Care Quality Commission

Inspection Evidence Table

The Vine House Health Centre (1-540724807)

Inspection date: 2 October 2019

Date of data download: 7 October 2019

Overall rating: Good

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

Safe Rating: Requires improvement

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

- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence: All the staff we spoke with demonstrated they understood the relevant safeguarding processes and their responsibilities. Some non-clinical staff were not recorded as having completed adult safeguarding training. Most staff had completed adult and child safeguarding training to the appropriate level before the intercollegiate guidance on safeguarding competencies was published in August 2018 (adult safeguarding) and January 2019 (child safeguarding). (Intercollegiate guidance is any document published by or on behalf of the various participating professional membership bodies for healthcare staff including GPs and nurses). Following publication of the guidance, some non-clinical staff and the phlebotomist at the practice were required to complete higher levels of safeguarding training. Senior staff at the practice told us they were aware of this and action was being taken to ensure these staff completed the appropriate level of training.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: During our inspection, the practice demonstrated that all but two direct patient contact staff (GPs, nursing staff and receptionists) had either received the required vaccinations for their roles, provided a positive antibody test, or provided evidence of a history of infection where this was permissible. Of the two non-clinical staff for whom this information was not available, one was on long-term absence from the practice and one was booked to receive all the required vaccinations on 14 October 2019. The practice had extended its staff vaccination process to include non-clinical staff who were not in direct patient contact on a regular basis. These staff were requested to have the measles, mumps and rubella (MMR) and tetanus/polio/diphtheria vaccinations. This included two managerial staff, two secretaries and five administration staff. Of these nine staff, seven were recorded as having received the vaccinations, having provided a positive antibody test, or having provided evidence of a history of infection where this was permissible. The remaining two staff had agreed to receive the vaccinations in response to a letter from the practice requesting they do so.	

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: 15 December 2018	Y
There was a record of equipment calibration. Date of last calibration: 15 March 2019 for most equipment.	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: 18 July 2019	Y
There was a log of fire drills. Date of last drill: 3 September 2019	Y
There was a record of fire alarm checks. Date of last check: Weekly test records were completed throughout 2019 and there were partial alarm service and inspections in April, June and September 2019.	Y
There was a record of fire training for staff. Date of last training: Between February and September 2019.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Originally completed in July 2006 and reviewed in December 2018.	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: August 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2019	Y
Explanation of any answers and additional evidence: A Legionella risk assessment was completed in May 2012 and had been reviewed in May 2019. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). In adherence with the assessment's recommendations, the practice completed regular water temperature checks.	

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
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2019	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:

We saw the practice was visibly clean and tidy. Comprehensive equipment cleaning schedules were maintained by the nurses. There were appropriate processes in place for the management of sharps (needles) and clinical waste. Hand wash facilities, including hand sanitiser were available throughout the practice. Regular infection control audits were completed. All staff had completed infection control training as part of the practice's essential training requirements. The staff we spoke with were knowledgeable about infection control processes relevant to their roles. We found the infection control lead had not completed any additional infection control training beyond the essential training completed by all staff.

A cleaning contract was in place. We saw the contracted service provided single use mops that were used more than once. The mops were stored incorrectly.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

During our inspection, we saw that built-in emergency buttons were available on the computers throughout the practice.

We found that one of the GPs had received a level of sepsis training appropriate to their role and had cascaded the learning to other staff at the practice through meetings and one-to-one conversations. Senior staff at the practice told us the training provider had been contacted to attend the practice and provide the training to all staff. The staff we spoke with demonstrated a good understanding of the condition and their role in identifying patients with presumed sepsis and ensuring their urgent clinical review. Appropriate guidelines were available throughout the practice for staff to follow.

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

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.

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)	0.87	0.83	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)	9.3%	9.5%	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)	5.13	5.89	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)	2.10	1.60	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).	N
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines	Y

Medicines management	Y/N/Partial
including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The competence of the nurses to do this was signed by the practice manager. Recently updated British Medical Association (BMA) guidance states this should only be done by a GP or pharmacist. During our inspection, we were told the practice would change the procedure and GPs would sign the PGDs.	

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:	Seven
Number of events that required action:	Seven
Explanation of any answers and additional evidence: There was an effective system in place for reporting and recording incidents and significant events. The staff we spoke with were clear on the reporting process used at the practice and we found that lessons learnt were shared to make sure action was taken to improve safety in the practice.	

