

Care Quality Commission

Inspection Evidence Table

Chelsea Medical Services (1-6654175832)

Inspection date: 30 November 2020

Date of data download: 28 November 2020

Overall rating: Requires improvement

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

Safe improvement

Rating:

Requires

The practice was previously rated inadequate for providing safe services, as the systems for safeguarding, recruitment, staff training, infection prevention and control, high-risk medicines monitoring, medicine management, storage of patients' records, health & safety monitoring, patient safety alerts were not embedded or effective. At this inspection, we found that most of the issues previously identified had been addressed.

We rated the practice **requires improvement** for providing safe services because:

- The practice did not have clear systems and processes to keep patients safe. In particular, we found three patients prescribed a high-risk medicine without being monitored appropriately.
- We found five patients who were not informed of the side-effect of a medicine they were prescribed.

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

Safeguarding	Y/N/Partial
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence	
At the last comprehensive inspection:	
<ul style="list-style-type: none"> The provider could not demonstrate that practice policies were regularly reviewed and updated as required. The provider was not aware of the recent intercollegiate guidance update regarding training requirements for some clinical and non-clinical staff. At this inspection, we saw that practice policies had been updated, and all staff had received safeguarding training at the appropriate level. We reviewed five staff records regarding DBS checks. We saw evidence that the last DBS check undertaken for one member of staff was in 2015 and from a previous employer. The provider had not undertaken a written risk assessment as to whether a new DBS check should be undertaken. At this inspection, we saw that all staff had received a DBS check. Staff told us they invited Health Visitors to meetings to support and protect adults and children at risk of significant harm. However, they could not demonstrate evidence of this. At this inspection, we did not see evidence of the involvement of a health visitor but did see evidence of liaison with the local social work team. Following the inspection, the provider forwarded evidence that the practice was assigned a health visitor in November 2020. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence	
At the last comprehensive inspection:	
<ul style="list-style-type: none"> The provider could not demonstrate they had a safe recruitment system in place. We reviewed five staff records and found gaps in these records. For example, three records did not contain a 	

photo ID. There were no induction records for four out of four staff. At this inspection, we found that recruitment and induction records were in place for all staff.

- The provider could not demonstrate that any member of staff in direct clinical contact had a complete record of the requisite blood tests and vaccinations to keep patients safe, or who had certified immunity, in line with current Public Health England (PHE) guidance. At this inspection, the provider showed us evidence of the required blood tests and vaccinations for all clinical staff.
- The provider could not demonstrate they had a system in place to monitor registrations for professional staff on a regular basis. At this inspection, we saw that the provider had a system to monitor registrations for professional staff on a monthly basis.

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: 25/02/2020	Y
There was a record of equipment calibration. Date of last calibration: 25/02/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 19/11/2020	Y
There was a log of fire drills. Date of last drill: 15/11/2020	Y
There was a record of fire alarm checks. Date of last check: 19/11/2020	Y
There was a record of fire training for staff. Date of last training: 15/11/2020	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 19/11/2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence	
At the last comprehensive inspection:	
<ul style="list-style-type: none"> • The provider could not demonstrate they had undertaken portable appliance testing (PAT). At this inspection, we saw that equipment had been PAT tested in February 2020. • The provider submitted evidence of the control of substances hazardous to health (COSHH) risk assessment. However, it did not contain data sheets and did not include all substances held on the practice premises in the COSHH risk assessment. At this inspection, we saw there was a COSHH risk assessment for all hazardous substances stored on the practice premises. 	

