

Care Quality Commission

Inspection Evidence Table

Mitchley Avenue Surgery (1-5760194874)

Inspection date: Remote Clinical Review on 26 May 2021; Site Visit on 27 May 2021

Date of data download: 18 May 2021

Overall rating: Requires Improvement

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

During the last inspection the practice was rated as requires improvement overall (requires improvement in safe and well-led) for issues in relation to recruitment checks, safety systems and records, risk assessments for patients, medicines management, management of significant events, staff training, appraisals and governance arrangements. While there had been some improvements, we found new issues and the practice was again rated as requires improvement.

Safe

Rating: Inadequate

The practice was rated as inadequate for providing safe services because:

- The systems and processes in place to keep patients safe were not adequate.
- The practice did not have appropriate systems in place for safeguarding.
- Infection prevention and control procedures in place required improvement.
- The practice did not have appropriate systems in place for the safe management of medicines.

Safety systems and processes

The practice did not have 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.	Partial ¹
Partners and staff were trained to appropriate levels for their role.	Y

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	Partial ²
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial ³
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.	Partial ⁴
<p>1. During the inspection we found that the practice safeguarding policy did not have information about female genital mutilation, child exploitation and radicalisation. Following the inspection, the provider sent us separate policies in relation to these; however, there was no reference to these in the practice safeguarding children and adults' policy.</p> <p>2. During the inspection we saw no evidence of follow up information being consistently recorded in the patients' notes following safeguarding referrals. For example, we reviewed a child safeguarding referral made to social services and saw no documented evidence of any outcomes from this referral in the patient's record and there was no safeguarding alert for this patient on the practice's electronic patient management system. Following the inspection the provider informed us that the referral was made by secondary care and was discussed at a local clinical meeting; however, the review of patient's record indicated that the referral was made by the practice and we saw no evidence of discussion of safeguarding concerns in relation to this referral in a clinical meeting.</p> <p>3. During the inspection we reviewed the records of four patients on their local child safeguarding register and found there were no safeguarding alerts for family members of children on three out of four records. We also reviewed the records of four patients on their local adult safeguarding register and found there were no safeguarding alerts for any of these patients.</p> <p>4. During the inspection the provider informed us child safeguarding concerns were only discussed at local clinical meetings.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y ¹
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>1. During the inspection we reviewed the recruitment records of three members of staff and found there was no record of check of qualification and registration check for one member of clinical staff. Following the inspection, the provider informed us this was stored electronically and sent us evidence to support this.</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: 16 March 2021	Y
There was a record of equipment calibration. Date of last calibration: 13 April 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 20 November 2019	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: 4 July 2019	Partial ¹
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 4 July 2019	Partial ¹
1. The provider completed a health and safety risk assessment in 2019; however, the risk assessment and actions had not been updated since then. The provider had completed COVID-19 specific risk assessments which covered infection prevention and control and use of face masks. The provider informed us they had undertaken Safety Assessment And Decision risk assessments for staff.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were partially met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial ¹
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: 5 August 2020	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
1. During the inspection we found that the infection prevention and control policy was brief and had no details of the practice infection prevention and control lead, their roles and responsibilities, key contacts for staff, frequency of audit and references to other policies, procedures and protocols in relation to infection prevention and control. Following the inspection, the provider informed us that they use this policy in conjunction with the infection prevention and control protocol and waste management policy and that the practice lead names were displayed in the reception.	

During the inspection we found that the curtains used in the practice were not changed every six months and staff we spoke to informed us they were not aware of this requirement; the provider informed us that they had changed the curtains on the day of inspection.

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.	Partial ¹
<p>1. During the inspection we found that staff had not completed any formal training on identifying deteriorating or acutely unwell patients. Following the inspection, the provider informed us that all clinical staff and some reception staff had training on identifying deteriorating or acutely unwell patients and that informal training was provided to all members of staff. They told us that formal training would be provided by one of the GPs at their next non-clinical staff meeting.</p>	

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.	N/A

Appropriate and safe use of medicines

The systems for the appropriate and safe use of medicines required improvement.

