Care Quality Commission

Inspection Evidence Table

Bethany Medical Centre (1-571428856)

Inspection date: 16 October 2019

Date of data download: 24 September 2019

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

A rating of requires improvement has been made as: -

- **The system for ensuring that all the required documentation to demonstrate safe recruitment and on-going staff suitability was not comprehensive.**
- **The systems for ensuring the premises and equipment were fit for use were not comprehensive.**

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but improvements were required.

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 took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
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:

- Staff had access to written policies and procedures for safeguarding vulnerable adults and children. The procedures indicated how to identify and report safeguarding concerns. The procedure had not been reviewed and updated to include information about the range of abuse that patients could potentially experience, such as modern slavery, radicalisation and female genital mutilation. The provider told us that a range of information was available through the CCG and that they would ensure that the safeguarding procedures were updated and discussed with the staff team.
- There was no record of three non-clinical staff having completed child safeguarding training and of one not completing adult safeguarding training. The provider told us this had been completed but not recorded. Following the inspection, the provider told us that they had a plan to address this.
- There was a system in place to respond to requests from social services for information to inform their decision making about safeguarding children and vulnerable adults.
- There was a system to communicate with health and social care professionals regarding concerns about vulnerable patients.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial

Explanation of any answers and additional evidence:

- We looked at the recruitment records for one new member of clinical staff. This showed evidence of suitable checks being undertaken such as Disclosure and Barring Service (DBS) and identity checks. An assessment of physical and mental suitability for employment was undertaken and recorded during the interview process.
- The provider told us that pre-employment checks of the registration of clinical staff (including nurses) were undertaken, however this was not recorded, and a system was not in place to ensure this was regularly monitored.
- The provider did not have complete documentation to show that all staff had immunisations suitable to their role. They were aware of this and were gathering this information. We saw that this information was available for a newly appointed clinical member of staff.

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: 07/11/2018	Y
There was a record of equipment calibration. Date of last calibration: 22/01/2019	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: 03/2019	Y
There was a log of fire drills. Date of last drill: 10/04/2019	Y
There was a record of fire alarm checks. Date of last check: 10/04/2019 maintenance check	Y
There was a record of fire training for staff. Date of last training: Various	Partial
There were fire marshals.	No
A fire risk assessment had been completed. Date of completion:	No
Actions from fire risk assessment were identified and completed.	No
Explanation of any answers and additional evidence: Designated staff had responsibilities for fire safety however no staff had received fire marshal training. The provider told us that the fire risk assessment for the premises was out of date and not comprehensive. They had recently obtained a quote from a fire safety company to undertake a fire risk assessment and provide fire marshal training. One member of staff had not completed fire safety training and two needed to refresh this training. The practice manager had a plan to address this.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Not recorded	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/08/2019	Partial
Explanation of any answers and additional evidence:	

There were measures in place to promote the security of the premises, equipment and information however these had not been formally recorded in a risk assessment.

An external provider had completed a health and safety risk assessment for the building and had identified a number of areas where improvements were needed. The provider was taking steps to address the action plan. For example, an external service had undertaken a legionella risk assessment and wires in the reception area had been tidied. However, a number of issues needed attention or were unresolved. For example, emergency lighting was not being checked monthly. Further works were needed to the premises before the legionella action plan could be implemented.

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 training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 05/12/2018	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:	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: • Information on how to identify sepsis and the action to take was available for clinical and non-clinical staff to refer to. The reception staff had not received formal training in this area. An on-line training module had recently been introduced and the provider assured us that this would be addressed.	

- One new non-clinical staff member needed their basic life support training to be renewed. They had undertaken this training at another service and the practice manager was planning for them to undertake an on-line training course until the next face to face training course was available.

- Consideration should be given to obtaining a paediatric pulse oximeter for patient assessment.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence:	

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.97	1.04	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	8.3%	6.9%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	6.12	6.00	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	2.12	2.63	2.08	No statistical variation

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

- The provider told us that they informally monitored the consultations, referrals and prescribing of clinicians. A record of these checks was not recorded. The provider told us that a recording system would be put in place.
- We found one emergency medicine to be out of date. This was removed at the time of the inspection and replaced.
- We noted there was no formal policy for the monitoring of high-risk medicines however we found that effective repeat prescribing processes were in place and audits of high risks medicines were undertaken to ensure patients received the necessary checks.

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:	4
Number of events that required action:	4

Explanation of any answers and additional evidence:

- Staff we spoke with knew how to report an incident. They were confident it would be dealt with appropriately and the outcome communicated.

- The practice had recorded four significant events which is a low number given the number of patients receiving a service.

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

Event	Specific action taken
Incorrect patient booked into extended hours service.	The procedure for checking patient details was re-iterated to all staff to ensure that a similar situation did not occur.
Missing prescription pad	The pad was located. The procedures for the management of written prescriptions taken on home visits was strengthened. An audit of GP bags and written prescriptions was introduced. The GPs no longer take these on home visits as they now use a portable electronic device if required.