- The provider could not demonstrate they had a fire safety policy in place. At this inspection, we saw that the practice had created a fire safety policy that was accessible to all staff.
- The provider submitted a record of fire extinguisher checks. However, this expired in May 2019. At this inspection, we saw evidence of up-to-date fire extinguisher checks.
- We saw in minutes of a practice meeting they had discussed a fire drill. However, the provider could not demonstrate any other evidence regarding this. At this inspection, we saw evidence of fire drills taking place.
- We saw in minutes of a practice meeting they had discussed fire safety training for staff. However, the provider could not demonstrate any other evidence regarding this. At this inspection, the provider submitted evidence of regular fire drills carried out at the practice.
- The provider could not demonstrate they had fire marshals in place who were adequately trained for this role. In addition, there were no contingency plans in place for when this member of staff was away from the practice. At this inspection, we saw that all staff had received instruction in the role of a fire marshal and that a nominated fire marshal was available onsite to cover all contingencies.
- The provider could not demonstrate they had a fire safety risk assessment in place. At this inspection, the provider showed us their fire risk assessment carried out by a professional company.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 28/02/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 28/02/2020	Y
<p>Explanation of any answers and additional evidence</p> <p>At the last comprehensive inspection:</p> <ul style="list-style-type: none"> • The provider had an asbestos risk assessment in place. However, this did not meet the standards required in line with national guidance. At this inspection, we saw an appropriate asbestos risk assessment with evidence of regular checks as recommended by the risk assessment. • The provider could not demonstrate they had carried out health and safety and premises, and security risk assessments. At this inspection, we saw that the practice's health and safety risk assessment was updated to include the premises and security. 	

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: 02/09/2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence	
At the last comprehensive inspection:	
<ul style="list-style-type: none"> We found the NHS England (NHSE) Infection Prevention & Control (IPC) unit had undertaken an external IPC audit on 28 August 2019. We found some mandatory action points had not been completed within the correct timescale. At this inspection, we saw evidence that they had held a meeting with NHS property and the Clinical Commissioning Group (CCG) to organise funding and permission to carry out the outstanding mandatory actions. However, this had been put on hold due to the Covid-19 pandemic. The provider demonstrated they had done all that was reasonably practicable to address the points on the audit and that there were no outstanding risks to patient safety that required immediate attention. The provider could not demonstrate they had a Legionella risk assessment in place. This had been identified as being a high priority during an NHSE external IPC audit on 28 August 2019. NHSE IPC unit had given a four-week time scale for this to be completed. At this inspection, we saw that a Legionella risk assessment had been carried out. Cleaning equipment was incorrectly stored. Mops were not inverted, and buckets were stored close together, increasing the risk of cross contamination. At this inspection, we saw that cleaning equipment was appropriately stored. The provider could not demonstrate they undertook internal IPC audits. At this inspection, we saw that an internal IPC audit was carried out at regular intervals to ensure compliance with IPC standards. 	

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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y

The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence</p> <p>At the last comprehensive inspection:</p> <ul style="list-style-type: none"> We reviewed staff employment and recruitment records and found gaps in relation to staff induction records. At this inspection, we found induction records were in place for all staff. We found gaps in staff training for basic life support. At this inspection, all staff had received basic life support training. The provider submitted evidence of risk assessments for most areas of health and safety. The non-clinical staff we interviewed told us what actions they would take if a very unwell patient attended the practice. However, the practice could not demonstrate that all staff had undertaken sepsis or red flag signs training in line with national guidance. At this inspection, the provider submitted evidence of sepsis training completed for all staff. 	

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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence</p> <p>At the last comprehensive inspection:</p> <ul style="list-style-type: none"> We saw the practice managed electronic clinical records in line with national guidance and legislation. However, we saw that paper medical records were stored in their reception area and in a 'server room' which is easily accessible to others. At this inspection, the provider submitted evidence to show that paper medical records were no longer accessible to people passing by the reception back office area and were now stored in secure filing cabinets. We reviewed the system and process the provider had in place regarding two-week wait for urgent referrals. However, the provider could not demonstrate they operated a fail-safe system. At this inspection, the provider submitted evidence of a fail-safe system to ensure all patients were followed up by the practice. The provider could not demonstrate they had a fail-safe system in place to manage and monitor cervical smear screening. We were not assured regarding patient safety. At this inspection, the provider submitted evidence of a fail-safe system in that a record was kept of cervical smears undertaken and a system to cross-check all results were returned to the practice. 	

