

Care Quality Commission

Inspection Evidence Table

Greet Medical Practice (1-2060398293)

Inspection date: 27 July 2021

Date of data download: 28 July 2021

Overall rating: Good

When we inspected the service in October 2019, we rated the practice as requires improvement overall and in the safe, responsive and well-led key questions. This is because the practice was unable to demonstrate that systems to ensure that risks to patients were fully effective or working as intended. The practice was further unable to demonstrate that they had fully considered all patient feedback or taken proactive steps to address areas of low patient satisfaction. At this inspection we rated the practice good overall and in the safe, responsive and well-led key questions. The practice had responded to our previous findings and we saw evidence that improvements have been achieved.

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

Safe

Rating: Good

The practice was inspected in October 2019 and rated as requires improvement for providing safe services. This was because not all systems in place to keep patients safe were effective or working as intended. During this inspection we found the practice had made improvements and we have rated the service as good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y

Safeguarding	Y/N/Partial
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
<p>When we inspected the service in October 2019 we saw that the practice did not always share relevant safeguarding information with the out of hours (OOH) provider. During this inspection we saw the practice had made improvements. They told us that they used the Adastra clinical patient management system which made it easier to extract and share all relevant safeguarding information.</p> <p>The practice had access to a social prescriber through the Federation who was able to signpost patients to other services. We saw evidence where patients had been signposted to other resources for support when we reviewed the practice records.</p>	

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

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: October 2020	Y
There was a record of equipment calibration. Date of last calibration: August 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N/A
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: : April 2021	Y
Actions from fire risk assessment were identified and completed.	N/A

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: April 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2021	Y
In our previous inspection the practice was not able to demonstrate that fire drills had been completed. At this inspection we saw documentary evidence regular fire drills were being carried out and staff members we spoke with confirmed this.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
The practice had carried out an infection prevention and control audit and identified two areas which were actioned. They included putting up a leaflet in a baby change room advising patients how to dispose of waste correctly. The practice had put up a wall mounted soap dispenser in one of the rooms where it was missing.	

Risks to patients

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

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

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>There was a process for managing pathology results. Urgent abnormal results are phoned through by the lab and passed to the on-call GP for action. Results are reviewed daily by the lead GP and there is an on-call rota identifying which GP should review the results when the lead GP was away from the practice. We reviewed the pathology inbox and found no results were waiting to be processed for more than 24 hours.</p> <p>We reviewed the practice's referrals process and saw that referrals were made promptly and in accordance with relevant guidelines such as the National Institute for Health and Care Excellence (NICE). Referral templates contained appropriate information and patients were provided with appropriate information and advice.</p> <p>The practice has a process for managing two-week wait referrals. The practice's Referrals Manager was responsible for running regular two week wait audit searches. These searches were seen on the clinical system. The audits checked if patients had been seen and this process helped to pick up a significant event where a patient appeared to have been booked to be seen by the hospital but had not received an appointment.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.53	0.69	0.70	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	7.1%	9.3%	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)	3.74	5.22	5.37	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	42.1‰	108.4‰	126.9‰	Variation (positive)
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)	0.77	0.67	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	6.2‰	7.4‰	6.7‰	No statistical variation

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

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>When we inspected the practice in October 2019, we found the prescription stationery were not kept securely. At this inspection we found that the practice had ensured these were now kept locked and there was an audit system to monitor usage.</p> <p>The practice had improved the management of patients on high risk medicines since our inspection in October 2019. The practice ran monthly searches of the clinical system to identify which patients were on high risk medicines and contacted patients using text messages as well as directly to ask them to arrange checks. There was a pharmacist in the Federation's Central Prescribing Service who also put messages on prescriptions regarding monitoring requirements.</p> <p>The practice was able to demonstrate that they had relevant medicines in the event of a medical emergency.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

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

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

Event	Specific action taken
Home visit undertaken and where patient had not declared symptoms of COVID-19	The GP prescribed relevant medicines and left the house with further discussion to be had over the phone. The GP then worked from home for two weeks. Discussed during team meeting and staff reminded to ensure when arranging home visits, to also ask about Covid symptoms in any family members. Ensure adequate PPE available and to minimise exposure and time in the house e.g. take history over the phone. A laminated sheet regarding PPE was added to the home visit bag.
Referral error	A patient was referred to cardiology instead of respiratory clinic in error. This was investigated and the learning was discussed in team meeting. No harm was done to the patient who was informed, and an apology was made. The GP was advised to be precise on which department they wanted the patient to be referred to and to send a separate task for each referral. If staff were unsure of the destination, they were asked to check with the referrer.

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

The practice has a process for managing safety alerts and used a safety alert log to record actions taken in response to alerts. The lead GP identified any actions needed in response to safety alerts which were recorded on GP TeamNet and sent to relevant staff for information.

