

Care Quality Commission

Inspection Evidence Table

South Norwood Hill Medical Centre (1-547367777)

Inspection date: Remote Clinical Review on 13 July 2021; Site Visit on 15 July 2021

Date of data download: 05 July 2021

Overall rating: Requires Improvement

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

During the last inspection the practice was rated as requires improvement overall (requires improvement in safe and well-led) for issues in relation to maintaining staff vaccination records, medicines management, medicines reviews, uptake for childhood immunisations and cervical screening. While there had been some improvements, we found new issues and the practice was again rated as requires improvement.

Safe

Rating: Requires Improvement

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

- The systems and processes in relation to safeguarding required improvement.
- Recruitment records were not complete and accessible.
- Fire and infection control procedures in place required improvement.
- The provider had not carried out premises and health and safety risk assessments.
- The practice did not have appropriate systems in place for the safe management of medicines.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Partial ¹
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y

Safeguarding	Y/N/Partial
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
<p>1. The safeguarding adults' policy did not include local authority contact details for staff to make safeguarding referrals. The safeguarding policy did not include information on female genital mutilation (FGM) and how staff would report incidences of FGM. The provider had a separate FGM policy; however, there was no reference to the FGM policy in the safeguarding adults and children policy.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>1. During the inspection we reviewed the recruitment records of a clinical member of staff and found there was no signed contract, appraisal, references and Disclosure and Barring Service (DBS) check for this staff. The provider informed us that the recruitment records needed to be organised. Following the inspection, the provider was able to send us a copy of the signed contract and DBS check; however, they were not able to provide us with details of appraisal and references for this staff.</p> <p>The provider had a recruitment policy in place; however; on review it read like a recruitment checklist. After we raised this issue with the provider, they devised a detailed recruitment and selection policy and sent us evidence to demonstrate this.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 25 June 2021	Y
There was a record of equipment calibration. Date of last calibration: 21 June 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Partial ¹
A fire risk assessment had been completed.	Y

Date of completion: June 2021	
Actions from fire risk assessment were identified and completed.	Y ²
<p>1. The provider had a fire procedure in place; however, this was not displayed in the waiting area for patients. The provider informed us that staff were aware of the fire procedure. Following the inspection, the provider informed us that they had displayed the fire procedure in the waiting area and sent us evidence to support this.</p> <p>The provider undertook fire drills every six months. However, the provider had not recorded any details of these fire drills to ensure learning. Following the inspection, the provider informed us that they had put a system in place to record details of the fire drills and sent us evidence to support this.</p> <p>2. The fire risk assessment had not identified any actions were necessary.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 14 July 2021	Partial ¹
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14 July 2021	Partial ²
<p>1. The provider had completed a premises and equipment safety assessment; however, on review the assessment only included details of responsibilities of staff and guidance for staff to follow when handling non-clinical equipment and did not include a risk assessment of the premises.</p> <p>2. The provider had a health and safety policy which included details of how to conduct a risk assessment; however, they had not carried out a risk assessment.</p> <p>After we raised this issue with the provider, they completed a premises and health and safety risk assessment on 14 July 2021 and sent us evidence to support this. A review of the risk assessment indicated that the provider had completed all actions.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	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>During the inspection we found that the room used for minor surgery had been recently refurbished; however, the flooring where the floor met the wall was not curved at the junction to assist with cleaning and maintenance. The provider informed us that they had requested quotes from contractors to undertake this work and would address this issue in the near future.</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 ¹
1. Staff we spoke to were aware of actions to take if they encountered a deteriorating or acutely unwell patient; however, one of the non-clinical staff we spoke to indicated they had not completed any formal training on identifying such patients.	

