

Care Quality Commission

Inspection Evidence Table

Hesa Medical Centre (1-6211203676)

Inspection date: 23 September 2021

Date of data download: 25 August 2021

Overall rating: Good

At the previous inspection in January 2020 we rated the practice requires improvement overall. This was because we found concerns around staff recruitment, supervision of clinical staff the management of patients on high risk medicines and patient safety alerts. At this inspection in September 2021 we found improvements had been made.

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

Safe

Rating: Good

At the previous inspection in January 2020 we found not all staff files contained copies of references, there was no evidence of regular clinical supervision or peer review for all clinical staff. We also found the practice did not have a consistent process for monitoring patients on high risk medicines and there was no process for ensuring patient safety alerts were actioned appropriately. At this inspection in September 2021 we found these concerns had been resolved.

Safety systems and processes

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

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

Safeguarding	Y/N/Partial
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>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • One of the GP partners was the lead for safeguarding at the practice. Staff were aware who that was. There was a chart on display in the practice which set out areas of responsibility. This was also discussed at team meetings. • The safeguarding policy covered both vulnerable adults and child protection. It was accessible on the shared computer drive. The policy was last reviewed in July 2021. • All staff had undergone safeguarding training to the appropriate level. All GPs, the physician's associate and the nurses were trained to level 3. Two of the healthcare assistants (HCA) were trained to level 3 and the other to level 2. All administrative and reception staff members were trained to level 2. • The safeguarding lead attended safeguarding meetings where possible and notes were made into patient records. Where they could not attend the meetings, they reviewed the minutes, and these were discussed at clinical meetings. • An alert was added to the records of any patients involved in safeguarding concerns. These patients were prioritised for appointments. If these patients failed to attend appointments they were contacted and reported to the local safeguarding team, where appropriate. • DBS checks were undertaken for all staff under the practice's recruitment policy. • All administrative/reception staff and healthcare assistants (HCA)'s acted as chaperones. All had undergone relevant training. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At the previous inspection January 2020 we found there were a number of locum GPs working at the practice and not all their files contained copies of references. At this inspection we found there were only two locums working there and they had already been at the practice for up to two years. Therefore, we looked at a sample of other recruitment files, two being of salaried GPs, one of whom had recently joined and another who was due to join the practice shortly. The files we looked at contained two references, in line with the practice recruitment policy. • Registration checks were carried out with the relevant professional regulatory body. Revalidation and appraisal checks were carried out for nurses and GPs to ensure they continued to meet the requirements of their registration. 	

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: 16/09/21	Y
There was a record of equipment calibration. Date of last calibration: 27/11/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 7 April 2021	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Fire risk assessments were carried out regularly by NHS property services (NHSPS) who were responsible for the health centre. These risk assessments related to the entire building. The practice carried out its own risk assessments monthly. We saw the most recent fire risk assessment which had been carried out for the whole building. There were a number of actions identified, most of which did not related to the parts of the premises occupied by the practice. These actions had been completed.</p> <p>Assessments of the storage of hazardous substances (COSHH) were carried out annually by NHSPS. The last was in December 2020. Regular reviews were carried out monthly by the practice. We saw no concerns had been found.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 3/6/21	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3/6/21	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The most recent premises and health and safety risk assessment was carried out in June 2021. This was a comprehensive review carried out annually by NHSPS and followed up monthly by the practice. We saw actions were completed. 	

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: 2/8/21	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: <ul style="list-style-type: none">• One of the practice nurses was the infection control lead.• We saw actions identified at the most recent infection control audit had been completed.• Records we saw showed all staff had undergone annual infection control training within the last year.• Legionella checks were carried out monthly.• The health centre had a contract in place for the safe removal of waste.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice recruited additional staff on a contract basis to ensure cover if staff have to go off sick or self-isolate due to the Covid19 pandemic. They also had a contract with a locum agency although they had not had to use them.• The practice had a written induction guide for locums and agency staff covering emergency procedures, logging on to system, security issues and telephone system use.• The practice had medicines and equipment in order to respond to medical emergencies. We saw oxygen cylinders with both adult and child masks, two defibrillators with adult and child pads and four nebulisers with accessories. Records showed these items were checked regularly to ensure they were in good working condition. The practice also had spillage and first aid kits.	