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:

There was a clear system in place for notifying staff about safety alerts. We looked at a sample of safety alerts and discussed the action taken with the clinicians. A record listing each alert and the action taken would make it easier to review this information.

Effective Rating: Requires improvement

A rating of requires improvement has been made as: -

- **The system for ensuring staff training in safety systems was not comprehensive.**

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:	

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) (01/07/2018 to 30/06/2019) (NHSBSA)	1.02	1.47	0.75	No statistical variation

Older people Population group rating: Requires Improvement

Findings
• The practice liaised regularly with health care professionals such as district nurses and the community matron about older patients with complex needs to provide continuity of care.

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

- The practice carried out structured annual medication reviews for older patients.

- A list of vulnerable older patients was held to prioritise appointments. When a home visit was requested this was discussed with the GP who knew the patient the best to ensure continuity of care and appropriate signposting.

- The Patient Participation Group (PPG) supported the practice to distribute winter warmer packs from Age UK to vulnerable older patients.

People with long-term conditions

Population group rating: Requires Improvement

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 provider 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 provider encouraged patients to self-manage their conditions for example, through care plans and provision of rescue packs for patients with chronic obstructive pulmonary disease.
- Patients were encouraged to provide feedback on any home monitoring of long-term conditions when requesting prescriptions on-line.

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)	75.9%	83.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	7.8% (14)	17.0%	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)	81.1%	81.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	6.1% (11)	10.9%	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)	83.7%	82.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.0% (27)	15.4%	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)	75.1%	78.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.7% (6)	13.6%	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)	83.6%	91.5%	89.7%	No statistical variation
Exception rate (number of exceptions).	13.1% (11)	13.7%	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)	89.0%	84.7%	82.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	2.4% (16)	3.7%	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)	95.7%	89.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.1% (1)	4.7%	6.7%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had met the WHO based national target of 95% (the recommended standard for achieving immunity) for the four childhood immunisation uptake indicators.
- The practice had systems in place to promote attendance for childhood immunisations. For example, the practice nurse discussed immunisations with expectant mothers when they attended for their pertussis vaccination appointment.
- A weekly baby clinic was held with a GP and practice nurse.
- 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents were signposted to sources of support in the local community. The practice supported families in poverty with the provision of food bank vouchers.

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) (01/04/2018 to 31/03/2019) (NHS England)	48	49	98.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	46	46	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	46	46	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	46	46	100.0%	Met 95% WHO based target

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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice offered a travel assessment and vaccination service.
- A fulltime worker appointment slot was available in the evenings.
- Patients were able to access an extended hours service provided by St Helens CCG.

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)	78.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	78.3%	73.3%	72.1%	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)	64.5%	57.6%	57.3%	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)	76.2%	79.0%	69.3%	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)	54.5%	49.7%	51.9%	No statistical variation

Any additional evidence or comments

- Cervical cancer screening was below the 80% coverage target. To increase uptake the provider was offering early morning and evening appointments, opportunistic screening, monitoring of non-attendance and putting flags on the records of patients who had not attended so they could be reminded.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held meetings and communicated with health and social care professionals to ensure that end of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients with a learning disability and offered annual health checks to these patients. The provider told us they had good links with the social workers from the learning disability team and worked with them to ensure patients received the health checks they needed.
- The provider had supported a number of refugee families and used interpreting services to assist them.
- The provider told us how they identified patients with alcohol or drug dependency and how these patients were referred to support services.

- A carers register was held. Carers were identified and provided with relevant information about GP and local services. Information for carers was publicised and carers were offered an influenza vaccination.
- The practice referred or signposted bereaved relatives to support organisations where appropriate

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients experiencing poor mental health, including dementia, an annual health check and a medication review.

Same day and longer appointments were offered when required.

When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.3%	89.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	10.0% (3)	14.6%	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)	92.3%	91.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	13.3% (4)	12.3%	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)	84.8%	81.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.7% (2)	8.2%	6.6%	N/A

Monitoring care and treatment

The practice carried out quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543.6	547.2	537.5
Overall QOF score (as a percentage of maximum)	97.2%	97.9%	96.2%
Overall QOF exception reporting (all domains)	3.9%	6.7%	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.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

past two years

Audits in the last two years had mainly been related to prescribing to ensure that this was appropriate. The audits reviewed showed changes to practice as a result. For example, as a result of an audit of treatment of atrial fibrillation patients had their medication reviewed and medication was altered if assessed as appropriate. A programme of quality improvement was not in place which would ensure a more planned approach driven by external influences and practice learning needs.

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.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
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:

The provider told us they were currently not receiving cover to enable protected learning time to be planned. The administrative/reception team were currently short-staffed resulting in staff working additional hours. Both factors had resulted in less time available for staff to complete training. The provider had a system to identify training needs and some staff had not completed training in all areas to promote safe working practices and safe patient care. Some staff needed training updates in these areas. The provider had a plan to address this. The provider was advertising for the two administrative/reception vacancies to provide additional time for staff to undertake training. The provider had introduced a new on-line learning system and they had contacted staff to plan time for this training to be undertaken.