Appropriate and safe use of medicines

The practice systems for the appropriate and safe use of medicines, including medicines optimisation, 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) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.49	0.47	0.82	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2019 to 30/09/2020) (NHSBSA)	6.7%	8.5%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2020 to 30/09/2020) (NHSBSA)	7.34	5.48	5.34	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	35.8‰	52.4‰	124.1‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	0.72	0.75	0.68	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> We reviewed the system and process the provider had in place to monitor and manage high-risk medicines. The provider could not demonstrate they operated a safe, effective system regarding this. For example, we found evidence that six patients had not received appropriate blood monitoring. During the inspection, the provider informed us that all of the six patients had been contacted to make arrangements for them to have a blood test. <p>At the last comprehensive inspection:</p> <ul style="list-style-type: none"> The provider did not maintain stock of a medicine used for the treatment of croup in children. The provider had not conducted a risk assessment as to why they did not stock this medicine. At this inspection, the provider had the full list of emergency medicines. We found the vaccine fridges were overstocked. We found that temperatures had fallen below recommended on several occasions on the vaccine fridge in a consultation room, and no remedial actions had been undertaken regarding this. The practice did not have a system in place to monitor new stock and manage the stock rotation. Therefore, we could not be assured that the cold chain was being maintained in accordance with the Public Health England guidance. At this inspection, we found that the fridge was maintained appropriately, and the temperature checks were within range. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence</p> <p>At the last comprehensive inspection:</p> <ul style="list-style-type: none"> We were not assured that the practice monitored and reviewed information from a variety of sources to demonstrate a comprehensive approach to learning and quality improvement. They did not undertake an annual thematic analysis to identify any trends that may require further investigation. At this inspection, we saw that the provider had carried out a thematic review of significant events within the last 12 months. We reviewed evidence that demonstrated staff knew how to raise concerns regarding significant events. The practice policy for significant events did not contain information regarding significant events processes in primary care and the analysis of an incident. The practice did not use a proforma to collect relevant information when an incident had occurred and could not demonstrate that learning was shared with the staff. At this inspection, we found that the practice had submitted four significant events to the NRL in the last 12 months. All other issues identified in this area were rectified. Staff told us they did not undertake clinical meetings and therefore could not demonstrate that significant events concerning clinical concerns were thoroughly reviewed and learning was disseminated. We reviewed minutes from practice meetings; significant events were not a standing agenda item. Therefore, we could not determine if learning was adequately shared with all staff to ensure any learning was disseminated. At this inspection, we saw that the provider had implemented monthly clinical meetings; we reviewed the meeting minutes, which had significant events as a standing agenda item. 	

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

Event	Specific action taken
Delayed cancer diagnosis during COVID	<p>The practice carried out a review and determined GP action was appropriate.</p> <p>Undertook a review of all referrals that had been marked as 'non-urgent' to check they had been actioned properly during COVID and none were left outstanding.</p>

Fire door locked	The practice's daily checklist was amended to include the fire door.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence</p> <p>At the last comprehensive inspection:</p> <p>The practice could not demonstrate a consistent and fail-safe system for receiving, recording and acting on patient safety alerts. They could not show they had captured all alerts; what actions had been taken and by whom; when actions had been completed and that this information was shared with all staff. We were not assured regarding patient safety. We also found that the practice did not undertake clinical meetings. Therefore, there was limited potential for relevant patient safety alerts to be discussed by clinical staff.</p> <p>At this inspection, we reviewed the practice's detailed spreadsheet for capturing patient safety alerts. Patient safety alerts had been recorded and action taken. The provider had introduced clinical meetings and the minutes of these meetings provided evidence that patient safety alerts were discussed by clinical staff. However, the practice had not taken retrospective steps to ensure all safety alerts before the inspection carried out in November 2019 had been captured and actioned; as a result, we found that the practice had not acted on a safety alert published in February 2019 by the Medicines and Healthcare products Regulatory Agency. Following the inspection, the provider forwarded their plan to address this, actions included: identifying the relevant patients; adding a note to their record to inform the GP they should inform the patient of the side-effects of the medication before a new prescription is issued; proactively contact the patients; record in patient's notes that they have been contacted and informed of side effects and action to take if they have any symptoms.</p>	

