

# Care Quality Commission

## Inspection Evidence Table

### Ashfield Road Surgery (1-4628491711)

Inspection date: 23 September 2021

Date of data download: 21 September 2021

## Overall rating: Good

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

At our previous inspection in February 2019 we rated the practice as Requires Improvement overall. This was because we identified issues related to safeguarding, health and safety and the lack of general oversight of processes and governance arrangements. At this inspection we found that these areas had been addressed and the practice is now rated as good overall.

## Safe

## Rating: Good

At our previous inspection in February 2019 we rated the practice as requires improvement for providing safe services because:

- Effective systems were not in place to ensure the appropriate management and monitoring of the practice safeguarding registers.
- Health and safety risk assessments had not been completed in all areas to ensure the safety of patients.

At this inspection we found the practice had adequately addressed all the issues previously raised and we rated the practice 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes

<b>Safeguarding</b>	<b>Y/N/Partial</b>
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the last inspection in February 2019 we found that the practice had child and adult safeguarding policies in place, but these had not been updated to reflect current guidance. At this inspection we found that policies and procedures had been updated to include information on issues such as female genital mutilation and modern day slavery. We found that staff were knowledgeable about safeguarding procedures and knew how to identify and report concerns.</li> <li>The practice had identified lead roles for three members of its administration staff. One of the staff was responsible for the ongoing updating and reconciliation of the safeguarding registers for both children and adults. The staff carried out regular audits to ensure patients were appropriately coded, follow up and safety netting of all patients was in place. Regular planned meetings were held with the lead clinician to discuss the registers and outcome of audits.</li> <li>At the last inspection we found that not all staff had received safeguarding training appropriate to their role and not all staff who acted as chaperones were trained for this role. At this inspection we found that this had been addressed and all staff had completed the level of training required for their role.</li> <li>Where possible meetings were held with the health visitor to discuss children and families where concerns had been identified.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We found that recruitment checks had been completed, which included checks for locum staff.</li> <li>Staff files were organised so that relevant documents were readily and easily accessible in one place.</li> <li>The practice manager had put systems in place to ensure that the current registration status for clinical staff was routinely checked online through the respective professional websites.</li> </ul>	

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: 24 July 2021	Yes
There was a record of equipment calibration. Date of last calibration: 28 September 2020	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 13 May 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice carried out weekly fire alarm checks. Further checks carried out included fire extinguishers.</li> <li>• The practice could demonstrate that staff had completed fire training.</li> <li>• At the inspection in September we found that training records were not organised to ensure they were easily accessible. At this inspection we found this had significantly improved.</li> <li>• We saw evidence of four staff who had been trained and identified as fire marshals.</li> </ul>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 14 September 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 6 September 2021	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Monthly checks of the premises were carried out and records maintained to identify actions needed and completed.</li> <li>• At the inspection in February 2019 we saw that the practice had window blinds with looped cords in communal and office areas. Risk assessments had not been carried out. At this inspection we found that the practice staff had addressed this. A risk assessment had been completed and action taken to make safe which included the installation of safety catches on all blinds.</li> <li>• We found that the contents of the spillage kit had been replaced and were within their expiry date.</li> <li>• Other recent checks carried out included emergency lighting, legionnaires, electric and gas checks.</li> </ul>	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• One of the practice nurses was the designated lead for infection prevention and control.</li> <li>• All staff were up to date with infection prevention and control training.</li> <li>• Infection prevention control procedures had been reviewed and implemented in line with national and local guidance to minimise the risk of COVID-19 infections. The practice had external cleaners and a cleaning schedule was in place.</li> <li>• Due to COVID-19 restrictions the practice had not had an external infection prevention and control audit carried out. However the practice infection and control lead had carried out infection and control checks to ensure staff followed COVID-19 infection prevention guidance.</li> <li>• Following this inspection the practice manager shared the outcome of the external infection control audit, which was carried out on 28 October 2021. The practice scored 98% at both sites and had plans in place to address the action identified.</li> </ul>	