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 31/01/2021) (NHS Business Service Authority - NHSBSA)	0.55	0.59	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)	11.5%	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)	5.09	5.53	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	93.9‰	60.3‰	127.1‰	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)	0.65	0.60	0.66	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.	Partial ¹
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial ²

Medicines management	Y/N/Partial
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.	Partial ³
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial ⁴
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>1. We reviewed the records of five patients who have had their medicines reviewed in the last three months and found that two of these patients had not received structured medicines reviews. We found issues with regular blood monitoring not being recorded for three of these patients.</p> <p>2. During the inspection we reviewed the records of five patients taking methotrexate (a medicine used to suppress the immune system) of which one patient appeared not to have regular blood monitoring and there was no record of the prescriber checking blood test results before the issue of the prescription. Following the inspection, the provider informed us that this patient had had their blood tests done and recorded in their electronic patient management system. We also found that for all five patients on this medicine there was no record of day of the week that the tablet had to be taken. Following the inspection, the provider informed us that they would add day of the week information for these patients.</p> <p>During the inspection we found that two out of five patients taking azathioprine (a medicine used to suppress the immune system) had potentially not had the required monitoring. Following the inspection, the provider sent us dates when blood tests were undertaken for all five patients on this medicine; on review we found that blood test results were overdue for one of these patients.</p> <p>During the inspection we reviewed the records of five patients taking leflunomide (a medicine used to suppress the immune system) and found there was no record of up to date blood monitoring for three patients and for some of the patients there was no record of a recent check for blood pressure and weight. However, all these patients had recently been contacted to arrange for monitoring checks. Following the inspection the provider had taken action to ensure monitoring was up to date and sent us the dates of blood test, blood pressure and weight for these patients; however, for one patient the blood pressure and weight checks were still not up to date.</p>	

During the inspection we found that one patient taking lithium (a medicine used to treat mental health disorders) did not have the required monitoring. Following the inspection, the provider informed us that they contacted this patient and had arranged for a blood test appointment and their monitoring was completed. The evidence they sent us indicated that a blood sample was taken, and their weight was checked. However, it was not clear if this patient had had other monitoring including renal function, calcium and thyroid function.

During the inspection we reviewed the records of five patients taking spironolactone (a medicine used to treat heart failure) and three of these patients did not appear to have had the required monitoring. Following the inspection, the provider sent us the dates of blood test results for seven patients taking spironolactone which confirmed that blood tests were overdue for three patients.

During the inspection we reviewed the records of three patients taking ACE Inhibitor or Angiotensin II reception blocker (medicines used to lower blood pressure) and found all three patients did not have the required monitoring; two of these patients have not had their required monitoring since 2015.

During the inspection we reviewed the records of three patients taking warfarin (a medicine used to thin blood) and found that for all three patients there was no record of a recent blood monitoring test. Following the inspection, the provider informed us that monitoring was undertaken in secondary care for these patients and sent us the dates of the blood test results for all these patients. This confirmed that the monitoring was up to date for all the patients taking warfarin.

During the inspection we reviewed the records of three patients taking novel oral anticoagulants (medicines used to thin blood) and found all three patients did not have the required monitoring i.e. a calculation performed using the blood test results (when first prescribed) to ensure correct dose of this medicine was prescribed (in total we found that 50 patients did not have the required monitoring). The results of the audit of patients on these medicines sent by the practice before the inspection indicated that out of 84 patients only 32 patients had this calculation and had the required monitoring. Following the inspection, the provider sent us the dates of the last blood test results for 50 patients on this medicine and informed us that only two patients had not had their blood test and that they were recalled. However, the provider had not sent any evidence to confirm if these patients had the calculations performed to ensure the correct dosage of the medicines was prescribed.