- All staff have undergone basic life support (BLS) training within the last year.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a process in place for registering new patients which included the summarising of new patient notes. This was carried out by a designated member of staff.• There were documented processes in place for referrals, including cancer referrals, to ensure none were missed and patients were followed up on to ensure they had received and attended appointments in secondary care.• Test results were allocated to duty GP for that day and they assigned them to the requesting GP. The policy stated pathology results had to be dealt with the same day. During the inspection we checked the practice inbox and found there were no unactioned test results. One of the daily tasks allocated to the duty GP for the day was to ensure there were no unassigned test results at the end of the day.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.53	0.49	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	10.0%	10.8%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	5.00	5.60	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	57.6‰	58.0‰	126.0‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.33	0.50	0.65	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	2.9‰	4.8‰	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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the inspection in January 2020 we found there was no evidence of regular clinical supervision or peer review of the nurse prescribers and pharmacist. Further, there was no clear information about the areas of competence for the nurse prescribers. At this inspection in September 2021, we saw the practice had reviewed its operations and produced a list of all clinical roles they had and the corresponding medical issues each role was able to deal with. This list had been circulated to all staff. There was a named GP on a daily basis who was responsible for supervising staff such as the physician's associate (PA), advanced nurse practitioner (ANP) and practice nurse. We saw slots were allocated on the appointment system for this task to be carried out and staff were able to seek advice and discuss any concerns during that time. Staff told us they weren't restricted to those time slots and were able to seek advice as and when required, for example in the case of an emergency. We saw evidence of regular supervision of clinical staff where the senior GPs reviewed a sample of patient consultation notes to ensure safe prescribing, consistency and quality. Blank prescriptions were registered and stored securely. They were placed in the printers at the start of the day and stored in a locked cabinet overnight. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • Repeat prescriptions were to be requested with 48 hours' notice but could be expedited in an emergency. They could be requested by telephone and online. The practice prioritised some staff for repeat prescriptions such as those receiving palliative care. • At the inspection in January 2020 we found the practice did not have a consistent process for recording blood results of some patients prescribed high risk medicines. The practice took steps to address this soon after the previous inspection, including producing a written protocol for how they managed blood test results. At this inspection we found those improvements had been maintained. We reviewed a sample of these patients' notes and these notes were complete with blood test results. • Medicines reviews were carried out by all GPs with the assistance of the pharmacist. As part of this inspection we carried out searches of the practices patient records to review how the practice monitored patients prescribed certain medicines deemed to be high-risk. We found these patients were being monitored in a way which kept them safe. • We checked the practice's stock of emergency drugs and found an appropriate range of medicines was held. These were all in date and in visibly good condition. Records showed these were checked monthly. We saw records of risk assessments carried out to decide which emergency drugs the practice should hold. 	

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:	11
Number of events that required action:	11
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Feedback from staff demonstrated they knew how to identify and report significant events. We examined the records of significant events which had occurred at the practice within the previous year and found they had been managed appropriately Significant events were a set agenda item and were discussed at monthly practice meetings. 	

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

Event	Specific action taken
Letters for patient's son placed on father's medical records. Both patients had the same name and address.	Alerts added to patients' notes to make staff aware of the need carry out additional checks such as NHS number and date of birth to ensure they are adding letters to the correct patient.
Medication error; patient's medication dosage was not reduced in accordance with letter from secondary care.	Patient was contacted and given an apology, patient's blood monitoring test results were reviewed again to ensure the patient was not at risk. Internal investigation carried out to identify how the error/omission occurred and missed opportunities to identify the error were highlighted for learning.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the previous inspection in January 2020 we found whilst there was evidence that alerts were received there was no process for ensuring they were actioned appropriately. The practice had taken immediate action to address this and we reviewed this at this inspection in September 2021. 	

- At this inspection we found the practice had put in place a formal process for the management of safety alerts and this was followed in practice. We reviewed a sample of records to check how the provider responded to drug safety alerts and updates. We found the practice managed these alerts appropriately.
- A printed copy of each alert was circulated amongst the clinicians and signed by each clinician to ensure they had read it. These paper copies were kept in a folder.

Effective

Rating: Good

At the previous inspection in January 2020 we found concerns around childhood immunisation and cervical cancer screening rates and concerns around the management of diabetic patients. At this inspection we found the management of diabetic patients had improved, however concerns remained around childhood immunisations and cervical screening rates. Whilst we found these remained areas of challenge for the practice they had taken and continued to take positive steps to address these issues and improve their performance.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Records showed patients mental and physical wellbeing was discussed and planned for as well as patient's clinical needs.	