## 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff records showed that newly appointed staff had an appropriate induction period which was ongoing with the support of a mentor.</li> <li>• All staff had attended training on how to respond to emergencies.</li> <li>• Reception staff were aware of how to recognise and respond to a deteriorating or unwell patient.</li> </ul>	

## 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Our review of the practice workflow found that test results were managed in a timely way.</li></ul>	

## 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.73	0.69	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	4.6%	6.8%	10.0%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	5.42	5.17	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	120.3‰	132.0‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.94	0.69	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	7.0‰	8.5‰	6.8‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes

Medicines management	Y/N/Partial
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At this inspection we found that the systems for the safe management of medicines had been reviewed and procedures updated. For example, records we examined showed emergency medicines held at the practice were checked to ensure the medicines were in date and fit for use.</li> <li>Where recommended emergency medicines were not routinely held, the practice had undertaken appropriate risk assessments.</li> <li>Prescribing data showed the practice to be in line with or showing positive variation when compared to other practices locally and nationally.</li> <li>We reviewed records for patients prescribed two different anti-inflammatory medicines that required regular monitoring. We found for one of the medicines that two of the eleven patients had not had the appropriate monitoring carried out. We also identified that the day of the week this medicine should be taken was not routinely recorded in line with best practice.</li> <li>We reviewed a sample of records for patients prescribed two high risk medicines requiring routine blood tests and found that appropriate and routine monitoring had not been completed for all patients. For example, we found that the blood test results for one of the medicines (used to stop the blood clotting as normal) were not recorded in patient records. Our discussion with the GPs identified that this was due to an issue with accessing external test results. To address this the practice had requested access to the relevant reporting system.</li> <li>The practice followed up all the issues relating to medicine management mentioned above immediately. Evidence to demonstrate the action taken or planned was obtained prior to the inspection site visit and confirmed on the day of the visit.</li> <li>There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately.</li> </ul>	

## 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	9
Number of events that required action:	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was a system for recording and acting on significant events.</li> <li>• Practice staff confirmed that significant events had been discussed at practice meetings.</li> <li>• Staff told us that incidents were logged and reported to the lead GP and managers.</li> <li>• We found that the format used to document significant events had been reviewed and improved. Documented information showed evidence of learning and dissemination of information to staff.</li> </ul>	

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

Event	Specific action taken
Inappropriate behaviour/communication of patient	<ul style="list-style-type: none"> <li>• A risk assessment was completed and one to one counselling provided for the staff involved. Staff also received training on personal safety and instructed on how to raise an alert when dealing with an aggressive or threatening situation.</li> </ul>
Incorrect test results given to patient	<ul style="list-style-type: none"> <li>• Patient contacted and correct results given and an appointment was arranged.</li> <li>• A review was carried out and staff received training relating to who and by what method test results should be shared with patients</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We found that the practice had a system in place to act on alerts which may affect patient safety. However, five records randomly examined identified concerns with the combination of medicines prescribed for three patients, which did not reflect best practice. We also found that recent blood tests results were not recorded for the three patients. The practice addressed this immediately and evidence was provided to confirm that all patients had been reviewed and the medicines prescribed were in line with current guidance. The need for the change in patient's treatment was discussed with them.</li> <li>• We also found that the safety alerts action sheets were not easy to read. This was discussed with the management team and plans put in place to address this.</li> </ul>	



## 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Our review of the practice clinical system identified appropriate management of patients care and treatment. Staff told us how they had responded to changing guidance during the pandemic and had undertaken training related to remote consultations and the administration of the new vaccines.</li> </ul>	

## Older people

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>The practice carried out structured annual medicines reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> </ul>

## 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 suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	74.3%	75.5%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.5% (6)	6.7%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.3%	88.4%	89.4%	No statistical variation
PCA rate (number of PCAs).	5.0% (6)	8.6%	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>	81.5%	80.6%	82.0%	No statistical variation
PCA* rate (number of PCAs).	0.7% (1)	3.9%	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>	54.3%	64.0%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.2% (8)	11.8%	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>	66.6%	70.5%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.7% (31)	5.6%	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) <small>(QOF)</small>	95.4%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	6.5% (6)	3.7%	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>	64.9%	73.0%	75.9%	No statistical variation
PCA rate (number of PCAs).	2.4% (9)	8.4%	10.4%	N/A