Effective improvement

Rating:

Requires

The practice was previously rated inadequate for providing effective services because there was limited monitoring of the outcomes of care and treatment; the provider could not demonstrate they undertook any quality improvement activity; the practice was unable to show that staff had the skills, knowledge and experience to carry out their roles; some performance data was significantly below local and national averages.

At this inspection, the practice was rated as **requires improvement** for providing effective services due to the steps taken since the November 2019 inspection to improve patient outcomes. While the practice had demonstrated improvement, there were areas where performance remained below target and uptake rates:

- The practice had not met the minimum 90% for all four child immunisation uptake indicators.
- The practice was below the 70% uptake rate for cervical cancer screening.

Effective needs assessment, care and treatment

Patients' care and treatment was not always delivered in line with current evidence-based guidance.

	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.	N
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

The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
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Explanation of any answers and additional evidence:

At the last comprehensive inspection:

- We found evidence that patients' treatment was not always reviewed regularly. For example, six patients on high-risk medicines did not have appropriate regular monitoring in line with national guidance. At this inspection, we found evidence that patients' treatment was not always reviewed regularly. For example, three patients on high-risk medicines did not have appropriate regular monitoring in line with national guidance.
- Staff told us that patients with potentially serious illness were followed up in a timely way. However, they could not demonstrate they had a system and policy in place to manage and monitor this. For example, two-week-wait urgent referrals. At this inspection, the provider submitted evidence of fail-safe for two-week-wait urgent referrals and for cervical screening.

Older people

Population group rating: Good

Findings

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

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice 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.

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 <small>(QOF)</small>	98.1%	76.1%	76.6%	Significant Variation (positive)
PCA* rate (number of PCAs).	38.4% (33)	9.2%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	87.5%	88.7%	89.4%	No statistical variation
PCA rate (number of PCAs).	17.2% (5)	10.3%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.3%	80.4%	82.0%	No statistical variation
PCA rate (number of PCAs).	4.3% (2.0)	5.4%	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>	55.8%	67.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	2.3% (1.0)	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>	63.7%	72.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	5.5% (11.0)	8.2%	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>	95.7%	89.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	8.0% (2)	5.1%	4.9%	N/A

Any additional evidence or comments

The achievement rate for the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months is 98.1% this is a positive variation. However, the personalised care adjustment (PCA) rate is 38.4% (33 patients), compared to 9.2% locally and 12.3% nationally. The provider told us they believe there had been an administrative error which led to patients being added under the PCA who had received a review; we were told that the provider was looking into this and expected figures to improve next year.

Findings

- The practice has not met the minimum 90% for all four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The practice did not have a nurse at the location; patients requiring a nurse appointment were sent to a neighbouring practice that was part of the practice's GP federation. We discussed the figures with the provider and was told that several patients took their children to have their immunisations with private providers. We were also told that several patients had recently been deducted from the list of children requiring immunisation after discovering they had received their vaccinations at other practices. However, it would take a month for the data to update on their system; which would result in an improvement in their child immunisation figures. We saw that the provider had tasked an administrator with the responsibility of contacting patients to find out if they had received their vaccinations at another practice, whether they wanted to opt-out of the vaccination scheme and to book an appointment. Following the inspection, the provider submitted evidence showing that the practice received payment from their clinical commissioning group, for achieving 90% in the Q3 and Q4 immunisation targets for two and five year olds.
- 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.
- 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.

