Care Quality Commission

Inspection Evidence Table

Dr WA Cotter + Dr JCJM Bohmer -Laubis (1-562029218)

Inspection date: **22/02/2019**

Date of data download: **28 January 2019**

Overall rating: add overall rating here

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Inadequate

Safety systems and processes

The practice did not have 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.	Partial
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	N
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	N
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
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
Policies for safeguarding adults and children were found to be out of date on the day of inspection. They were last reviewed in September 2015 (adults) and January 2011 (children). The practice updated these during the inspection. One member of staff (non-clinical) who was on the chaperone list did not have a DBS or risk assessment in place. Following the inspection, the practice informed us that a DBS was in progress for the member of staff and that they would not undertake chaperone duties or supervise children in the meantime. Staff (clinical and non-clinical) had not received formal chaperone training. One member of staff told us that they had received some verbal chaperone training a long time ago but there was no record of this. One member of staff was unaware that they needed to stand inside the curtain during an examination to fulfil their role as a chaperone and two members of staff were not aware of a chaperone policy. 15 members of non-clinical staff had not received safeguarding adults or children training within the last three years. Two practice nurses had not attended safeguarding children training within the last year. Following the inspection, the practice informed us that all mandatory training would be completed within three months.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and 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
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: We were unable to find proof of ID for six members of staff in their staff records on the day of inspection. Seven members of staff did not have references in their staff records. Following the inspection, the practice sent us copies of the required documentation. The practice told us that some members of staff did have proof of ID and that it had been kept alongside their DBS documentation.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y
There was a record of equipment calibration. Date of last calibration: 2018	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: 2018	Y
There was a log of fire drills. Date of last drill:	N
There was a record of fire alarm checks. Date of last check: 21/02/19	Y
There was a record of fire training for staff. Date of last training: See below	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: June 2016 – low risk	Y
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

Fire drills had not taken place at the practice. This had also been identified at the previous inspection on 25 August 2015.

Training records showed that 11 members of staff had not received formal fire training. 17 members of staff had not received formal fire training since 2015. Two members of staff had not received formal fire training since 2017. Following the inspection, the practice informed us that all mandatory training would be completed within three months.

The fire risk assessment action plan for the practice stated, ‘Oxygen cylinder sign is recommended for the practice in order to warn fire and rescue personnel about hazardous storage’. An oxygen cylinder sign was not found on the door to the room where the oxygen cylinder was kept. The practice attached an appropriate oxygen sign during the inspection.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken.	Y

Date of last assessment: January 2019	
Explanation of any answers and additional evidence:	

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.	Partial
Date of last infection prevention and control audit: March 2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: Four members of clinical staff and 14 members of non-clinical staff had not attended infection control training. Following the inspection, the practice informed us that all mandatory training would be completed within three months.	

Risks to patients

There were some gaps in 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
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Partial
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.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence:	

Not all staff were able to demonstrate an understanding of the signs of sepsis. Sepsis guidance for staff was not available and easily accessible. One member of clinical staff told us that they would look at a national early warning score flowchart on their personal phone if needed. Another member of clinical staff told us that the GPs have sepsis guidance and that they would seek advice from them. Following the inspection, the practice told us that information on ‘How to spot Sepsis’ had been given to reception staff and that it would be accessible. The practice also told us that one of the GP partners planned to arrange a sepsis awareness session within one month for reception staff.

Information to deliver safe care and treatment

Staff did not always have 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.	Y
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.	*Partial
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
Explanation of any answers and additional evidence: *See safety of medicines section below.	

Appropriate and safe use of medicines

The practice did not always have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.93	0.88	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2018 to 31/12/2018) (NHSBSA)	8.6%	9.8%	8.7%	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 (01/04/2018 to 30/09/2018) (NHSBSA)	7.65	6.31	5.64	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	3.70	1.79	2.13	Tending towards variation (negative)

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

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
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
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	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

Explanation of any answers and additional evidence:

An audit undertaken by the practice in April 2018 identified issues with five patients not having three monthly bloods as required. The most overdue of these five patients was reviewed by the practice and found to have been prescribed Methotrexate despite no further bloods being done since December 2017. The patient's repeat had expired and their annual medication review was overdue. Immediate actions and secure process checks had not been undertaken to ensure patient safety as a result of the audit findings.

