

Care Quality Commission

Inspection Evidence Table

Dr Christopher John George Wright (1-506336798)

Inspection date: 26 May 2021

Date of data download: 14 May 2021

Overall rating: Good

The practice is now rated as Good overall due to improvements made to the oversight and governance of the services provided, and quality improvement activity.

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

Safe

Rating: Requires Improvement

This practice is rated as requires improvement for providing safe services because:

- Although the practice had a system in place to monitor and review patients prescribed high-risk medicines, we found some examples of incomplete monitoring or recording of monitoring activities.
- The practice had systems in place for responding to safety alerts; however, this was not always effective.
- The practice was correctly monitoring indemnity arrangements and professional registrations for most clinical staff, but this was not case for one clinician.
- Infection prevention and control arrangements were not always in line with published guidelines.
- The provider had appropriate arrangements in place to manage safeguarding and significant events.

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	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

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.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>¹The practice had a system in place for ensuring that clinical staff were registered and indemnified; however, we found the staff file for one member of staff did not contain evidence that they were registered or indemnified. We have seen evidence that the practice is in the process of obtaining this information.</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:	Y
There was a record of equipment calibration. Date of last calibration: 07/08/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed.	Y

Date of completion: 22/10/2020	
The risk assessment identified the use of portable heaters as a medium risk as they were more likely to cause fires than fixed heating systems. They were still in use at the time of the inspection and we were told this was due to the main heating system not working.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 22/10/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 22/10/2020	Y

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: 13/05/2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial ¹
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
<p>Explanation of any answers and additional evidence:</p> <p>¹The practice had effective infection prevention and control (IPC) arrangements in place. However, the practice carried out an IPC audit and identified an external cleaning company had failed to clean to an adequate standard and had not been completing cleaning schedules. They had made several attempts to resolve these issues; however, during the inspection we found that the cleaning schedules were still not being completed. We also found that the mops in the cleaning cupboard had not been stored properly and in accordance with the colour codes assigned to each cleaning area. The practice told us they had terminated the contract with this company.</p>	

Risks to patients

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

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

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.65	0.59	0.76	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). (01/01/2020 to 31/12/2020) (NHSBSA)	10.2%	9.6%	9.5%	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 (01/07/2020 to 31/12/2020) (NHSBSA)	5.35	5.57	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	30.9‰	73.4‰	127.1‰	Significant Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	1.20	0.44	0.67	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.	Y

Medicines management	Y/N/Partial
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.	Partial ^{1, 2}
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹There was a process in place for the monitoring of high risk drugs; however, we found instances when this was not followed. We reviewed the records of three patients prescribed one high risk drug whose monitoring appeared to be incomplete. Two of these patients had not had their required Body Mass Indicator (BMI) recorded, and one patient had not received the required blood monitoring since 2014. Following the inspection, the practice had contacted the patient requiring the blood monitoring and arranged for this to be completed. The practice told us that it has been difficult to obtain BMI for patients during the pandemic as some patients do not wish to attend the practice, and many patients did not own weighing scales.</p> <p>²A fourth patient was identified who had been prescribed a high risk drug but there was no record to confirm they had received the required blood monitoring. Following the inspection, the practice provided evidence that the patient had received the required regular monitoring at the hospital, and this will be transcribed to the patient records going forward. There was no record to indicate that the results of this monitoring had been checked by the prescriber before a prescription was issued.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y ¹
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:	8
Number of events that required action:	8
Explanation of any answers and additional evidence:	
<p>¹At the last inspection the practice was advised to undertake an assessment of how clinical incidents can be identified, recorded and analysed for improvements. At this inspection we found the practice had an effective system for recording and acting on significant events and provided several examples of incidents which had been recorded and discussed in team meetings.</p>	

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

Event	Specific action taken
The process for two week referrals was not followed, resulting in an unnecessary delay.	Relevant staff are to be given clearer instructions regarding the procedure for two week referrals.
The process for a new on call system was not always being followed. The practice identified a number of actions where it was unclear if they had been completed.	The practice provided further training; and introduced a new process where a named duty doctor and non-clinical staff were responsible for ensuring that actions were completed properly.
The telephone system failed due to a network issue.	The business continuity plan was actioned to ensure patients could access the service.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

¹The practice had processes in place to respond to safety alerts; however, we found instances where these processes had not been followed. We reviewed the records of three patients who were prescribed one of three medicines that were the subject of safety alerts. No record was found to indicate that action had been taken in response to the safety alerts, name advice regarding the risks. Following the inspection, the practice provided evidence that all these patients had received the necessary advice from a consultant, but this had not been recorded. The patient records have now been updated.

