

# Care Quality Commission

## Inspection Evidence Table

### Triangle Group Practice (1-559769040)

Inspection date: 26 July 2021

Date of data download: 22 July 2021

## Overall rating: Requires improvement

We carried out an announced focused inspection of Triangle Group Practice on 26 July 2021. The practice was rated requires improvement overall due to concerns identified in the safe, effective and well-led key questions. The responsive and caring key questions were not inspected. At the previous inspection on 26 November 2019, we rated the practice as requires improvement overall. We rated Safe as inadequate because the practice did not have safe arrangements for the management of patients prescribed high risk medicines. The practice did not have one of the recommended emergency medicines and had not undertaken a risk assessment for not having this medicine. There was no paediatric pulse oximeter and the practice had not undertaken a risk assessment for not having this.

At the follow up unrated inspection on 27 January 2020, we found arrangements for identifying, monitoring and managing risks to patient safety had improved. The practice had made improvements to systems to ensure that patients and others in the practice were kept safe.

We inspected all six population groups. We rated all population groups as **requires improvement overall**.

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

## Safe

## Rating: Requires improvement

*Following the inspection on 26 July 2021 we rated safety as requires improvement because although there were some strong systems and processes to manage risks to patients, there were some risks that were not well managed.*

### At our last inspection

*Action had been taken on the issues identified at the previous comprehensive inspection. We found arrangements for identifying, monitoring and managing risks to patient safety had improved.*

### At this inspection

- *There were some areas where the provider had not been able to sustain all improvements following our last inspection. For example, systems for monitoring patients prescribed high risk medicines required improvement.*

- *The system for recording and acting on safety alerts required improvement. For example, staff did not keep a log to monitor safety alerts and there was no effective system to document action taken in response to these.*

## Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. There were some areas where these were not consistently implemented, particularly systems to review blood monitoring appropriately.**

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:	

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.	P <sup>1</sup>
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:	
1. The practice was aware of the current Public Health England (PHE) guidance on vaccination. There was a process for checking clinical and non-clinical staff immunity status. The provider had	

requested immunisation details from all members of staff. We looked at a sample of staff recruitment records and found that there were protective measures in place for staff working at the practice. For example, staff were given an information sheet about the occupational hazard of Hepatitis B for health workers. Staff were also required to sign a consent form so that they were fully aware of the risks of not being immunised against Hepatitis B. However, where staff had exercised their right to refuse immunisation, the practice did not have a documented risk assessment to assess the risks to staff and they had not fully considered the risks to patients.

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: 25/09/2020	Y
There was a record of equipment calibration. Date of last calibration: 25/09/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. Risk assessment dated 26/02/2021	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 21/12/2020 fire safety risk assessment carried out by PM and no deficiencies identified. Fire safety policy / procedure YES Fire drill annual 29/04/2021 Weekly Fire alarm tests done on Weds afternoons last test 21/07/2021 Fire alarm maintenance service 05/11/2020 Fire extinguisher service 05/11/2020	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: 30/04/2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30/04/2021	Y <sup>1</sup>
Explanation of any answers and additional evidence:	

1. The provider had completed a documented health and safety/premises and security risk assessment. We saw that building, security, contents, health and safety checks were recorded and undertaken every three months.

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y <sup>1</sup>
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: 23/08/2018	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:	
1. At the site visit inspection, we were not able to speak with the infection prevention and control (IPC) lead as they were on sick leave. We reviewed the practice's IPC risk assessment done inhouse by the IPC lead on 9 July 2021. No actions were identified during the assessment. The form did not have a date column to show when actions were completed or a date for review.	

## 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 did not always have 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.	N <sup>1</sup>
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.	P <sup>2</sup>
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. Our inspection found there was no effective system in place to ensure patient information received from secondary care was actioned in a timely way. Patient records were therefore at risk of being incomplete. These failures put patients at risk of not being appropriately re-called, followed up, and reviewed.</li> <li>2. Although the practice had a documented approach to manage test results, we found it had not been implemented effectively. Of 143 patients prescribed a particular medicine which required monitoring, we identified three patients where appropriate monitoring had not been carried out prior to prescribing, and where there was no explanation in the clinical record for departing from the current national prescribing guidance.</li> </ol> <p>When the monitoring happened in hospital, the provider did not have effective processes to ensure all clinicians could monitor information and document that they had looked at the results and determined it was safe to prescribe. While we were assured that the test results were available to be reviewed, there was no indication in a patient's clinical records (which would be good practice) that the results of the test were considered when issuing a prescription.</p>	

### Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, including medicines optimization. Although systems were in place to review secondary care blood monitoring results, there was no effective process of oversight and risk assessing prior to prescribing.**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR	0.55	0.54	0.70	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)				
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)	4.5%	10.3%	10.2%	Variation (positive)
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)	6.17	5.64	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	89.0‰	72.9‰	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)	0.61	0.44	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	4.3‰	4.7‰	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
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	P <sup>1</sup>
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

Medicines management	Y/N/Partial
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.	P <sup>1</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	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 <sup>2</sup>
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>1. At the previous inspection on 26 November 2019, we reviewed a sample of records for patients prescribed high risk medicines. Patients were being issued with repeat prescriptions, when they had not had blood test result documented in the last three months. Following that inspection, the practice sent us their action plan. They told us they had reviewed procedures and made changes to the proper and safe management of medicines.</p> <p>At the last inspection on 27 January 2020 we reviewed all records of patients prescribed high risk medicines. We found that all patients prescribed high risk medicines were being prescribed and monitored appropriately.</p> <p>At our monitoring review call on 24 November 2020 the practice had established a number of quality improvements and procedures for monitoring patients on high risk medicines which included:</p> <ul style="list-style-type: none"> <li>• The practice had trained up admin staff to maintain the practice spreadsheet for monitoring patients on high risk medicines. The practice told us they audit the log and support the staff member to contact patients who are due for a review and blood test.</li> <li>• The practice had safety nets in place as the review dates are printed on prescriptions.</li> <li>• Staff told us that any patients on high risk medicines, who have not gone for blood tests, are flagged with the duty doctor who will contact them.</li> <li>• The practice shared a copy of their updated high-risk medicines policy which included guidance on repeat prescribing of high-risk medicines and frequency of required blood tests. It included</li> </ul>	

Medicines management	Y/N/Partial
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guidance on what to do when patients have failed to go for monitoring blood tests including guidance on stopping medication safely.

At this inspection, not all staff had followed the repeat prescribing policy on what to do when patients prescribed high-risk medicines failed to go for monitoring blood tests. Although we found notes in the audit of patients on high risk medicines which recorded that bloods were done in secondary care, there was no documentation in the patient records. This was a repeat concern from the previous inspection.

We found that three of the five patients taking azathioprine (a medicine used to suppress the immune system) did not have the evidence on their practice clinical record that they had received appropriate monitoring prior to being prescribed this medicine. However, the provider informed us they had introduced a system for quarterly monitoring for patients on these medicines to ensure all patients were monitored appropriately. We reviewed the monitoring log and saw notes about bloods done for patients prescribed azathioprine who were under secondary care, but tests were not recorded in the patient record. While we were assured that the patients were monitored appropriately prior to prescribing, patient records were at risk of being incomplete which potentially could put patients at risk of not being appropriately re-called, followed up, and reviewed.

When we discussed our reviewed records with the practice, staff told us that some patients who had been invited to attend for blood tests had not attended because of anxiety associated with risks of infection from COVID-19. Staff told us they knew that some patients who were shielding were worried about going for blood tests and the practice had promoted the special phlebotomy service provided by the GP federation at Lewisham University Hospitals for patients who were concerned and at high risk. However, none of this information was recorded against specific patient records when there had been a decision to prescribe outside current guidance.

The practice had a programme of clinical audit of high-risk medicines. For example, staff shared a report of an audit of high-risk medicines from May 2021. The audit was to check blood monitoring was done at the correct intervals and frequency and if not, whether the repeat prescribing policy was followed.

2. The provider had appropriate systems in place for the safe management of medical emergencies. There was an emergency drugs checking protocol. We checked the stock and found all emergency medicines were available. The practice stocked prednisole instead of dexamethasone which is an acceptable alternative.

### 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.	P <sup>1</sup>
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:	
<ol style="list-style-type: none"> <li>1. The practice had systems in place to manage significant events and medicines and safety alerts. However, recording of actions following safety alerts could be improved.</li> <li>2. We spoke to staff who told us anyone directly involved in an event was responsible for recording it in the practice's significant event template. Non clinical staff told us they would verbally report it to the practice manager who would document and save it in the significant events log. Staff told us significant events were discussed at weekly clinical meetings and at the end of the meeting the senior receptionist attended. Staff told us learning from significant events was discussed in monthly protected learning time and during quarterly practice team meetings.</li> </ol>	