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

### Any additional evidence or comments

- Reported outcomes for the management of most patients with long term conditions were in line with local and national averages. One indicator for the percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c was 58 mmol/mol or less in the preceding 12 months for the period 1 April 2019 to 31 March 2020 that showed a negative variation when compared to the local and England average. However, the Personalised Care Adjustment (PCA) was significantly lower than the local and England average.
- Our review of patient records identified 13 patients as having a potential missed diagnosis of diabetes. We found that four of the five records examined identified concerns with coding. We discussed the data and our findings with the clinicians, which included the advanced nurse practitioner. The clinicians took immediate action to reconcile the patient records to ensure appropriate coding.
- The clinicians also shared with us, details of a two cycle audit that they had started to improve the management of patients with diabetes.

**Findings**

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

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	57	62	91.9%	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)	67	70	95.7%	Met 95% WHO based target
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)	67	70	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	67	70	95.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	65	70	92.9%	Met 90% minimum

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

**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: 31/03/2021) <small>(Public Health England)</small>	69.6%	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>	65.4%	65.7%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	54.0%	54.9%	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>	92.6%	84.9%	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>	48.0%	48.0%	54.2%	No statistical variation

**Any additional evidence or comments**

- The practice uptake for cervical screening was 69.9%, which was below the Public Health England (PHE) target of 80% and just below the England comparison uptake target of 70% at the snapshot date of 31 March 2021. The practice attributed this slight decline to the suspension of cervical cancer screening in the early months of the COVID-19 pandemic. The practice was aware of this and had discussed how improvements could be made. A proactive call and recall system was in place and staff opportunistically, offered the procedure to female patients when they attended the practice.
- Trend data overtime showed that the practice uptake had increased over the past five years.
- With the exception of breast cancer screening, data we looked at for the uptake of cancer screening, referral and diagnosis showed an increase on the previous year.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

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

## People experiencing poor mental health (including people with dementia)

Population group rating: Good

### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and 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) <sup>(QOF)</sup>	70.5%	75.1%	85.4%	No statistical variation
PCA* rate (number of PCAs).	0.0% (0)	15.8%	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) <sup>(QOF)</sup>	85.7%	66.7%	81.4%	No statistical variation
PCA rate (number of PCAs).	9.7% (3)	9.8%	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)	530.8	533.9
Overall QOF score (as a percentage of maximum)	95%	95.5%
Overall QOF PCA reporting (all domains)	4.1%	5.9%

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

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

The practice had started the first of a two cycle audit to identify and improve the management of patients diagnosed with type 1 and 2 diabetes. The first cycle of the audit had identified 85 patients with poorly controlled diabetes. At the time of this inspection the first cycle of the audit was still in progress and 69 of the 85 patients identified had been reviewed. The outcomes of the first cycle to date, had identified patients who were compliant with treatment, non-compliant or declined treatment. Based on the practice findings clinical management plans were put in place to assess, educate and review the individual needs of all the patients' identified by the audit. The care management plan would also involve collaboration with diabetes specialist teams in secondary care.

### Any additional evidence or comments

The practice had developed a programme of audits planned to be completed in 2020/2021. Examples included the management of diabetes, cervical cytology, medicine management and the outcomes related to contraceptive implants. The practice also carried out regular audits relating to the governance arrangements and the day to day operation of the practice.