The records reviewed showed that actions had been taken in response to safety alerts such as Valproate and Carbimazole amongst others with appropriate notes on relevant patient's records.

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.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs 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 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)	73.0%	74.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	4.5% (21)	8.8%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	93.1%	89.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	11.6%	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) <small>(QOF)</small>	80.9%	80.7%	82.0%	No statistical variation
PCA* rate (number of PCAs).	1.8% (2)	3.7%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	55.8%	65.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	18.4% (83)	13.4%	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>	78.5%	71.2%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.2% (9)	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>	80.0%	88.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	79.6%	74.3%	75.9%	No statistical variation
PCA rate (number of PCAs).	2.2% (10)	9.8%	10.4%	N/A

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

Findings

- The practice had not met the minimum 90% for four of the five childhood immunisation uptake indicators between 01/04/2019 to 31/03/2020. However, the latest data (between 01/04/2020 to 31/03/2021) supplied by the practice showed that it had made significant improvements for all the indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	89	95	93.7%	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)	79	93	84.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	78	93	83.9%	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	93	84.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	105	122	86.1%	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>

Any additional evidence or comments

Some childhood immunisation levels were below WHO targets. The practice said that getting children in for immunisations has been much harder during the COVID-19 pandemic as there is a lot of misinformation about the vaccines causing patients concern. The practice had been working on a project with the CCG to improve both immunisation and cancer screening uptake rates. An Immunisation Champion had been put in place and staff have been trained. Children who were not brought for immunisation were contacted three times and then referred to the Health Visitor. The practice was considering developing a video on immunisations in Urdu to help dispel myths about vaccinations. The practice provided us with the latest data from the Child Health Information service (CHIS) which showed improvements in their immunisation rates. For example,

- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) was 90.3%
- 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) (01/04/2020 to

31/03/2021) was 91.3%

- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) was 89.3%.
- The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) was 96.2%.

The practice told us that there were errors in the CHIS data as some children who had been immunised at the appropriate time were not reflected in the data. The practice told us that they would be following this up currently.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- The practices cervical screening uptake was slightly below the 70% uptake target and below the national target. The practice had undertaken significant work to improve cervical cytology and other cancer screening. Data showed that the practice was making improvements year on year.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	69.0%	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)	59.6%	62.6%	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)	35.1%	50.3%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	100.0%	94.7%	92.7%	N/A

occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>				
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>	16.7%	53.8%	54.2%	Tending towards variation (negative)

Any additional evidence or comments

The practice’s cervical screening uptake was slightly below the 70% uptake target and below the national target. We were told the practice found it difficult to encourage the patient to attend appointments for cervical cytology but had taken steps to improve. The nurse telephoned patients if patients did not attend their appointment after three reminders.

The lead GP was the cancer champion for the Primary Care Network (PCN). PCNs are groups of practices working together to focus local patient care. The practice was able to demonstrate that they had undertaken significant work to improve their cancer screening uptake including cervical cytology. For example, the practice had carried out an internal patient survey on the cancer screening service which included breast, bowel and cervical cytology screening in June 2020. Following analysis of the feedback the practice had developed a comprehensive action plan to improve uptake. Whilst most patients were positive about the cervical cytology screening, the practice also identified through patient comments that some patients did not opt for screening due to them not being sexually active along with additional cultural barriers. The practice aimed to better inform these patients by making leaflets available in different languages and through displaying of more posters in the practice. The practice also planned to regularly carry out audits, discuss targets in meetings, engage with the Patient Participation Group (PPG) as well as improve staff skills and knowledge through further training.

Publicly available data we looked at showed that the practice was making slight improvements every quarter. We saw that the practice achievement for screening uptake (Q4, 2021) was similar to the CCG average for 25-49-year olds and above the CCG average for 50-64-year olds.

The number of new cancer cases resulting from a two week wait referral was below the national average. One of the lead GPs was the cancer lead for the PCN and had audited their cancer cases. The audit identified a possible cause due to a young population which was less likely to have a cancer diagnosis. The audit showed that there had been no delays in diagnosis and no missed cancer diagnosis. The practice was confident that they were doing all they could to detect cancer cases.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice had developed links with two local homeless hostels. The hostels provided the practice with lists of homeless or refugee patients who were finding it difficult to register with a GP. The practice then helped these patients to register and offer them support including HIV and Hepatitis screening as well as latent TB screening.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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 other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) ^(QOF)	96.3%	87.0%	85.4%	No statistical variation
PCA* rate (number of PCAs).	1.8% (1)	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) ^(QOF)	73.7%	82.5%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.0% (1)	6.2%	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)	545.6	533.9
Overall QOF score (as a percentage of maximum)	97.6%	95.5%
Overall QOF PCA reporting (all domains)	6.5%	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

We reviewed a palliative care audit which led to all patients on the register being contacted to be offered support in putting in place advanced care plans.