Effective

Rating: Good

At our previous inspection in October 2019 the practice was rated requires improvement because:

- There were gaps in staff training in the areas of Safeguarding, Sepsis and Mental Capacity
- Act.
- The childhood immunisations and cervical screening uptake were below average.
- Some of the non-clinical staff we spoke to said that staffing levels were not sufficient.

During this inspection we found these issues had been addressed.

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: Requires Improvement

Findings

- Not all patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The percentage of patients with chronic obstructive pulmonary disease (COPD) who had been reviewed by the practice was lower than the national average.
- There were clinical indicators suggesting people with diabetes did not have their condition properly managed and controlled.
- 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, COPD, atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with 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>	77.6%	75.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	2.3% (6)	11.6%	12.3%	N/A

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) ^(QOF)	74.4%	90.2%	89.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	0.0% (0)	11.7%	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) ^(QOF)	89.5%	83.1%	82.0%	No statistical variation
PCA rate (number of PCAs).	5.0% (2)	4.5%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) ^(QOF)	55.0%	65.2%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	6.7% (13)	12.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) ^(QOF)	69.6%	71.9%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.3% (16)	6.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) ^(QOF)	89.5%	89.3%	91.8%	No statistical variation
PCA rate (number of PCAs).	9.5% (2)	5.2%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) ^(QOF)	78.9%	75.7%	75.9%	No statistical variation
PCA rate (number of PCAs).	4.1% (8)	9.4%	10.4%	N/A

Any additional evidence or comments

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The practice had continued to improve their performance in respect of reviewing patients with COPD. The percentage had increased since the last inspection from 63.4% to 74.4%; however, performance remained below the national average.

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 was higher than the national average. The practice told us they had dedicated long-term slots for pharmacists to carry out reviews for patients with long-term conditions, including for patients with diabetes. They also ran searches to support their recall system for patients with long-term conditions. The practice told us that that they took part in Healthier You, an NHS Diabetes Prevention Programme.

The Personalised Care Adjustment (PCA) rate for patients with atrial fibrillation was 9.5% and higher than the national average of 4.9%.

Findings

- The practice has not met the minimum 90% for all 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 all five childhood immunisation uptake indicators
- The practice had arrangements for following up failed attendance of children's appointments 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) (NHS England)	42	48	87.5%	Below 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)	35	42	83.3%	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)	36	42	85.7%	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)	37	42	88.1%	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)	31	43	72.1%	Below 80% uptake

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

Any additional evidence or comments

The practice performance in respect of childhood immunisations was below the WHO target of 90% for all five indicators, however uptake had increased since the previous inspection for the three indicators relating to two year olds. The practice contacted the parents or guardians of children due to have childhood immunisations (27 children), and discussed the reasons for hesitancy. The practice was able to confirm four parents did not want to have their child vaccinated. The practice was able to arrange three appointments; however, only one child went on to be vaccinated.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) <small>(Public Health England)</small>	67.6%	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) <small>(PHE)</small>	59.3%	64.8%	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>	50%	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>	100.0%	92.1%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	54.5%	56.8%	54.2%	No statistical variation

Any additional evidence or comments

The practice demonstrated that they had been monitoring their performance in relation to cancer screening and were aware that their performance was below local and national averages. They had prepared a cancer quality improvement plan with the aim of increasing uptake for cervical, breast and bowel cancer screening.

Actions included adding extra time to practice nurse appointments to allow cervical screening to be completed opportunistically. A monthly audit was also conducted to monitor performance in respect of

cervical screening and to track the progress of referrals. The practice aimed to increase uptake to 70% by April 2021 and 75% by September 2021.

The practice aimed to improve breast cancer screening administration to ensure eligible patients who had not received a mammogram were identified, and to improve uptake to 61% by September 2021 and 70% by April 2022. The practice planned to achieve this by writing to patients who have not responded to invites for screening, and by sending quarterly invites to have a discussion with clinicians about the benefits of screening.

The practice aimed to improve bowel cancer screening uptake to 42% by September 2021 and of 53% by April 2022. A monthly recall programme was introduced to invite patients identified as “non responders” to invitations for bowel cancer screening. This included offering to send the patient another sample kit.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered 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.

**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)	72.7%	86.1%	85.4%	No statistical variation
PCA rate (number of PCAs).	5.2% (3)	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)	100.0%	79.6%	81.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	37.5% (3)	7.4%	8.0%	N/A

Any additional evidence or comments

Although the percentage of patients with dementia who had their care plan reviewed was 100%, the exception PCA rate for this group of patients was higher than the national average.