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

Event	Specific action taken
Patient commenced on wrong medicine.	Practice investigated and found there had been confusion over similar medicines. Following the event the practice protocol for prescribing the medicine was updated. The practice audited to determine if any other patient had been affected.
Patient with sepsis	Patient admitted to A&E and diagnosed with sepsis which picked up inadequate read coding (coding on the electronic patient record) of a deficiency from previous hospital correspondence. Practice updated process so that duty doctors are responsible for read coding new incoming letters.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P <sup>1</sup>
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. At this inspection, the practice had systems in place to manage significant events and medicines and safety alerts. However, recording of actions following safety alerts needed to be improved. The practice had signed up for email notifications of Medicines &amp; Healthcare products Regulatory Agency (MRHA)</li> </ol>	

alerts. Staff told us the practice manager forwarded the safety alerts on to the clinical staff and they were left to individual clinicians to action. There were no reviewing arrangements in place to check relevant actions were completed. Staff told us affected patients who had been identified from searches were contacted and reviewed. Staff told us safety alerts were discussed in the weekly clinical meeting. However, clinical meeting minutes did not contain sufficient detail of discussions of safety alerts and actions. There was no log of actions taken in response to safety alerts.

The provider did not have a clear system in place to monitor the implementation of medicines and safety alerts. We found that four patients of childbearing age did not have clear documentation in their records evidencing that risks of their medication had been discussed with them.

We spoke to the lead GP about action taken following a recent MHRA safety alert for carbimazole, a medicine used in the management of hyperthyroidism and there was evidence of searches undertaken to identify patients affected. The consulting GP told us they had discussed the risks with the patients. However, there was no documentation to show that the consulting clinician had informed the patients about the possible health risks of a medicine they were prescribed on repeat prescription.

## Effective

## Rating: Good

*At our last inspection on 26 November 2019, the practice was rated as requires improvement for effective because there was evidence that patients on high risk medicines were not monitored appropriately.*

*There was evidence that the care of patients in three population groups, people with long-term conditions, families, children and young people and working age people (including those recently retired and students) did not meet national targets or was below average.*

*When two or more population groups are rated as requires improvement for effective care, the practice is rated requires improvement for effective overall.*

### **At this inspection we rated Effective as requires improvement because**

- The process of scheduling and recording medication reviews was managed in line with current guidelines. However, the provider did not have systems in place to review blood monitoring appropriately. We were not assured that patients were always receiving the correct care, treatment and monitoring for their conditions.*
- There was evidence that the care of patients in the three population groups people with long-term conditions, families, children and young people and working age people (including those recently retired and students) did not meet national targets or was below average.*
- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the target of 95% in five areas where childhood immunisations are measured.*
- The practice had not demonstrated it had an effective strategy to improve their performance for cervical screening which was lower than CCG and England averages.*

### **Effective needs assessment, care and treatment**

**Patients' needs were not always assessed, and care and treatment was not delivered consistently 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.	P <sup>1</sup>
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
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>The practice had systems to keep all clinical staff up to date. Staff had access to local and national guidelines and used this information to deliver care and treatment that met patients' needs. While the standard of recording consultation notes was satisfactory, we found there was no common approach to documenting blood monitoring carried out in secondary care on the patient record system, which is best practice.</li> </ol>	

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. From records we reviewed we found some patients on long term medications did not always have their blood monitoring documented in their clinical record. This meant patients were not always receiving the care, treatment and monitoring required.
- 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)	85.8%	75.7%	76.6%	Tending towards variation (positive)
PCA* rate (number of PCAs).	3.1% (16)	11.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	96.8%	90.2%	89.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	1.6% (2)	11.7%	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)	84.3%	83.1%	82.0%	No statistical variation
PCA* rate (number of PCAs).	0.0% (0)	4.5%	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)	58.6%	65.2%	66.9%	No statistical variation
PCA rate (number of PCAs).	8.4% (26)	12.4%	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) <small>(QOF)</small>	77.1%	71.9%	72.4%	No statistical variation
PCA rate (number of PCAs).	3.6% (27)	6.5%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	87.9%	89.3%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.9% (1)	5.2%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	87.9%	75.7%	75.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	4.5% (14)	9.4%	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

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## Families, children and young people

## Population group rating: Requires improvement

### Findings

- The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five childhood immunisation uptake indicators. Practice did not meet minimum 90% target in four areas but met 90% in one. The trend since March 2019 has been variable. They were above 80% for four immunisation indicators, but below 80% uptake for one area (age 5 MMR was 76%).
- 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 contacted the parents or guardians of children due to have childhood immunisations. Staff told us how they had engaged with all patients to understand why they were not attending.
- 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)	73	80	91.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	78	95	82.1%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	78	95	82.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	79	95	83.2%	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)	64	84	76.2%	Below 80% uptake

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 told us that since our last inspection they had started to use a clinical decision support tool. Staff used EMIS web templates and reports to run searches in order to do recalls and follow ups of children. Staff told us they will train the new healthcare assistant to help with recalls.