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)	18	24	75.0%	Below 80% uptake
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)	8	18	44.4%	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)	10	18	55.6%	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)	11	18	61.1%	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)	12	30	40.0%	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

- Public Health England (PHE) data demonstrated that the achievement rate for eligible women for cervical cancer screening up to 30 June 2020 was 37.8%. This was below their 2017/2018 achievement rate of 38.8%. The national achievement target is 80%. The provider told us patients in the area tend to have their screening done privately. Following the inspection, the provider submitted unverified data which showed that as of December 2020 the practice increased the cervical smear uptake to 64% for patients aged between 24 and 45 years old, and to 81% for patients aged between 50 and 64 years old. We were also told of their plan to increase the working hours of the pharmacist to focus on this area.
- 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 medication 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: 30/06/2020) (Public Health England)	37.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	48.3%	54.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	26.6%	38.4%	58.0%	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)	76.9%	93.1%	92.7%	N/A

Any additional evidence or comments

We discussed the practice's performance for persons screened for bowel cancer in the last 30 months which was 26.6%, compared to 38.4% locally and 58% nationally; this was a decline on the previous year when the practice achieved 30.3%. Following the inspection, the provider forwarded their Bowel Cancer Screening Protocol, which outlined steps the practice would take if a patient had not completed their bowel cancer screening test. The actions included: contacting at least 90% of non-responders within one

month;clinically coding any verbal advice that is given to patients; patients that are uncontactable via telephone should be sent a letter or information leaflet.

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 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 medication.
- 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>	72.0%	84.3%	85.4%	No statistical variation
PCA rate (number of PCAs).	10.7% (3)	9.2%	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>	70.0%	85.8%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	4.7%	8.0%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity which enabled them to review the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	467.45	Not Available	533.9
Overall QOF score (as a percentage of maximum)	83.6%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	4.3%	Not Available	5.9%

	Y/N/Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

At the last comprehensive inspection, we found there was a limited programme of clinical and internal audit. At this inspection, we found that the practice had broadened their quality improvement activity. The provider submitted the following audits as part of their information provider return:

- An audit of patients on antipsychotic medicines to ensure safe prescribing.
- High-risk medicine monitoring audits.
- An audit of patients on lithium audit to ensure safe prescribing.
- An audit of patients on Nonsteroidal Anti-inflammatory Drugs (NSAIDs) to ensure safe prescribing.
- An audit of patients on Direct oral anticoagulants (DOACs) to ensure safe prescribing.
- Sodium valproate audit to ensure compliance with MHRA safety alert.
- A cervical smear audit to monitor and improve cervical smear uptake.
- Monthly sodium valproate audits.

Additional quality improvement activity carried out:

- Review of the referral action required worklist to determine the number of returned referrals, common reasons why referrals are being returned to the practice and to develop an organised approach to managing future returned referrals.
- Telephone answering patterns of reception staff to assess if targets are being met.

Sodium valproate audit, July 2020:

To check if the practice has any patients of childbearing age on sodium valproate and that they are having an annual assessment and are on highly effective contraception. The search identified one patient who had undergone an assessment. The search was repeated in August 2020, when no patients were identified.

Lithium audit, July 2020:

To check patients had received a six month calcium level check.

The search identified two patients prescribed lithium who had not had their calcium levels checked within the last six months. The search was repeated in November 2020, when the practice achieved 100% compliance.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
Explanation of any answers and additional evidence	
At the last comprehensive inspection:	
<ul style="list-style-type: none"> • The provider could not demonstrate they had oversight of the clinical pharmacist role and work undertaken with patients in the practice. At this inspection, we saw evidence of the pharmacist's monthly supervision by the lead GP. • The practice could not demonstrate they assessed the learning and development needs for staff. For example, the practice had not identified that the healthcare assistant was required to undertake Care Certificate training. At this inspection, the provider showed us evidence that they had booked the healthcare assistant (HCA) onto a Care Certificate training workshop however this had been postponed due to the Covid-19 pandemic. In the meantime, the HCA was working in the capacity of an administrator. • The provider could not demonstrate policies and protocols to monitor and manage tasks undertaken by the healthcare assistant. At this inspection, the provider we saw that protocols were in place to monitor and manage the tasks undertaken by the healthcare assistant and to ensure they were appropriately supervised to carry out their role safely. • The provider could not demonstrate they had an appropriate embedded system of learning and training for staff. For example, they did not have a programme of regular training in place. They could not evidence that any staff had undertaken appropriate training regarding fire safety training and sepsis/red flag signs. At this inspection, the provider submitted evidence of a system to monitor staff training and demonstrated that staff had filled the gaps in training identified at the last inspection. • We reviewed four staff records and saw that none of them had undertaken an induction programme. We also reviewed five staff records and saw that three out of five did not contain 	