Following the inspection, the practice sent us a copy of a re-audit which was completed on 23 February 2019, which identified two patients (including the patient not having bloods done since December 2017) not having regular three monthly tests and three who had outpatient tests. Only one of these had traceable bloods. The re-audit identified that the number of overdue patients had reduced from five to four.

Following the inspection, the practice sent us a copy of their Methotrexate action plan. It stated that Methotrexate would be deleted from repeats of patients where bloods are not done for over 12 months. A letter with advice and a blood card would also be sent to patients who are prescribed Methotrexate with a telephone follow-up to confirm there will be no more prescriptions issued until bloods are done.

Medicines management	Y/N/Partial
All Methotrexate and high risk drugs are to be reviewed by a pharmacist on being issued. The practice confirmed that the case will also be investigated as a significant event.	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	N/A
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	
Prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	
Explanation of any answers and other comments on dispensary services:	

Track record on safety and lessons learned and improvements made

The practice did not always have a system to learn and make 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.	*Partial
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:	2
Number of events that required action:	2
Explanation of any answers and additional evidence: See evidence in medicines section above. The outcome of the Methotrexate audit did not lead to a significant event being acted on and recorded at the time.	

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

Event	Specific action taken
Dispensing error by community pharmacy. Patient handed in three boxes of dispensed medication labelled with their name. None of them had been prescribed by the surgery.	Correct medicine has been dispensed for the correct patient. Medication returned to pharmacy for safe destruction.
Patient complaint letter was mistakenly given to scanning and scanned into the patient's record. The complaint was not dealt with straight away.	Complaints letter was reviewed, discussed with appropriate staff members and recorded in the patient's notes. Documentation and communication to be improved.

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
Explanation of any answers and additional evidence: The practice did not have a robust system in place to track and monitor safety alerts. The practice manager told us that they currently check the alert and liaise with the appropriate clinician. However, actions taken are not recorded and there is no monitoring and oversight.	

Effective Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	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 were in place 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:	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHSBSA)	0.65	0.59	0.79	No statistical variation

Older people Population group rating: Good

Findings
The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks were offered to patients over 75 years of age. Patients are discussed at monthly palliative care and integrated team meetings attended by the district nurse, palliative care nurse, community psychiatric nurse for elderly care, rapid response and social services. Home visits were offered if older patients have transport issues or needed carers to bring them to the practice. The practice reviewed patients at a local nursing home.

Clinicians attend meetings held by Bexley CCG or Oxleas, who are the community providers, on elderly, frailty and three monthly palliative care workshops or monthly practice Integrated Team Meetings. Many members of this group of patients have multiple co-morbidities. The 1% at highest risk are put on the admission prevention register and are followed up by the Care Co-ordinator nurse at the practice. When clinically indicated, regular examinations are carried out at the practice or in the patient's home by district nurses and clinicians. Those patients on the admission avoidance scheme have been given a separate phone number which is responded to by a clinician within a short space of time.

People with long-term conditions Population group rating: Good

Findings

Patients with long-term conditions had 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.

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.

The practice ran specialist clinics. For example, diabetes, chronic obstructive pulmonary disease (COPD) asthma, heart disease and hypertension. These patients were regularly invited for structured examination and management.

The practice has a high rate of overweight patients and encourage onward referral to weight management services and exercise referral.

The practice has the highest impaired fasting glucose register in Bexley.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	84.0%	80.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	7.9% (41)	14.1%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	87.8%	79.2%	77.7%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.7% (40)	10.5%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	87.1%	79.8%	80.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	8.3% (43)	13.3%	13.5%	N/A

Other 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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	73.4%	73.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (14)	8.1%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	99.4%	87.5%	89.7%	Significant Variation (positive)
Exception rate (number of exceptions).	9.6% (17)	11.6%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.4%	82.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.4% (56)	5.0%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	81.8%	87.6%	90.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.8% (5)	6.6%	6.7%	N/A

Any additional evidence or comments

Families, children and young people Population group rating: Good

Findings

Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.

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.

The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	152	162	93.8%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	146	160	91.3%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	147	160	91.9%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	148	160	92.5%	Met 90% minimum (no variation)

Any additional evidence or comments

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 medication without the need to attend the surgery.

The practice has a walk-in surgery every day from 7.00am until 10.30am. There is a worker's clinic which runs from 4.00pm until 7.00pm on Thursdays. These appointments are booked with the nurse practitioner and are for full-time workers only.