The practice had completed an audit to monitor the uptake of annual physical health screenings for patients on the practice's mental health register. The practice found that 12% of these patients had received a health check. In order to improve uptake, the practice called the 45 patients who had not received a health check and was able to book appointments for 24 patients, 18 did not answer the call and 3 declined.

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	CCG average	England average
Overall QOF score (out of maximum 559)	519.4	Not Available	533.9
Overall QOF score (as a percentage of maximum)	92.9%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	3.9%	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.	Y

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
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Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice successfully increased the uptake of annual physical health screenings for patients on the practice's mental health register.

Any additional evidence or comments

The practice had undertaken six audits in the past year in relation to the uptake of cancer screening and childhood immunisations; two week breast cancer referrals; issuing statins for patients with diabetes with CVD; and patients on the practice mental health register who had not received a health check. Through these audits the practice identified areas for improvement and devised improvement plans.

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

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

Well-led

Rating: Good

At this inspection the practice was rated as Good for providing well led services due to improvements made:

- The leadership governance and culture supported the delivery of high-quality person-centred care.
- The arrangements for governance and performance management were clear and operated effectively.
- There was evidence of quality improvement activity with clear strategies to achieve targets.
- There was a culture of learning and development.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y ^{1, 2}
They had identified the actions necessary to address these challenges.	Y ^{1, 2}
Staff reported that leaders were visible and approachable.	Y ³
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: ¹ The practice management team had changed since the previous inspection. The current partners assumed the management of the practice in April 2020. During the previous inspection staff told us they had reported a staff shortage to the management team which had not been addressed. During this inspection staff reported that staffing levels were adequate, although they did sometimes need to work additional hours to provide cover when necessary. ² During the last inspection we saw there was no oversight, audit or quality assurance processes in place. During this inspection we saw evidence that the practice had carried out audits to identify areas of improvement and devise plans for improvement. This included the low uptake for cancer screening and childhood immunisations. The practice had also put in place an effective system for recognising and learning from significant events. ³ Staff we spoke to told us that the management team were approachable and had made positive changes since acquiring leadership of the practice. They told us that operational systems were clearer and more organised.	

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.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>¹During the last inspection there was a lack of evidence that the practice was undertaking quality assurance activities and had been relying on their CQC inspection findings to identify issues. During this inspection we saw that the practice was proactively identifying areas of improvement; however, further breaches had been identified in respect of the monitoring of patients prescribed high risk medicines and responding to medicines subject to safety alerts. Following the inspection, the practice provided evidence that the omissions have been addressed.</p>	

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 ¹
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
<p>Explanation of any answers and additional evidence:</p> <p>¹During the last inspection some staff told us that the management team were not proactive, and staff did not always feel able to raise this with them. Staff we spoke with during this inspection told us that the management team were approachable and there was an open door policy should they wish to raise any issues.</p>	

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

Source	Feedback
Staff questionnaire/interviews	<ul style="list-style-type: none"> Staff told us that they felt supported by the management team, and the processes in place had become more integrated and well established amongst staff. The staff we spoke to were positive about the changes that had been implemented over the previous 12 months. Staff told us they felt supported by the management team and were able to raise concerns with them.

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

Managing risks, issues and performance

There 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.	Partial ¹
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 ²
Explanation of any answers and additional evidence:	
<p>¹The practice had systems in place to recall patients with long-term conditions who required a review, and to monitor and respond to safety alerts. However, further breaches had been identified in respect of the monitoring of patients prescribed high risk medicines and responding to medicines subject to safety alerts. Following the inspection, the practice provided evidence that the omissions have been addressed.</p> <p>²During the previous inspection there was no evidence of structured governance, or an auditing process in place. During this inspection we saw that audits had been completed and improvement plans had been implemented.</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

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

Any additional evidence

Staff we spoke to told us they felt involved in the planning and delivery of services and were positive about the changes that had been made to the practice over the previous 12 months. This included the introduction of new IT systems used by the practice.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

- The practice had undertaken six audits in the past year in relation to the uptake of cancer screening and childhood immunisations; two week breast cancer referrals; issuing statins for patients with diabetes with CVD; and patients on the practice mental health register who had not received a health check. Areas of improvement were identified with plans to achieve this.
- We saw evidence that the practice had put in place an effective system for recording significant events, which were discussed in team meetings to assist with staff 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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -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.