## 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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the last inspection in February 2019 the practice management team did not have a structured approach to collating evidence and monitoring the training received by staff. At this inspection we found that staff training records had been organised to demonstrate recent training completed by staff.</li> <li>Training records we reviewed showed that staff had completed relevant mandatory training and training applicable to their role. Staff were aware of the training they had to complete and had access to online training.</li> <li>At the inspection in February 2019 we found that only one member of staff had had an appraisal completed. At that time the practice manager was responsible for completing appraisals for all staff. At this inspection the role had been reviewed. We saw that the lead GP was formally involved in the appraisal of the advanced nurse practitioner, practice nurses and advanced clinical pharmacist. The practice manager carried out the appraisal of non-clinical staff.</li> <li>We saw that the advanced nurse practitioner and practice nurse took responsibility for their professional development. Staff confirmed that they were supported to meet the requirements of professional revalidation. The advanced nurse practitioner told us that they had an allocated supervisor at the practice and had received supervision of their clinical and non-medical prescribing practices. However, we were told that this was an informal process and records were not maintained to evidence the process and discussions that took place. The practice responded positively to this and forwarded a detailed supervision programme.</li> </ul>	



## 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence:	

## 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had a self-care page on its website, which signposted patients to advice and health and wellbeing information.</li> <li>• The practice had access to a social prescriber who was able to provide support to patients and signpost them to relevant services in the community.</li> <li>• Staff at the practice helped to support the local COVID-19 vaccine programme. Home visits were made to patients who were assessed as vulnerable and their health needs prevented them from attending the practice or designated hub sites.</li> </ul>	

## 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Practice staff were aware of legislation and guidance when considering consent and put this into practice when providing care and treatment to patients.</li><li>• Our clinical searches identified that DNACPR decisions made were appropriate and clearly recorded.</li></ul>	

## Well-led

**Rating: Good**

At our previous inspection in February 2019 we rated the practice as requires improvement for providing well led services because:

- The practice did not have a documented strategy.
- There were gaps in the practice's governance arrangements.
- Effective management oversight of systems to confirm ongoing monitoring, continuous learning and improved processes was not evident.
- The practice did not have management oversight of the maintenance of up to date records of staff qualifications and training.
- When incidents happened, the practice investigated but there was an absence of fully documented records of the incident to clearly show the actions taken to prevent further occurrence and embedded learning from events.
- Minutes of meetings lacked information to demonstrate, who had attended, discussions held, decisions made, action to be taken and by who and learning to be disseminated.

At this inspection we found the practice had adequately addressed all the issues previously raised and we rated the practice as good for providing well led services.

### 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.	Yes	
They had identified the actions necessary to address these challenges.	Yes	
Staff reported that leaders were visible and approachable.	Yes	
There was a leadership development programme, including a succession plan.	Yes	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice spoke about the challenges of the COVID-19 pandemic and how they had adapted to this in order to continue to deliver services to their population.</li><li>• The practice was also part of a local Primary Care Network (PCN), working with other local practices to deliver and improve services locally.</li><li>• At the last inspection the practice did not have a documented strategy. At this inspection we found that improvements had been made. We saw evidence of a clear and identified leadership structure and staff expressed a confidence in the leadership team. The practice had considered succession planning and had recently taken on a salaried GP.</li><li>• The provider and management team with the inclusion of all the staff working at the practice had developed a detailed business and development plan.</li><li>• The development of the practice included areas to improve services for patients. For example, the practice worked with local colleagues and services to ensure patients had continuous access to care and treatment during the COVID-19 pandemic.</li><li>• The practice had plans to increase the diversity of staff within the practice. This was evidenced by the active support and encouragement for existing staff to develop their skills and advance professionally.</li></ul>		

## 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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our last inspection in February 2019 we found that the practice did not have a strategy in place to achieve its vision and values and monitor its progress. At this inspection we found that this had been rectified and the practice vision and values formed part of its overall written strategy.</li> <li>The vision of the practice aimed to provide a service which fulfilled the health care needs of its patients. The practice values linked to this included looking after its patients and staff by supporting development, involvement and explaining decisions.</li> </ul>	

## 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Following our last inspection in February 2019, the practice management team had reviewed the processes in place for managing complaints and significant events. We found that new systems which included paperwork had been put in place. Records we examined showed that they were more comprehensive and included details of the investigation and analysis of incidents and concerns raised.</li> </ul>	

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

Source	Feedback
Staff Interviews	<ul style="list-style-type: none"> <li>Staff we spoke with said they felt supported and found the leadership of the practice approachable.</li> <li>Staff also said they felt they could raise and discuss any issues or concerns.</li> </ul>