evidence of an annual appraisal. At this inspection, the practice demonstrated they had implemented induction training for new staff and a system of appraisal for all staff.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
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
For patients who accessed the practice’s digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider undertook regular multi-disciplinary meetings with the broader healthcare team regarding palliative care and older people. We reviewed minutes of meetings to evidence this.</p>	

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, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Information was available for patients on the practice website regarding signposting to other services, including social prescribing, for example, mental health well-being. • Patients had access to appropriate health assessments and checks. 	

Consent to care and treatment

The practice 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
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Caring

Rating: Good

We rated the practice as **good** for providing a caring service because:

- The practice had identified 2% of their patients as carers.
- Data from the GP Patient survey showed that the practice was in-line with local and national results.
- Patients we spoke with told us that staff dealt with patients with kindness and respect and involved them in decisions about their care.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Source	Feedback
Patient interviews	We remotely spoke with four of the practice's patients all felt they were treated with respect and dignity within the practice.
NHS Choices	One five star comment recorded in July 2019. The reviewer said they had a "professional, courteous and dignified experience".

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	90.6%	90.4%	88.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	94.8%	87.8%	87.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	95.6%	95.1%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	94.3%	84.8%	81.8%	Tending towards variation (positive)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Partial

Any additional evidence
The practice undertook feedback from patients via the Friends and Family Test.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients.	Patients provided consistent positive commentary regarding the practice and its staff. Patients told us medicines were discussed thoroughly, and the GP will explain if they can not prescribe the medication wanted.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	97.5%	92.9%	93.0%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: There was limited information available to patients in the waiting room. The practice website contained information on a variety of topics, for example, carers support, those patients who wish to access support for domestic violence and healthy living information including in other languages. Information was available to view in different languages on the provider's website.	

Carers	Narrative
Percentage and number of carers identified.	53 (2%)
How the practice supported carers (including young carers).	The practice supported carers with priority appointments, flu jabs and health checks. The practice signposted carers to local community support groups.
How the practice supported recently bereaved patients.	Bereaved patients were referred to a local bereavement organisation.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

The practice was previously rated as requires improvement for providing responsive services due to overarching issues which affected all population groups.

At this inspection, we rated the practice as **good** for providing responsive services because:

- Results from the GP patient survey showed that the practice was in line with the local and national average.
- Patients told us they could access care and treatment in a timely way.

Responding to and meeting people's needs

The practice was not fully organised to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence	
<ul style="list-style-type: none">• The provider had not employed a practice nurse since the last one retired over 12 months ago, women were signposted to the local GP hub for cervical screening. We discussed this with the provider and was told they had experienced difficulty in recruiting a nurse. However, they did not feel this significantly impacted their ability to provide nursing services.	
At the last comprehensive inspection:	
<ul style="list-style-type: none">• The premises are located in the basement of a building, and there was no lift within the practice premises. Therefore, access for older people, those with a disability and mobility issues, and parents and carers with babies and young children would have difficulty in accessing the practice. Patients told us GPs' would conduct home visits for those people who had mobility issues. At this inspection, we saw correspondence from the practice to the CCG and NHS England requesting a grant to purchase a stairlift. Appointments were available at a local GP hub service, which provided step-free access for patients, in the evenings and at weekends.	
In response to the COVID-19 pandemic, the practice changed it's working pattern to manage demand. Most patients received consultations via video conference or telephone consultations. When patients visited the practice, they had to ring the doorbell and wait until a receptionist opened the door when	

they would have their temperature taken before being allowed into the main building. If the patient had a high temperature, they were asked to call NHS 119 to book a coronavirus test.