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) (01/04/2017 to 31/03/2018) (Public Health England)	75.7%	74.2%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	78.7%	76.8%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	61.4%	54.4%	54.5%	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. (01/04/2017 to 31/03/2018) (PHE)	59.5%	68.6%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	44.4%	54.4%	51.9%	No statistical variation

Any additional evidence or comments

People whose circumstances make them vulnerable

Population group rating: Good

Findings
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 held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. The practice demonstrated that they had a system to identify people who misused substances. The practice attempts to keep patients in their own environment and works with the Rapid Response Team to prevent hospital admission for those with non-emergency conditions.

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. 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. The practice has carried out a search on patients who have been diagnosed with mild cognitive impairment to assess if a further follow up is required. These patients are coded.

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 (01/04/2017 to 31/03/2018) (QOF)	90.6%	91.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	22.0% (9)	11.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.2%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	17.1% (7)	8.9%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	75.7%	79.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.2% (8)	5.3%	6.6%	N/A

Any additional evidence or comments

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.2	515.4	537.5
Overall QOF exception reporting (all domains)	6.2%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

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

Several audits had been undertaken which had resulted in changes to clinical management and medicines for individuals, in line with guidance.

Examples of audits completed are cancer, cervical smears, prescribing, minor surgery and increased PSA.

Any additional evidence or comments

Effective staffing

The practice was not 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.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial
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.	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: Some staff members (clinical and non-clinical) were not up to date or had not completed mandatory training, such as safeguarding, fire safety, infection control and sepsis (see Safe section above). The practice did not have an overall staff training matrix in place on the day of inspection. This was sent to us following the inspection.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	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
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.0%	94.4%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.0% (24)	0.9%	0.8%	N/A

Any additional evidence or comments

Consent to care and treatment

The practice was able to demonstrate that it 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
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: Written consent was sought for minor surgery procedures. Consent for other procedures, such as childhood immunisations and cervical screening was verbally sought and recorded on the patient's clinical record.	

Caring Rating: Good

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
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	70
Number of CQC comments received which were positive about the service.	69
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Patient interviews	Patients we spoke with on the day of the inspection told us staff were always kind and respectful.
CQC comments cards	Patients' comments were extremely positive and some went into detail how the practice had supported them and their families. Other comments included – 'friendly and polite receptionists', 'the doctors listen and are caring' and 'the surgery provides an excellent service'. One negative comment stated that appointments were not made available when needed. This was discussed with the practice on the day of inspection.
NHS Choices	We noted there were positive comments about the level of service and patient care.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12095	268	111	41.4%	0.92%

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 (01/01/2018 to 31/03/2018)	88.7%	85.7%	89.0%	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 (01/01/2018 to 31/03/2018)	85.8%	84.7%	87.4%	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 (01/01/2018 to 31/03/2018)	95.9%	93.7%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	90.4%	80.1%	83.8%	No statistical variation

Any additional evidence or comments

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

Any additional evidence
The PPG carried out a patient survey in April 2018. 287 questionnaires were returned which represented 33% of the patients seen at the practice over the period of one week. Patients were asked about the access to the practice, reception and reception staff, booking appointments and opening and waiting times. The survey concluded that that very many patients are satisfied with the service, particularly the open surgery. The practice had a suggestion box in reception. Patients comments were gathered and discussed. The practice sent response letters to patients where patients had provided contact details.

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
Explanation of any answers and additional evidence: Leaflets and information were available at the practice for carers to access. Following the inspection, the practice sent us a list of patients who are on the carer's register.	

Source	Feedback
Interviews with patients.	Patients we spoke with told us that they had plenty of time during consultations, that they felt able to contribute to any decision making and had enough information about choices they might have.

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 (01/01/2018 to 31/03/2018)	95.9%	92.0%	93.5%	No statistical variation

Any additional evidence or comments

	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.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	0.008% (97 patients in total)
How the practice supported carers.	We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.
How the practice supported recently bereaved patients.	Staff told us that if families had suffered bereavement, the practice would either be contacted by the GP involved or a sympathy card would be sent to the family.