### 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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection in February 2019 we found there was a lack of clear oversight in the day to day running of practice. At this inspection we found the management team had made significant improvements and could demonstrate clear governance arrangements were in place.</li> <li>The practice held monthly governance meetings with staff to ensure important information was shared and discussed.</li> <li>Staff responsibilities covered governance arrangements and these were proactively monitored and reviewed.</li> <li>The management team had oversight of training completed by staff and staff recruitment and training records were organised to ensure they were easily accessible.</li> <li>At this inspection we found that the minutes of meetings were available and were more detailed to demonstrate, who had attended, discussions held, decisions made, action to be taken and learning to be disseminated. We found that some handwritten reports were difficult to read. This was discussed with the management team who assured us that these would be reviewed.</li> <li>We found at this inspection that overall systems and processes such as safeguarding, staff appraisals, record keeping, minutes of meetings and training had been reviewed and improved.</li> </ul>	

### 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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

- Health and Safety risk assessments had been completed and acted on where issues had been identified.
- The practice had a business continuity plan to mitigate risks to patients, staff in the event of any disruption to the service.
- Risks assessments and arrangements were in place for managing the premises and staff.
- The practice's overall performance in relation to patient and outcomes and satisfaction with the service were in line with local and national averages.
- Our clinical system searches found appropriate management of patients and clinical risks.
- Staff had received appropriate training to help manage potential risks to patients and the service, such as basic life support and fire safety training.
- The practice was able to share with us examples of audits undertaken to support service improvements.

**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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Explanation of any answers and additional evidence:

- There were arrangements in place for staff to work remotely to support the continuity of services, if needed.
- Patients that were potentially digitally excluded could still contact the practice via telephone and were assessed by a clinical member of staff. A face to face appointment was provided if needed.
- Home visits were available to the practice's most vulnerable patients.
- Results from the latest published GP national patient survey showed high levels of patient satisfaction with access. Of the four access related questions we reviewed the practice scored between 10% and 20% higher than the national averages.
- Infection prevention and control measures had been put in place to maintain staff and patient safety during the pandemic.

## 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.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection in February 2019 we found that the management team did not have oversight of the maintenance and updating of records which would support effective governance arrangements. This included inappropriate maintenance of staff records, the absence of fully documented records of significant events to demonstrate actions taken and learning from events.</li> <li>Records checked at this inspection showed that the availability and quality of documentation had significantly improved.</li> <li>Our remote searches of the practice clinical system did not identify any significant concerns related to the use of data and information to support decisions specific to patient care and treatment.</li> </ul>	

## 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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice used NHS approved software when consulting with patients remotely.</li> <li>Staff had received training and had access to guidance when undertaking remote consultations.</li> </ul>	

## 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.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff were able to raise suggestions through the practice meetings.</li> </ul>	

## Continuous improvement and innovation

**There were systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the last inspection we found there was a lack of information to demonstrate processes were embedded and that there was a structured approach to support learning and improvement. At this inspection we found that the practice had improved. Systems had been introduced to enable staff to discuss issues related to the operation of the practice.</li> <li>Records examined showed shared learning with staff and changes implemented and monitored to support improvement. For example, all staff which included reception and administration staff were encouraged to be involved in the audit process and share the outcomes of these at practice meetings.</li> </ul>	

## Examples of continuous learning and improvement

<ul style="list-style-type: none"> <li>Practice staff were encouraged to develop their skills to maintain competences and professional development was supported. For example, the practice nurse was being supported by the practice to complete the advanced nurse practitioner course.</li> <li>The practice worked with other practices within their primary care network group based in Wolverhampton. This provided peer support and opportunities for learning and improvement.</li> <li>The practice was continuing to increase the number and skill mix of clinicians and nursing staff within the practice to support the diversity of skills and services it would be able to offer patients. Recent staff recruited at the practice was a newly qualified nurse who would be enrolled onto and be supported by the practice to complete the practice nurse foundation course. One of the receptionists had completed their apprenticeship at the practice and was successful in securing a permanent role as a receptionist.</li> </ul>
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## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

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

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

## Glossary of terms used in the data.

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