3. During the inspection we found that the provider did not stock one of the emergency medicine diclofenac injection (medicine used to decrease pain and swelling). The provider informed us they had not been able to get new supply since the last one expired; however, the provider had not risk assessed how they would deal with acute pain and swelling in the absence of this medicine.
4. During the inspection we found that the provider did not have child defibrillator pads. Following the inspection, the provider informed us they had obtained these.

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:	5
Number of events that required action:	5

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

Event	Specific action taken
A patient who attended a vaccination clinic was pricked with an empty syringe.	<p>Following the incident, the following actions were undertaken:</p> <ul style="list-style-type: none"> All empty unused syringes were separated from pre-filled syringes with separate pots for both. Vaccine appointment times were extended to avoid time pressures for staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Y
<p>1. The provider maintained a log for medicines and safety alerts; however, the actions undertaken following these alerts were not always recorded. Following the inspection, the provider informed they would record the actions in the future. However, this does not ensure patients already taking these medicines were identified and how patients who are prescribed them in the future would be identified and appropriate actions taken.</p> <p>During the inspection we reviewed the records of five patients on SGL-2 inhibitors (a medicine used to lower blood sugar) and found that for four patients there was no record of the patient being advised of risks of using this medicine. We also found that the medicines review was overdue for three patients on this medicine.</p> <p>During the inspection we reviewed the records of three patients on carbimazole (a medicine used to reduce thyroid hormone) and found that the discussion of the risks of pregnancy and the use of effective contraception was not always documented in the patient notes. Following the inspection, the provider informed us all three patients were monitored by secondary care; however, except for one patient who had a note about contraception on their prescription, it was not clear from the records review that these patients had been advised of the risks of not being on effective contraception.</p>	

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

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.
- 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: Requires Improvement

Findings

- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. However, we found issues with regular blood monitoring and medicines reviews for some patients.
- The provider had only achieved 69.23% for the Quality and Outcomes Framework diabetes indicators compared to 87% Clinical Commissioning group average and 88.4% England average.

- 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.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with Chronic Obstructive Pulmonary Disease were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	82.0%	75.3%	76.6%	No statistical variation
PCA* rate (number of PCAs).	3.6% (6)	9.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	87.9%	90.2%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	8.6%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	84.4%	82.2%	82.0%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	3.4%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	59.5%	64.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	5.1% (9)	10.7%	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>	74.3%	71.0%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.2% (8)	4.9%	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>	86.7%	90.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.6% (2)	4.8%	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) <small>(QOF)</small>	85.1%	74.9%	75.9%	No statistical variation
PCA rate (number of PCAs).	1.7% (3)	8.6%	10.4%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice has not met the minimum 90% for one of the five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the five childhood immunisation uptake indicators. Unverified results shared by the provider indicated some improvement.
- 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.
- 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) <small>(NHS England)</small>	51	53	96.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation	38	41	92.7%	Met 90% minimum

for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)				
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)	38	41	92.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	38	41	92.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	46	56	82.1%	Below 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The uptake for cervical screening was below the 80% target at 75.2%. Unverified latest results shared by the provider indicated that the provider had achieved 79% uptake. The provider informed us they had a call/recall system in place and that they had signed up to utilise the local GP hubs which provided cervical screening service in order to improve access for patients and to improve uptake.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	75.2%	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)	78.8%	67.1%	70.1%	N/A

Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	76.1%	N/A	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) <small>(QoF)</small>	95.8%	93.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	52.9%	54.4%	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.
- All patients with a learning disability were offered an annual health check. The provider informed us that all seven patients with a learning disability had received a health check in the last year.
- 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.