Older people

Population group rating: Good

Findings

- Designated doctors performed weekly nursing home visits for palliative older adults.
- Dementia screening took place with emphasis on diagnosis, investigation and referral to the memory clinic.
- The practice organised transportation for patients to the practice and hospital appointments.

- Bowel screening and flu campaigns were held at the practice.
- 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.

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.
- The practice had designated appointment slots with clinicians for diabetes, COPD, asthma, and other long-term conditions.
- All patients diagnosed with long term conditions were signposted to patient groups and support networks including locally developed education programmes organised by clinical commissioning groups (CCG).
- Diabetic patients were referred to eye screening and podiatry services.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Care plans were completed for patients with multiple comorbidities and individual cases discussed in multidisciplinary team meetings at primary care network (PCN) level.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	75.6%	76.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	3.0% (18)	7.6%	12.3%	N/A

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	95.1%	90.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	7.2% (8)	9.4%	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) (QOF)	83.2%	83.4%	82.0%	No statistical variation
PCA* rate (number of PCAs).	6.7% (9)	4.2%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	59.6%	66.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	9.7% (92)	12.9%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	73.6%	73.8%	72.4%	No statistical variation
PCA rate (number of PCAs).	7.3% (77)	6.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	89.1%	90.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	4.2% (2)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	74.6%	76.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	8.2% (78)	8.6%	10.4%	N/A

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

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. This was an ongoing concern from the previous inspection in January 2020.
- We saw evidence of the steps taken by the practice to address these concerns since the previous inspection and we saw they continued to work towards improvement in this area.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- Same day appointments were prioritised for patients under 16 years.
- The practice worked closely with the health visitor's team and informed them of children who had recently moved into the area.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	230	268	85.8%	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)	229	305	75.1%	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)	231	305	75.7%	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)	224	305	73.4%	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)	210	301	69.8%	Below 80% uptake

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

Any additional evidence or comments

- The practice recognised their achievement for childhood immunisations was below average and had taken steps to increase the uptake.
- The practice held health education events within the community to engage with patients and encourage them to have their children immunised. For example the GPs held educational events at the local Islamic Centre.
- The practice had increased the number of nurse clinics to support more parents to have their children immunised.
- The nursing team contacted parents directly where necessary to encourage and educate them around vaccinations.
- The practice provided us with data which showed for the first quarter of 2021 (January to March 2021), for two year olds 92% of eligible children had been vaccinated. For five year olds, over the same period 87% of children had been vaccinated. This data was unverified data at the time of this inspection.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	62.8%	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)	49.0%	62.1%	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)	46.2%	51.4%	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)	58.1%	57.6%	54.2%	No statistical variation

Any additional evidence or comments

- At the inspection in January 2020 we found the practice achievement for cervical screening was below the national average (63%). At this inspection the achievement remained below average at 63%. The practice was aware of this and had taken action to try and address this. They told us there was significant challenge within the local community around cervical screening due to cultural and religious beliefs and misinformation.
- The practice contacted women directly who were due for their screening in order to discuss any concerns they had. Patients were offered appointments opportunistically when they attended the practice.

- The practice was participating in a new national cervical screening project which involved the introduction of a new call/recall system for cervical screening. They were also taking part in a project at clinical commissioning group (CCG) level which involved text message reminders for cervical screening.
- The practice had begun delivering extended access cervical screening appointments which was funded at primary care network (PCN) level. These appointments were provided during evenings and weekends.
- The practice showed us their cervical screening achievement as compared to the other eight practices in the PCN as at August 2021. This showed the practice was the second highest at 79% against the PCN average of 77%. They also showed us data around their cervical screening achievement as at the day of the inspection. This showed for 25 to 49 year olds they had achieved 74% and for 50 to 64 year olds, 82%. All of this data was unverified at the time of this inspection.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- These patients were flagged by alerts on the clinical management system. They were prioritised for same day and longer appointments.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks and referral 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.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	96.6%	85.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	4.1% (5)	10.0%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	81.4%	82.6%	81.4%	No statistical variation
PCA rate (number of PCAs).	4.4% (2)	5.5%	8.0%	N/A

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

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided/There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	547.1	533.9
Overall QOF score (as a percentage of maximum)	97.9%	95.5%
Overall QOF PCA reporting (all domains)	7.1%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Any additional evidence or comments	
<ul style="list-style-type: none"> The practice reviewed and monitored patients who were unexpectedly admitted to hospital and patients who were frequently admitted. They used a dashboard which displayed the relevant data so they could identify and contact these patients. Care plans were prepared or reviewed as appropriate with multidisciplinary team input. 	