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

**Population group rating: Good**

### Findings

- The practice's performance had improved since our last inspection in November 2019, when cervical screening performance indicator was 64.4% (01/04/2017 to 31/03/2018). However, as shown below, at this inspection the practice was still below the 80% coverage target for the national cervical screening programme (as measured by Public Health England). We looked at published Public Health England (PHE) cervical screening data for Q4 2020/21 which indicated an improvement. Data showed performance had improved to 70.2% which was above the CCG average of 69.8%.
- 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. This was provided through the local GP Federation One Health Lewisham. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Staff told us that the new HCA will be trained to undertake NHS health checks to help the practice to identify health concerns in patients.
- 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)	67.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	66.7%	64.7%	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)	55.3%	55.1%	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)	93.3%	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)	47.8%	56.7%	54.2%	No statistical variation



## People whose circumstances make them vulnerable

Population group rating: **Good**

### Findings

- Same day appointments and longer appointments were offered when required.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- All patients with a learning disability were offered an annual health check. The practice shared an example of a learning disability form used for monitoring the health of adults with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Staff told us they discussed palliative care with the nurse from the local hospice at MDT meetings. The nurse would contact the duty doctor if a patient deteriorated.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The lead GP at the practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young 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.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and	92.9%	86.1%	85.4%	No statistical variation

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>				
PCA* rate (number of PCAs).	2.0% (2)	12.3%	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>	88.9%	79.6%	81.4%	No statistical variation
PCA rate (number of PCAs).	3.6% (1)	7.4%	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)	534.6	533.9
Overall QOF score (as a percentage of maximum)	95.6%	95.5%
Overall QOF PCA reporting (all domains)	3.9%	5.9%

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

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

At this inspection the practice had a programme of clinical audit of high-risk medicines. The provider undertook four clinical audits in the last 12 months, all of them were completed cycle clinical audits where improvements were implemented and monitored.

For example, the practice undertook a quality improvement activity to ascertain if immunosuppressants (high risk medicines used to suppress the immune system) were prescribed appropriately. Staff shared a report of the audit from May 2021. The audit was to check blood monitoring was done at the correct intervals and frequency and if not, whether the repeat prescribing policy was followed.

A search generated 24 patients taking immunosuppressant medications under shared care protocol and three patients taking lithium. The practice identified that 75% of patients on these medicines have had the required monitoring at the correct intervals but 25% of patients had not. Two out of three patients on

lithium had monitoring done at correct intervals. We identified one patient on lithium as not having had required blood monitoring and as a result the practice contacted the patient and a blood test ordered.

The audit showed that staff had followed the repeat prescribing policy for high risk medicines for those who did not have monitoring. The report summary showed:

- Majority of patients have been monitored at correct time intervals
- Safeguard mechanisms were in place as described in the practice's repeat prescribing policy followed for 100% for patient who had not had their blood tests including:
  - Reminders
  - Review dates
  - Limited supply of medicine and contacting consultant if still not been for a blood test

### Any additional evidence or comments

The practice offers minor surgery, implants and coil insertion and removal. They had a consent form in place which was filed in patient notes.

## 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 <sup>1</sup>
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.	P <sup>2</sup>
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 lead receptionist attends the latter part of the practice's clinical meetings so they can be updated on relevant information.	

1. At the time of our inspection the practice nurse was on sick leave and was not available. The practice nurse was not a prescriber. Staff told us the practice had access to the nurse at the local extended access service and leaders were in the process of employing a locum nurse to concentrate on cervical screening and immunisations for children. During the inspection staff told us nurse registration was regularly checked throughout their employment. We saw that the practice nurse was registered with the National and Midwifery Council (NMC). The Health Care Assistant (HCA) had only been in post for two weeks. We spoke with the HCA who told us their induction included training in the Care Certificate standards.
2. Staff files we reviewed showed not all staff had received an appraisal or had an appraisal date scheduled. For example, the practice manager's last appraisal was in January 2020, and their next appraisal was scheduled for January 2022.