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.60	0.59	0.70	No statistical variation
The number of prescription items for co-	7.9%	10.8%	10.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	7.84	5.53	5.37	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	49.8‰	60.0‰	126.9‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.36	0.60	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	2.7‰	4.5‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial ²
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial ³
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>1. During the inspection we found three patients taking methotrexate (a medicine used to suppress the immune system) did not have the required monitoring. We reviewed the records of these patients and found that monitoring blood tests were requested for these patients on 6 July 2021.</p> <p>During the inspection we found two patients taking azathioprine (a medicine used to suppress the immune system) did not have the required monitoring. We reviewed the records of these patients and found that monitoring blood tests were requested for these patients on 6 July 2021.</p> <p>During the inspection we found all patients taking lithium (a medicine used to treat mental health disorders) had the required monitoring.</p> <p>During the inspection we found eight patients taking spironolactone (a medicine used to treat heart failure) have not appeared to have had the required monitoring. A review of records of five of these patients indicated that this medicine was stopped for two patients in the last six months; for the other three patients' blood results were overdue. Following the inspection the provider informed us that they had reviewed these eight patients and found that six patients had their blood tests in the last six months; for one patient blood tests were requested on 6 July 2021; for the remaining one patient blood test was requested following the inspection. The provider informed us that they had added this medicine to their monthly monitoring of medicines to ensure all patients were appropriately monitored.</p> <p>During the inspection we found six patients taking warfarin (a medicine used to thin blood) had not appeared to have had the required monitoring. A review of records of five of these patients' blood test results showed these were overdue for two patients.</p> <p>During the inspection we found that three patients taking novel oral anticoagulants (medicines used to thin blood) did not have the required monitoring. However, a review of records of these three patients indicated that this medicine was stopped for two patients and for one patient</p>	

Medicines management	Y/N/Partial
<p>blood results was overdue. Following the inspection, the provider informed us they had contacted this patient; however, did not receive a response.</p> <p>2. The practice did not stock the emergency medicine dexamethasone (medicine used to treat croup) and did not have paediatric defibrillator pads and had not carried out a risk assessment or considered the risk to patients of not having these. After we raised this issue with the provider, they ordered this medicine and paediatric defibrillator pads and sent us evidence to support this.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial ¹
Number of events recorded in last 12 months:	16
Number of events that required action:	16
1. Two of the staff members we spoke to during the inspection were not able to share an example of a recent significant event.	

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

Event	Specific action taken
A two week wait referral was missed by administrative staff for a patient due to a member of clinical staff not following the practice protocol for two-week wait referrals.	<ul style="list-style-type: none"> The patient was notified of this incident, reassured and a two week wait referral was completed. There was no detrimental impact on the patient. Protocol for two-week wait was shared with the member of clinical staff. The provider introduced a system of weekly searches by administrative staff to identify if any new referral requests made by GPs were missed.

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
1. During the inspection we reviewed the records of five patients on carbimazole (a medicine used to reduce thyroid hormone) and found that the discussion of the risks of pregnancy and the use of	

effective contraception was not documented in the patient notes for three patients. Following the inspection, the provider informed us that they contacted these patients and had sent them an information leaflet regarding carbimazole and pregnancy, with precaution guidelines. They informed us that the risks would be regularly discussed in medicines reviews in the future.

Effective

Rating: Requires Improvement

The practice was rated as requires improvement for providing effective services including the population groups families children and young people and working age people and inadequate for population group people with long-term conditions because:

- Outcomes for patients with long-term conditions were significantly below average.
- Medicines reviews were not always undertaken for patients with long-term conditions.
- Uptake for childhood immunisations and cervical screening was below average.
- The provider could not demonstrate improved outcomes for patients through clinical audits or other quality improvement activities.

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: Inadequate

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, only 16% of patients with asthma had received a review in the last year which is a significant decline when compared to 2019/20 results. Only 33% of patients with Chronic Obstructive Pulmonary Disease (COPD) had a review in the last year which is a significant decline when compared to 2019/20 results. The provider informed us this was due to the Covid-19 lockdown, patients who were shielding and lack of face to face consultations during the pandemic and due to the reduced availability of the practice nurse for a period of time which was no longer the case as the practice nurse had recently returned to normal sessions. The personalised care adjustment for patients with COPD for 2019/20 was significantly higher when compared to the local and England average.
- During the inspection we found there were 22 patients with a potential missed diagnosis of diabetes. We reviewed the records of five of these patients and found that two patients were not diabetic; the other three patients had been contacted during the last three months to arrange for repeat blood tests to ensure a diagnosis was made if relevant.
- During the inspection we found four patients who had been prescribed 12 or more asthma inhalers in the last 12 months. We reviewed the records of these four patients and found three of these patients had not received an asthma review for more than 18 months or a medicines review in the last 12 months.
- 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.
- 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>	62.1%	75.3%	76.6%	Variation (negative)
PCA* rate (number of PCAs).	7.8% (26)	9.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an	71.0%	90.2%	89.4%	Tending towards variation (negative)

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>				
PCA rate (number of PCAs).	34.0% (16)	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>	77.6%	82.2%	82.0%	No statistical variation
PCA* rate (number of PCAs).	3.3% (2)	3.4%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	60.6%	64.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	7.1% (25)	10.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	63.1%	71.0%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.7% (20)	4.9%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	91.7%	90.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	5.9% (3)	4.8%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.9%	74.9%	75.9%	No statistical variation
PCA rate (number of PCAs).	6.3% (22)	8.6%	10.4%	N/A

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

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice has not met the minimum 90% for any of the five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the five childhood immunisation uptake indicators.