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

<ul style="list-style-type: none"> • The practice had identified diabetes as an area for targeted improvement. They had introduced an inhouse phlebotomy service, increased the identification of diabetic and pre-diabetic patients and started group consultations and referrals to local diabetes education and support programmes. • The GPs carried out regular clinical audits. Examples we saw related to the management of patients with hyperthyroidism, diabetes, cancer reviews and audits relating to patients prescribed high risk medicines. We saw these audits were repeated to demonstrate effectiveness.
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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.	N
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Some staff told us their learning and development was supported. However feedback was mixed about how the practice supported development. We saw some examples of staff having expressed a desire to develop their careers and being promoted. However, some staff felt whilst they were encouraged to undertake training relevant to their role, they were not supported to obtain the training required to advance beyond that role. • Staff were able to access mandatory training materials online. However some staff told us they were not given protected time during their working hours to undertake this training and were having to complete this training at home during evenings and weekends. We have told the practice they should review this to ensure staff wellbeing was prioritised, along with their training and development. 	

- Staff had regular appraisals and reviews. These were an opportunity to discuss any training needs or developmental opportunities staff were interested in. However, some staff felt this was not always acted upon by the leadership. Clinical staff told us they were supported to meet the requirements of revalidation and continuing professional development (CPD).
- Clinical staff underwent regular supervision. We saw examples of supervision records for clinical staff. The GPs reviewed patient notes, advice given and prescriptions and discussed the patients and identified any learning gaps. GPs had allocated time in their day to carry out supervision and be available to advise other clinical staff. There was a list of which procedures/conditions were within each clinician's competence to deal with to ensure patients were seen by the best person to meet their needs.
- The practice had measures in place to address any poor performance including inhouse training and access to clinical commissioning group (CCG) funded training.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Multi-disciplinary team meetings took place regularly. Attendees included district nurses, health visitors, care coordinators and social prescribers. • The practice used coordinate my care (CMC), an NHS service which coordinated urgent care for patients. This included all of the pertinent details concerning that persons care and was accessible by all urgent care services. 	

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
Explanation of any answers and additional evidence:	

- Patients who were carers were encouraged to identify themselves to the practice and were signposted to services offering additional support. The practice offered health checks to carers and prioritised they were flagged on the clinical system to ensure their additional needs were supported.
- The practice worked cooperatively with palliative care nurses to ensure these patients were properly cared for.

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All clinical staff had undergone training in consent. Staff were able to give examples and we saw where consent had been documented in patient records. • We looked at a sample of DNACPR forms and found decisions were recorded appropriately. However, these forms were saved separately from the patients' notes in the clinical records system. We have said the practice should review this and consider keeping the forms with the patients' notes to make them more visible and easily accessible. 	

Well-led

Rating: Good

At the inspection in January 2020 we rated the practice as requires improvement for being well-led because we found the provider did not operate effective monitoring of their safety and governance processes to ensure they were always followed by all staff. At this inspection we found this had improved.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had a stable leadership structure. The three partners understood the needs of their local practice population and were able to articulate the challenges and risks they faced.They were able to demonstrate steps they had taken to address these challenges, for example, those around improving childhood immunisation uptake and cervical screening rates.At the inspection in January 2020 the partners had expressed difficulty in recruiting salaried GPs. At this inspection we found there were five salaried GPs in place with an additional one due to start the week after the 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 partners articulated their vision and values which included working in partnership with patients and staff to meet patients' needs. They told us they valued collaboration, respect and innovation. Staff feedback around the practice's vision and values resonated with this.The partners told us they planned to become a teaching practice and to become more involved in understanding and meeting their patients' needs, for example implementing more	

programmes and initiatives around healthy lifestyles and educating patients around diabetes, cancer screening and childhood immunisations which were of particular challenge in that area.

- The partners told us they planned to introduce a wider range of specialisms into the practice such as physiotherapists and dieticians.