The provider supported staff to do additional training. The practice nurse was undertaking a master's degree and had completed their prescribing training. Another member of staff was attending training to become a health care assistant.

The provider told us that they informally monitored the consultations, referrals and prescribing of clinicians. A record of these checks was not recorded. The provider told us that a recording system would be put in place.

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
Explanation of any answers and additional evidence: We met with the Community Matron who worked with patients who were frail and had complex needs meaning they were unable to visit the practice. The community matron told us that there was good communication with the practice, the clinicians were responsive to patients' needs and reception staff were helpful. They told us that there was positive feedback from the patients they saw about the service they received from the practice.	

Helping patients to live healthier lives

Staff were proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: The provider told us about the services that patients could be referred to locally for support with their health.	

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)	93.9%	95.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (5)	1.1%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Explanation of any answers and additional evidence: A discussion with the provider and clinical staff indicated that clinical staff obtained consent to care and treatment in line with legislation and guidance. Administrative staff had received guidance in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), however not all had completed formal training in this area. This training was available for staff to complete on-line and the provider told us they would ensure this was completed.	

Well-led Rating: Good

Leadership capacity and capability

There was compassionate and inclusive 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: The provider monitored how it was meeting the needs of patients. They had identified that more nursing appointments were needed and as a consequence they were training a member of administrative staff to become a health care assistant. The provider had also identified that more time was needed for clinicians to share practice updates. They had a plan to address this. The practice manager had been in post since May 2018 and had training courses planned to assist them in this role.	

Vision and strategy

The practice had a vision and 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: The provider had made a number of changes to improve the practice and had plans for further improvements to be made. A formal quality plan had not been recorded although the provider was aware that this should be completed and was planning to address this.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: A discussion with staff indicated that there were systems in place to promote good quality care. We also looked at the systems to manage complaints and found that this was operating appropriately.	

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

Source	Feedback
Staff feedback	• Staff stated they felt supported. • Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. • They told us there was good communication between all staff.

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 reviewed.	Y
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 systems to communicate changes with staff and to ask for their views. Clinical and non-clinical meetings were held and there were informal daily catch up meetings with clinicians. Minutes of meetings were not recorded. The main points were communicated to all staff via email. The manager had a plan to ensure that minutes were recorded when the current vacancies for staff had been filled. The practice monitored its performance through QOF attainment and benchmarking against other practices via the CCG.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, however improvements were needed.

	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.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: This inspection has identified that improvements were needed to the monitoring of staff training, to ensure staff had the required recruitment and on-going checks to ensure their suitability for employment and to ensure the premises and equipment were safe. A programme of quality improvement was not in place which would ensure a more planned approach driven by external influences and practice learning needs.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial

Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	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: The provider told us that staff were encouraged to give their views about the operation of the service. As a result of staff feedback changes had been made to the appointment system and the practice information leaflet.	

Feedback from Patient Participation Group.

Feedback
The practice had a Patient Participation Group (PPG). We met with four members who told us that they met six times per year with a representative from the practice. They said they were kept informed about changes at the practice, asked their opinion and felt listened to. They said that changes had been made at the practice as a result of their feedback. For example, changes had been made to the waiting area to make the information displayed more accessible for patients. A community noticeboard had been introduced. Changes had also been made to the reception area to promote privacy. The PPG had also worked with the practice to promote on-line services for patients and as a result had increased the number of patients registered for this service.

Any additional evidence
The practice sought patient feedback by utilising the NHS Friends and Family test (FFT). The FFT is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results from July to September 2019 showed there had been 83 responses and 75 (90%) were either extremely likely or likely to recommend the practice. As part of this inspection CQC asked patients to complete comment cards indicating their views about the service. Thirty-six comment cards were returned and 32 were positive about access, care and treatment. Three responses were mixed and one was negative. The negative comments related to access.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: A programme of quality improvement was not in place which would ensure a more planned approach driven by external influences and practice learning needs.	

Examples of continuous learning and improvement

- The practice reviewed the needs of its patient population and adjusted services accordingly. For example, they had made improvements to access to the service by extending the length of consultation times, provision of a new website with more information, taking steps to increase the number of patients who access on-line booking of appointments and introducing a triage system for same day appointments.

- In the last national patient survey (01/01/2019 to 31/03/2019) the practice scored above local and national averages for patients' overall experience of making an appointment, satisfaction with appointment times and satisfaction with appointment types. They scored above the national average for ease of getting through to the practice by telephone.

- The practice had introduced new computer technology for the benefit of patients. For example, an improved process to monitor high risk medicines had been introduced.

- The practice was working with the Primary Care Network to look at service developments in the local area. The Primary Care Network was planning to employ a pharmacist to work across the practices in the network.

- The practice had been extended to include additional clinical rooms, a larger waiting area and a room for unwell patients who needed to wait away from other patients or for patients who needed a low stimulus environment, for example patients with a learning disability.

- The practice participated in the apprenticeship scheme which was helping to bring in new ideas regarding computer systems and social media.

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. 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.