(please add additional comment for any childhood immunisations indicators below 90%). The latest results shared by the practice indicated some improvement; however, they still had not achieved the minimum 90% target.

- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	58	72	80.6%	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)	60	80	75.0%	Below 80% uptake
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)	60	80	75.0%	Below 80% uptake
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)	58	80	72.5%	Below 80% uptake
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)	36	58	62.1%	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>

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The uptake for cervical screening was below the 80% target at 66.2%. Unverified latest results shared by the provider indicated they had achieved 72% uptake.
- 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) (Public Health England)	66.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	68.1%	67.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	53.2%	57.8%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.0%	93.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	45.5%	54.4%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The provider informed us

all the 26 patients with a learning disability had received a health check in the last year.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

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

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	88.1%	88.1%	85.4%	No statistical variation
PCA* rate (number of PCAs).	1.7% (1)	11.2%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.3%	82.2%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	5.6%	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

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	486.7	533.9
Overall QOF score (as a percentage of maximum)	87.1%	95.5%
Overall QOF PCA reporting (all domains)	4.6%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial ¹
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

1. The provider had not effectively demonstrated improvements based on clinical audits or other quality improvement activities since the last inspection. However, they had completed the following audits which were all single cycle audits where improvements were not identified, implemented and monitored:

- Controlled Drugs prescribing audit (June 2021).
- Minor operations audit (June 2021).
- Cervical screening audit (June 2021).

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.	Partial ¹
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
There was a clear and appropriate approach for supporting and managing staff when	Y

their performance was poor or variable.	
1. During the inspection we reviewed the recruitment records of a clinical member of staff and found there was no appraisal for this member of staff.	

Coordinating care and treatment

Staff worked 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.	N/A ¹
During the inspection we did not find any patients with a DNACPR decision; hence, we were not able to review any decisions made. Following the inspection, the provider informed us that they had introduced a DNACPR template in their electronic patient management system and this would be used for recording discussions regarding palliative care, future planning and patient wishes.	

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led service because:

- The governance arrangements in relation to identifying, managing and mitigating risks required improvement.
- The practice had no access to a Freedom to Speak Up Guardian.
- The practice did not have an active Patient Participation Group.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y ¹
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
1. The provider informed us that the practice manager had recently left the practice and they were being supported by the part-time managing partner on a temporary basis until a new practice manager was recruited.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial ¹
The practice had access to a Freedom to Speak Up Guardian.	N ¹
Staff had undertaken equality and diversity training.	Y
1. The provider had a whistleblowing policy in place; however, the practice had no access to a Freedom to Speak Up Guardian. Following the inspection, the provider informed us that they had made the information on freedom to speak guardian accessible to staff and said it will be discussed in their next clinical meeting.	

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

Source	Feedback
Feedback from staff	<ul style="list-style-type: none"> Staff we spoke to reported they had seen improvements since the last inspection in areas including appointments, diabetic clinics and that patients were monitored regularly. Staff in general told us they observed an open culture, staff worked well as a team and felt supported by the management.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
1. While there were governance arrangements in place, the provider failed to identify, manage and mitigate risks.	

Managing risks, issues and performance

The processes for managing risks, issues and performance requires improvement.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial ¹
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial ²
There were effective arrangements for identifying, managing and mitigating risks.	Partial 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
1. The risks in relation to safeguarding, recruitment records, safety systems and records, health and safety and medicines management had not been identified by the provider's own governance systems. 2. The provider had not effectively demonstrated improvements based on clinical audits or other quality improvement activities in the last two years.	

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 (PPG).	N
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	Y

needs of the population.	
1. The provider informed us that they had not had any PPG meetings since the pandemic. They currently had three PPG members who provided their feedback to the practice. The provider informed us that they had put some notices in the waiting area in relation to PPG to encourage patients to join the PPG; however, this has not led to any new members.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial ¹
1. Two of the staff members (one clinical and one non-clinical) we spoke to during the inspection were not able to share an example of a recent significant event.	

Examples of continuous learning and improvement

We did not see any examples of continuous learning and improvement.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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