed up and information was shared with relevant staff members. The practice produced a newsletter on a regular basis.</p> <p>The practice obtained feedback from patients and Patient Participation Group (PPG) members. Results from the National GP Patient Survey had also been analysed. The practice had recently introduced a telephone system and had also increased clinical capacity which enabled them to offer more telephone and face to face appointments. The practice was also in the process of changing their website in order to further improve patient experience.</p> <p>The practice sought feedback from patients and had commissioned an external organisation to conduct a patient survey in June 2021. The practice had received 160 responses. Thirty two out of 91 patients (29%) said they had contacted the surgery by telephone to request an appointment and had found it extremely hard or hard to do so. Ninety nine out of 139 patients (71%) said they had used the online system to request an appointment and had found it extremely easy or easy to do so. Data from the latest National GP Patient Survey published in 2021 showed performance had improved when compared with data from the 2020 results.</p> <p>Information about how to make a complaint or raise concerns was available and it was easy to do. Patients were also able to submit feedback and complaints using the practice website. The practice offered apologies to patients, lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care. The practice undertook an analysis of complaints on a regular basis to identify key trends and themes.</p> <p>The complaint leaflet included information on the Parliamentary and Health Service Ombudsman (the PHSO make final decisions on complaints that have not been resolved by the NHS in England). From the sample of complaints we reviewed, we found the practice did not always provide patients with information on the role of the PHSO when sending a final response to patients. Following our comments, the practice told us that they would introduce a complaint final response letter template which would include information about the PHSO.</p> | |

Feedback from Patient Participation Group.

| Feedback |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Feedback from the PPG was positive. PPG members were working with the practice on the development of a new website. Feedback from patients was mixed. Some patients told us they found it difficult to get through to the practice by telephone and obtain an appointment convenient to them. |

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: The practice had taken steps to become a research practice and was committed towards innovation and improvement. The practice had applied to the local CCG for funding to introduce a clinic specialising in gynaecology. One of the senior GPs had recently completed specialist training in ear, nose and throat services and the practice had plans to offer an ENT community clinic for patients. The practice worked closely with GP practices within their locality and were an active member of their local Primary Care Network. | |

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.