## 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.	P <sup>1</sup>
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely or accessible way through the practice's patient record system. Information was shared between services, with patients' consent, using a shared care record. We saw minutes from multidisciplinary meetings (MDT). MDT meetings took place monthly with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs.</li> </ol>	

## Helping patients to live healthier lives

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

Y/N/Partial
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The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	

### 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:	

## Well-led

## Rating: Requires improvement

*At our previous comprehensive inspection in November 2019 we reviewed a sample of records for patients prescribed high risk medicines. We found some patients had not received appropriate monitoring and clinical review prior to prescribing.*

*At our focused inspection in January 2020, the practice had made improvements and had addressed the concerns we found at our previous inspection in November 2019.*

### **At this inspection we rated Well Led as requires improvement because**

- The practice had a clear plan as to the areas where improvement was needed and how this would be achieved. However, there were some areas where the provider had not been able to sustain all improvements following our last inspection. For example, systems were in place to review secondary care blood monitoring results and to chase patients to have their test done, but there was no effective process of oversight and risk assessing prior to prescribing high risk medicines which ensured results had been received and considered by the prescriber. This was a repeat concern which we had identified at a previous inspection.*
- The policy framework of the practice was not effective because there was no clinical oversight of safety alerts to ensure there was a record of alerts received which had been acted on.*
- The practice had established a programme of clinical audit. We saw evidence that the practice used the results of clinical audits to identify actions to improve performance.*

### **Leadership capacity and capability**

**There was compassionate, inclusive and effective leadership at all levels. However there were areas where leaders could not demonstrate high quality sustainable care for all patients.**

	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.	N <sup>1</sup>
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:	
1. There were areas where leaders had not identified the need to have an effective process in place, for example, a system to ensure clinicians were viewing patients' monitoring information prior to prescribing. However, leaders demonstrated willingness to address the concerns raised during the inspection and had improved in several areas identified in previous inspection and monitoring activities.	

Staff we interviewed told us that leaders were visible and approachable.

## Vision and strategy

**The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. Nevertheless, improvements were required to develop an effective system to monitor the quality of 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 supported 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: Staff told us and we observed there were positive relationships between staff and teams	

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

Source	Feedback
Feedback from staff	<p>Staff we spoke to reported they had seen many improvements since the last inspection in November 2019 which included:</p> <ul style="list-style-type: none"> <li>• Policies and procedures were maintained in an organised way and easily accessible to staff.</li> <li>• More structure in place in terms of meetings and sharing of learning with staff.</li> <li>• The management had streamlined procedures and allocated specific tasks for clinical and non-clinical staff.</li> <li>• Improvements in medicines management including monitoring patients with high risk medicines.</li> </ul>

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management. Despite that, there were areas where governance arrangements needed strengthening.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P <sup>1</sup>
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. The overall governance arrangements needed strengthening. Issues that could threaten the delivery of safe and effective care were not identified and managed. While the practice had made some improvements since our last inspection, it had not appropriately addressed concerns in relation to recording blood monitoring results in patient records.</p> <p>Leaders lacked oversight of the policy framework. Not all policies and procedures were reviewed regularly to ensure they were in line with best practice. For example, there was a prescribing and medication review policy but it did not contain sufficient guidance on recording blood monitoring in patient records.</p>	



## Managing risks, issues and performance

**There were processes for managing risks, issues and performance; however the provider had not demonstrated that all potential risk factors had been mitigated.**

	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.	P <sup>1</sup>
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:	
1. The risks in relation to monitoring patients on high risk medicines had not been identified by the provider's own governance systems. Leaders did not have full oversight of safety alerts.	

**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 <sup>1</sup>
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:	
1. The practice shared a copy of their continuity plan and recovery toolkit document which included pandemic arrangements to ensure a co-ordinated clinical response.	

## Appropriate and accurate information

### The practice did not always act on appropriate and accurate information.

	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.	P <sup>1</sup>
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
1. The practice did not always act on appropriate and accurate information. The practice did not act effectively on results of blood monitoring by recording results and decisions in the patient record system.	

## 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.	N/A

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 the public, staff and external partners to sustain high quality and sustainable care.**

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

Any additional evidence

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>The practice had a clear plan as to the areas where improvement was needed and how this would be achieved. However, leaders did not have full oversight of the areas of concern we identified. Some improvement actions were in progress and had not yet been completed. The practice had planned for recovery from the pandemic and was responding to patient feedback about accessing appointments. The practice had a system of pre allocated face to face appointments and reception staff could book in patients who called to request face to face appointments.</p>	

## 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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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