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.	Partial
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The leadership told us they prioritised keeping staff safe and carried out regular risk assessments to ensure this. They told us staff were supported with their training and development needs and were flexible where staff need to take time off. They gave examples of staff who had started in more junior roles and had progressed their careers within the practice. • However, some staff told us they were not allowed protected time during working hours to complete mandatory training for their role and were not supported in their ambitions to progress their career. We have told the practice they should review this. 	

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

Source	Feedback
Questionnaires completed by staff	Staff reported feeling supported and that there was an empathetic culture. The leadership was approachable and they all worked well as a team. However, some staff said they their career development plans were not always supported and some told us they were expected to complete mandatory training at home, in their own time.

Governance arrangements

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

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

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

- At the inspection in January 2020 we found the arrangements for reviewing performance did not always operate effectively as there were no process in place to ensure all staff received clinical supervision. At this inspection we found there was a clear policy in place for staff supervision and we saw this was being followed.
- The practice had a business continuity plan in place which was followed in case of an incident affecting their ability to operate normally. For example this was followed when there was an incident of flooding on the premises.
- The business continuity plan was being updated quarterly rather than annually due to the impact of the Coronavirus pandemic.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Due to the pandemic the practice had introduced a triaging process for all appointments in order to minimise the number of people on the premises. GPs decided, based on clinical need, which patients could be advised remotely and which would be seen face to face. • The practice had a dedicated isolation room for patients suspected of having Covid19. • The cleaning procedures and requirements had been adjusted and PPE was provided to keep patients and staff safe. • Patients were directed to use online consultations rather than attend in person, where appropriate. • The practice prioritised patients unable to use digital services and vulnerable patients for home visits or face to face appointments on the premises. • The practice was anticipating the challenges of delivering the flu vaccine and booster vaccinations for Coronavirus and had put plans in place to meet these challenges. • The practice told us staff had not needed to work remotely during the pandemic as they remained open with staff on site and had adequate numbers of staff to cover colleagues where necessary. However, they had laptops available, should this become necessary. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The performance collected and monitored its performance in areas such as cervical screening, childhood immunisations, management of patients with long term conditions and patients 	

prescribed high-risk medicines. This information was used to benchmark the practice's performance against neighbouring practices and national data.

- The practice used this data to plan quality improvement activity and team objectives.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had a policy in place which governed how digital and remote services were used. • Patients were provided with information to support them to use these services safely and their data was protected. 	

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).	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice had a PPG in place, however they had not met over the period of the pandemic. The practice manager told us they planned to meet at the beginning of the next year. At that meeting, they intended to review the practice's action plan and report on the progress made so far.• We were told the PPG was involved in discussions about the results of patient surveys including the national GP patient survey, comments and complaints and were asked for ideas about how these could be improved.• An example of changes made in response to patient survey was around patient choice of male or female GP. As a result of feedback the practice had ensured a balanced number of male and female GPs.• The practice had balanced the number of same day and advanced appointments in response to patient feedback and to meet the needs of some elderly patients who did not want to use digital consultation.• We saw the results of the most recent staff survey carried out between September and December 2020. This survey was designed and carried out by an external organisation. The results were largely positive, however there was some negative feedback about opportunities for career development.	

Feedback from Patient Participation Group.

Feedback
We spoke to the chair of the PPG who told us prior to the pandemic they met quite regularly. They told us they discussed survey results and other feedback from patients and practice performance generally. They were encouraged to contribute ideas around how the service could be improved. Examples given were around customer service and safety. They told us the practice had responded positively to concerns they raised. The PPG also opportunistically asked for feedback from patients on site and fed the results back to the management. Feedback from other members we spoke to was that the practice served them well and met their needs. They said they were treated with kindness and respect and staff were helpful and supportive.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice was involved in improvement initiatives around cervical screening, specifically a new NHS cervical screening management system, text reminder service and extended access for cervical screening.The practice had been involved in a project to improve the care of patients waiting to access physiotherapy services. The waiting time for physiotherapy was over eight months. The practice had supported patients to access a service where they could begin recommended exercises whilst waiting for physiotherapy appointments.The practice had carried out patient information and education events within the community to tackle misinformation around cancer screening, cervical smears and childhood immunisations. They told us these events had helped to encourage people to talk about their concerns so that any misconceptions could be correct. It was hoped that over time, this would encourage more people to take up immunisation and screening.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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