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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	95.5%	88.1%	85.4%	No statistical variation
PCA rate (number of PCAs).	8.3% (2)	11.2%	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) <small>(QOF)</small>	84.4%	82.2%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.9% (2)	5.6%	8.0%	N/A

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	533.7	Not Available	533.9
Overall QOF score (as a percentage of maximum)	95.5%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	2.2%	Not Available	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.	Partial ¹
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
1. The provider had not effectively demonstrated improvements based on clinical audits or other quality improvement activities in the last two years. However, they had completed the following audits which were all single cycle audits where improvements were not implemented and monitored: <ul style="list-style-type: none"> - A review of patients on novel oral anticoagulants (medicines used to thin blood); however, they had not analysed the findings and written up as an audit to ensure learning for staff. - An audit to ascertain the reasons for diabetic patients not attending appointments (January 2019 to January 2020). - Annual review of fridge temperatures (November 2019 to November 2020) - Audit to ascertain the quality of cervical smears (January to December 2020) 	

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.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

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 ¹
1. During the inspection we reviewed the records of five patients who have had a DNACPR decision and found that for three patients there was no record of DNACPR in the practice's electronic patient management system; however, they were on the electronic palliative care system. There was evidence of discussion of preferred place of death on the practice's electronic patient management system for all three patients.	

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led service because the governance arrangements in place required improvement.

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	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

Vision and strategy

The practice had a clear vision and 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 ¹
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
1. The provider informed us they had welfare meetings for all staff.	

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 improvements since the last inspection in September 2019 which included the following:</p> <ul style="list-style-type: none"> • Recruitment of new staff including GPs, administrative and reception staff. • Additional GP sessions to meet patient need. • Additional consulting room and sinks, taps and flooring was changed. • Change in telephone provider with the provision of additional telephone lines. • New practice website. • Introduction of fire drills and fire procedure updated. • Establishment of a Patient Participation Group and having regular meetings and more engagement with patients. • Policies and procedures in relation to complaints and significant events were updated and changes implemented. • More staff meetings. • Support from management has increased. <p>Staff in general indicated that there was open culture and they felt supported by the management.</p>

Governance arrangements

The overall governance arrangements required improvement.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Partial ²
1. The governance arrangements required improvement in relation to identifying, managing and mitigating risks.	
2. The governance arrangements with third parties in relation to safeguarding was not adequate.	

Managing risks, issues and performance

There were processes for managing risks, issues and performance; however, they required improvement.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial ¹
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial ²
There were effective arrangements for identifying, managing and mitigating risks.	Partial ³
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
<p>The provider had a detailed COVID-19 business continuity plan and COVID-19 pandemic strategy in place which covered areas such as appointment structure, home visits, PPE, patient flow, treating shielding patients, phlebotomy, flu vaccinations.</p> <ol style="list-style-type: none"> 1. Assurance systems in relation to safeguarding were not reviewed and improved. 2. The provider had not effectively demonstrated improvements based on clinical audits or other quality improvement activities in the last two years. 3. The risks in relation to safeguarding and medicines management had not been identified by the provider's own governance systems. 	

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
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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>As part of this inspection we received positive feedback about care from 31 patients using this practice. Please see below the summary of feedback received:</p> <ul style="list-style-type: none"> • Staff are sympathetic, caring, approachable, professional thorough, understanding and helpful. • GPs listen and answer patient queries. • Support for end of life care was outstanding. • Best care and treatment from the GPs, practice nurses and receptionists. • Many patients reported that access to telephone and face to face appointments were good. • Many patients reported they had used this service for a long time and found the care they received was excellent. • Many patients reported that the COVID-19 vaccination appointments were arranged by the practice in an organised manner. • Many patients reported that they had received good support from the GPs in dealing with their mental health issues. 	

Feedback from Patient Participation Group.

Feedback
<p>During the inspection we spoke to the chair of the practice's Patient Participation Group (PPG) who reported the following:</p> <ul style="list-style-type: none"> • The PPG meets every three months and they have about 11 members. • The practice had received very few complaints and care from the practice was exceptional. • The practice had changed the telephone system and appointed new GPs following patient feedback. • The PPG was planning to organise evening meetings to involve younger patients.

Continuous improvement and innovation

There were some 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

Examples of continuous learning and improvement
<ul style="list-style-type: none"> • The provider was part of a local primary care network to enable sharing of best practice. • Learning from incidents and complaints were shared with staff. • Staff were encouraged and supported in training and development.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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