Privacy and dignity

The practice always respect 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
Explanation of any answers and additional evidence:	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

	Y/N/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
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	7.00am – 6.00pm
Tuesday	7.00am – 6.00pm
Wednesday	7.00am – 6.00pm
Thursday	7.00am – 7.00pm
Friday	7.00am – 6.00pm
Appointments available:	
Monday	
Tuesday	
Wednesday	
Thursday	4.00pm – 7.00pm
Friday	
Saturday	8.45am – 10.45am

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12095	268	111	41.4%	0.92%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	95.6%	94.4%	94.8%	No statistical variation

Any additional evidence or comments

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.

People with long-term conditions — Population group rating: Good

Findings
Patients with multiple conditions had their needs reviewed in one appointment. The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

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.

The practice was open until 7.00pm on Thursdays and from 8.45am until 10.45am on Saturdays.

Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

The practice was able to offer coil and implants fittings.

Patients were able to book appointments on-line and order repeat prescriptions. There was also a telephone system to book appointments with GPs.

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.
The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
The practice could accommodate those patients with limited mobility or who used wheelchairs.

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
Explanation of any answers and additional evidence:	

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 (01/01/2018 to 31/03/2018)	86.7%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	71.8%	61.8%	68.6%	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 (01/01/2018 to 31/03/2018)	71.2%	59.5%	65.9%	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 (01/01/2018 to 31/03/2018)	77.2%	68.9%	74.4%	No statistical variation

Any additional evidence or comments

Source	Feedback
CQC comments cards	Comments cards had positive comments about being able to make appointments and the time frame involved.

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.	7
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.	1

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient referral not sent.	Apology and explanation to patient. Referred to Ombudsman.
Delay in offering appointment to have mole removed.	Internal investigation. Patient had been advised mole could be left and no action was required. Apology to patient.

Well-led Rating: Requires improvement

Leadership capacity and capability

Leaders could not always 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.	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:	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care. / The practice had a clear vision but it was not supported by a 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:	

Culture

The practice had a culture which drove high quality sustainable care / The practice culture did not effectively support 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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: A full practice meeting took place in May 2018 to gather ideas for planning and QoF meetings had taken place in November 2018 and March 2019. Integrated Team meetings took place monthly. However, administrative staff meetings had been suspended from February 2018 due to staff shortages and workload.	

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

Source	Feedback
Staff interviews	Staff told us they felt supported by management and worked well together as a team and all felt supported to carry out their roles. They told us they were encouraged to develop. Staff stated they felt respected, supported and valued. They were proud to work at the practice.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: There were significant areas that were not always being managed sufficiently in areas such as the monitoring of high risk medicines, mandatory training, safety alerts and staff recruitment records. These. Formal staff meetings were not taking place. Fire drills were not being carried out. These areas lacked a robust governance structure.	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	*Partial
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.	Training matrix did not identify this as a training area
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

Regular reviews took place of patients' medicines.

*Patients who had been prescribed one particular high risk medicine had not been monitored effectively.

All staff received an annual appraisal of their work, which included a discussion about their training needs.

The practice had a variety of risk assessments in place to monitor safety of the premises such as fire, infection control and legionella.

There was a system of reviewing significant events to identify possible themes or trends.

*Action was undertaken in response to patient safety alerts. However, there was not an effective oversight of alerts or any records to demonstrate that they had been reviewed, discussed and actioned.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

An audit undertaken in April 2018 identified issues with five patients not having three monthly bloods. Immediate actions and secure process checks had not been undertaken to ensure patient safety as a result of the audit findings.

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
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:	

Feedback from Patient Participation Group.

Feedback
We spoke with three members of the patient participation group. They told us that they are active and well-established. They consist of a core group of 13 members who meet every two months. The aims of the group are to create and improve two-way communications between patients, the practice and the community, to bring a sense of partnership between the practice and patients, to provide positive suggestions and to collect patient opinions and experiences to help the practice to evaluate its services. The PPG told us they felt that the practice and themselves were achieving the aims set out. They felt that the practice did not need to improve in any areas at present. They commented that they would like to have more information regarding the various members of staff and their roles and responsibilities. This would help the PPG to contribute further. They would also like to become more involved in public health and health promotion events.

Any additional evidence

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.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: The practice had identified a range of mandatory training topics it expected its staff team to complete on an on-going basis. However, gaps were identified in staff training during the inspection.	

Examples of continuous learning and improvement

All partners at the practice completed continued professional development and clinical appraisals. Clinical staff carried out quality improvement activities in the form of clinical audits. However, these were not always acted upon immediately when required, particularly with regards to the Methotrexate audit.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.

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

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.