The practice had carried out a hypnotics' audit (a class of medicines used to induce, extend, or improve the quality of sleep, and to reduce wakefulness during sleep). A re-audit identified significant improvements in most of the standards following.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Staff members we spoke with told us that they received protected time to undertake lead roles most of the time.	

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
During our remote searches of the patient records we saw evidence of patients being signposted to resources for support such as smoking cessation, weight management and mental health services.	

Consent to care and treatment

The practice was able to demonstrate that it 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
We saw evidence during the records review of mental capacity being assessed and documented when making DNACPR orders. Patients and their relatives had been involved in end of life care discussions. We saw Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were used to record patient wishes regarding resuscitation. Relevant staff demonstrated awareness of mental capacity and Fraser guidelines.	
The practice used standard local consent forms for fitting contraceptive implants/IUDs. We saw evidence that consent forms were being used for joint injections.	

Well-led

Rating: Good

We inspected the practice in October 2019 and rated as requires improvement for providing well-led services. This was because practice was unable to demonstrate that they had considered all patient satisfaction feedback. At this inspection the practice was able to demonstrate that they had considered all risks and had responded appropriately to improve services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership.

	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
The practice leadership demonstrated that they understood the challenges to quality and sustainability and were addressing this. For example, we were told that the practice contract was changing from a Personal Medical Services (PMS) to a General Medical Services (GMS) contract. The practice was aware this would pose a challenge to its finances and the leaders were looking at ways to work more efficiently. We were told that the practice was considering working more closely with another practice such as sharing resources. For example, the practice did not have a business manager and the other practice had a business manager but not a practice manager and they were exploring ways to work together utilising resources from both sites for mutual benefit.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
The practice had a vision to provide the best possible care in an efficient friendly and open manner. We saw the mission statement was displayed in the practice. The practice was exploring incorporating video and telephone triage following COVID-19. We were told that the practice wanted to offer a third of all appointments remotely as it worked well for the service and patients. The practice was also recruiting	

an advanced clinical pharmacist so that it could improve access, screening and diagnosis of chronic and common illnesses.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
The two lead GPs and the practice manager were related. However, all the staff we spoke with told us that they felt that they could raise any issues and it would be dealt with. Furthermore, they told us that they had access to whistleblowing policy and would raise issues externally such as with the clinical commissioning group (CCG) where relevant.	

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

Source	Feedback
Staff	Staff told us that they had good working relationships with the manager and lead GP and felt confident to raise any issues.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

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Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>The practice understood its risks and areas where improvements were required. For example, the practice was aware that its performance regarding access to appointments was below local and national averages in the national GP patient survey. The practice identified this as a risk and had taken measures to improve. As a result, we saw that the practice had improved its performance in the latest national GP patient survey results in July 2021 compared to July 2020.</p> <p>The practice had a PMS contract but was migrating to a GMS contract. The practice identified some of the financial risks and was exploring how best to manage the risk including working closely with another practice so that both practices could share resources.</p>	

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

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

Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>There was evidence that the practice had undertaken significant work to assess its performance. For example, in cancer screening, childhood immunisation, prescribing as well as other aspects of care such as delivering end of life care. There was evidence that the practice utilised relevant data to identify performance issues and developed relevant action plans to deliver improvement.</p>	

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

The practice told us that they followed appropriate data guidelines. They used the CCG application (iPlato) for making appointments and messaging patients which adhered to guidance.

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>We spoke with a member of the practice Patient Participation Group (PPG) on the telephone and they told us that the practice engaged with the group and sought their feedback on improving services. The practice was able to refer patients to a PCN First contact physiotherapist who were able to help patients with musculoskeletal issues such as back, neck and joint pain by assessing and diagnosing any issues, providing expert advice on how best to manage their condition. This service was accessed through the Primary Care Network (PCN).</p>	

Feedback from Patient Participation Group.

Feedback
<p>We spoke with a member of the PPG and they were positive about the practice. They told us that the practice listened to their feedback and was open and honest with them.</p>

Continuous improvement and innovation

There were 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
<p>The practice had carried out several audits demonstrating continuous improvements. We were told that the practice had signed up almost all its patients (99%) on the Electronic Prescription Service (e-prescribing) which helps to enhance patient safety, reduce costs, increases access to patient prescription records as well as improving workflow.</p> <p>The practice told us that they were able to switch to video consultation using new technology almost overnight, demonstrating their ability for continuous learning, improvement and innovation.</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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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

For example:

The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020) was 43%. The CCG average was 59% and the national average was 66%. However, the 2021 results showed that the practice achievement was 60% compared to the CCG average of 62% and the national average of 71%.

Similarly, the percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020) was 49% compared to the CCG average of 68% and the national average of 73%. The 2021 national GP patient showed that the practice had made improvements.