The practice was part of a primary care network with eight other practices; they arranged “hot hubs”. and “cold hubs” for patients to attend, depending on whether they had symptoms of covid-19. Patients suspected of having COVID-19 were asked to visit the “hot hubs” and patients that were not showing any symptoms were asked to visit the “cold hubs”.

Practice Opening Times	
Day	Time
Opening times:	
Monday	08.00am-08.00pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00am-6.30pm
Appointments available:	
Monday	08.00am-6.30pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00am-6.30pm

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Transport is organised for older patients when attending appointments with the older person care team at a local GP hub practice

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: Good

Findings

- Same day appointments are prioritised for this patient population group. There is no nursing provision provided at this practice currently. Patients requiring a nurse are directed to a local GP practice, which is part of the practice's GP federation.
- Staff told us childhood immunisations are offered at eight-week baby checks and they booked appointments for immunisations at the GP federation hub during extended hours and weekends.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Weekday evening appointments were

available (6.30pm-8pm) and weekend appointments (8am-8pm). The provider does not employ a practice nurse and women are signposted to the local GP hub for cervical screening.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- Extended appointments were offered to facilitate patients who had more complex needs. Longer appointments could be pre-booked if required.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed the practice's appointment system and saw that patients were able to access GP appointments quickly and the practice was flexible and accommodating with the appointments system. Staff told us they would prioritise at-risk groups for same-day or immediate appointments. For example, older people and babies and young children. 	

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2020 to 31/03/2020)	99.4%	N/A	65.2%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	83.5%	72.1%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	78.8%	72.7%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	84.8%	74.8%	72.7%	No statistical variation

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	3
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection, It was not possible to determine whether complaints were used to drive continuous improvement as they had received no complaints during the previous 12 months. The practice did not record verbal complaints. We reviewed evidence of patient feedback the practice had received via the portal on its website. An apology had been given to this patient. At this inspection, we found that complaints were managed appropriately, and the practice had carried out a review of the complaints received within the last 12 months.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Perceived delay in referral	GP discussed complaint with the Medical and Dental Indemnity UK (MDDUS) who advised on and approved action taken. The case was discussed at a practice meeting.
Problems with prescription issue and collection	Comments on clinical care reviewed by two Gps Complaint discussed with the reception team at the practice meeting.

Examples of feedback from staff or other evidence about the practice

Source	Feedback
Patient interview	Patients told us they were very pleased with the service provided and that they could access the practice on the same day. However, they did mention the fact that the practice did not have nursing provision.

Well-led

Rating: Good

The practice was previously rated as inadequate for providing well-led services due to concerns around insufficiency of governance systems and processes to ensure patient safety and the effectiveness of the care and treatment provided has adversely impacted on the rating of this key question.

At this inspection, the practice was rated **good** for providing a well-led service because:

- Leaders were aware of the challenges and had acted to implement improvement strategies.
- Since the last inspection, the provider improved systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

For the most part, leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• At the last comprehensive inspection, we found that leaders could not demonstrate the capacity to prioritise safety and quality improvement. At this inspection, we discovered that several systems and processes had improved; however, the provider recognised that more needed to be done, for instance, with the medicines management process.• The management demonstrated awareness of the challenges of delivering care within a primary care setting and the challenges specific to their practice. The practice had made significant improvement since the last comprehensive inspection.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice's mission statement was " We strive to improve health, well-being and lives of those we care for".• The provider demonstrated they had a credible strategy in place to address challenges. The provider showed they monitored the progress of the practice's strategy.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider demonstrated they had a speaking up policies in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy and that staff had access to a Freedom to Speak Up Guardian. We saw that staff had completed equality and diversity training.</p>	

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

Source	Feedback
Staff interview	Staff told us they felt supported by the management team and they were approachable.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found that there was a lack of systems and processes established and</p>	

operated to ensure compliance with the requirements to demonstrate good governance. At this inspection we found the practice had made significant improvements to their systems and processes and were able to demonstrate:

- A fail-safe system regarding two-week-wait referrals.
- A fail-safe system regarding cervical cancer screening.
- A system to monitor and manage regular staff training and supervision.
- Protocols and policy to monitor and manage the tasks undertaken by the healthcare assistant.
- Regular clinical meetings.
- An effective recruitment system.
- A system to monitor registrations for clinical staff on an annual basis.
- A system in place to monitor, manage and drive quality improvement in patient outcomes.
- Action plans to address low cervical screening and child immunisation achievement rates. However, cervical screening and child immunisation uptake remained significantly below national targets.
- A fail-safe system regarding complying with patient safety alerts; however, this did not capture retrospective safety alerts.
- A system to monitor and manage patients prescribed high-risk medicines. Although, this did not operate effectively, as we discovered through identifying patients that had not had their medication monitored appropriately.

At the last inspection, we found that the provider could not demonstrate that all practice policies were regularly reviewed and updated as required. For example, the safeguarding policy did not contain recent intercollegiate guidance and changes to levels of safeguarding training policy regarding different staff groups. At this inspection, we found that the policy had not been updated, but staff had the appropriate level of training.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance; however, these did not always operate effectively.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence</p> <p>At the last comprehensive inspection:</p> <ul style="list-style-type: none"> The provider had some systems in place to identify, manage and mitigate risks; however, these were not always effective; for example, the two-week wait urgent referral follow-up system. At this inspection, we found that the practice had developed a fail-safe for two-week-wait referrals. However, they had not effectively managed safety alerts and the monitoring of high-risk medication. The provider could not demonstrate what systems they had in place to manage performance that was poor or variable; for example, their achievement rate for cervical screening. At this inspection, we found that the provider had developed a plan to improve their achievement rates for cervical cancer. There was a limited programme of clinical and internal audit. We reviewed two monitoring audits related to dermatology referrals and high-risk medicines. At this inspection, we found that the practice had increased their quality improvement (QI) activity and had a continuous QI programme in place. The provider could not demonstrate they had considered the impact on quality and sustainability when service developments or changes had occurred. For example, the impact on childhood immunisations and cervical screening when the previous practice nurse left the practice and was not replaced. At this inspection, the provider informed us that patients had access to the nurse at a neighbouring practice, which was part of their GP federation. Following the inspection, the provider told us they had had a meeting, where it had been confirmed they would try to recruit a practice manager, a receptionist who would also work as an administrator and a practice nurse. 	

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 adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: At the last comprehensive inspection, the provider could not demonstrate there were adequate arrangements for identifying, managing and mitigating risks. At this inspection, we found the provider had taken steps to improve their ability to reduce risks, for example, in the management of two-week wait urgent referrals and the infection control risk assessment.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
The Patient Participation Group (PPG) told us the group was active, worked closely with the practice and met regularly. They described the practice as being open and responsive to patients' views. For example, members of the PPG informed us that the steps leading to the practice made it difficult for some patients to access the service. We saw that the practice had meetings with the CCG and NHS England to request permission for funding to have a pavement lift.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: At the last comprehensive inspection, we were not assured that systems and process for learning and continuous improvement were fully developed and implemented. The practice could not demonstrate a comprehensive approach to quality improvement. At this inspection, we saw that the practice had developed a comprehensive approach to quality improvement and had carried out several audits.	

Examples of continuous learning and improvement

Between October 2020 and November 2020, the practice reviewed their telephone answering patterns and implemented a new approach to reduce the percentage of calls put on hold and the time patients spent on hold. The percentage of calls put on hold went from 35.4% to 20.6%. The hold time decreased from a mean of 2:06 minutes to 48 seconds. After a practice discussion, the provider, felt the new process of answering telephone calls would be appropriate to reduce any emergency calls being kept waiting.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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