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

Event	Specific action taken
A cervical smear test was incorrectly labelled.	The practice informed the patient involved and they were requested to return to the practice for a re-test. The practice implemented a process change so that the labels and forms used are printed together for the patient to check for accuracy before the test.
Following an emergency in the waiting area which was well handled by practice staff, areas of potential improvements were identified.	A new proforma was developed to help guide staff in emergency situations and staff were reminded how to use the emergency alarms.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw a process was in place and adhered to for the receipt, review and monitoring of action taken in response to safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We saw examples of actions taken in response to recent alerts, including those regarding sodium valproate (a medicine primarily used in the treatment of epilepsy), pregabalin (a medicine used to treat epilepsy, anxiety and nerve pain) and carbimazole (a medicine used to treat hyperthyroidism).	

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
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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: The practice assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. The practice had systems in place to keep all clinical staff up-to-date. Staff had access to National Institute for Health and Care Excellence (NICE) best practice guidelines and a comprehensive system of templates based on best practice guidelines. They used this information to deliver care and treatment that met patients' needs.	

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)	0.69	0.59	0.75	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.
- As part of a local initiative, the practice was aligned to two care homes and nominated GPs at the practice visited the homes on a weekly basis to provide continuity of care and ensure residents' health needs were met.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Older people had access to targeted immunisations such as the flu vaccination. The practice had 2,214 eligible patients aged over 65 years. Of those, 1,661 (75%) had received the flu vaccination at the practice in the 2018/2019 year.
- Staff could recognise the signs of abuse in older patients and knew how to escalate any concerns.

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 GPs worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- GPs followed up patients who had received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease and prescribed statins had their care appropriately managed at the practice.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patient with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice provided its own anticoagulation clinic to monitor the treatment of patients taking oral anticoagulant medicines (medicines that help prevent blood clots). This included the provision of the appropriate blood tests.
- All newly diagnosed patients with diabetes were managed in line with an agreed pathway.
- The practice followed up on patients with long-term conditions discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

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)	78.5%	78.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	12.7% (82)	15.0%	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)	72.6%	76.6%	77.7%	No statistical variation
Exception rate (number of exceptions).	16.9% (109)	10.8%	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)	83.2%	79.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.8% (115)	13.2%	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)	81.7%	75.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	36.6% (271)	5.7%	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)	93.0%	90.1%	89.7%	No statistical variation
Exception rate (number of exceptions).	18.4% (45)	9.1%	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)	81.3%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.9% (99)	3.5%	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)	96.3%	91.1%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	6.5% (17)	5.9%	6.7%	N/A

Any additional evidence or comments

During our inspection, we reviewed the care provided to patients with long-term conditions and found these patients had received appropriate reviews or had been invited for a review. We found the practice had an organised approach towards managing these patients.

We discussed any areas of above averages exception reporting for the 2017/2018 year with senior clinical staff during our inspection. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This related to the individual clinical domains for chronic obstructive pulmonary disease (COPD) (14.5% exception reporting in 2017/2018) and diabetes (15% exception reporting in 2017/2018), and an individual asthma category (36.6% exception reporting in 2017/2018). The practice's current unverified data showed exception reporting for 2018/2019 was lower than in 2017/2018 in all these areas. Exception reporting for COPD and diabetes was 7% and for the individual asthma category it had reduced to 6%. In all the cases we looked at exception reporting was clinically appropriate.

Families, children and young people Population group rating: Good

Findings

- 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.
- A range of contraceptive and family planning services were available.
- There were six week post-natal and child health checks. Baby vaccination clinics were available at the practice.

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)	95	111	85.6%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	85	92	92.4%	Met 90% minimum
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)	85	92	92.4%	Met 90% minimum
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)	84	92	91.3%	Met 90% minimum

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

Any additional evidence or comments

Figures from the 2018/2019 year showed that at that time, the practice didn't meet the 90% national standard for one childhood immunisation category. We looked at the practice's own unverified data. This showed that at the time of our inspection, between 91% and 95% of children aged two to four months had received between one and three doses of the relevant immunisation, and 92% of children aged four months had received all three doses. This exceeded the national standard. We looked at the practice's records which showed 17 children aged between one and two years had not received a range of immunisations required by those ages. Nine of these children were documented as having appointments booked to receive the immunisations in October 2019. In six cases the practice had contacted the parents and invited them to attend the practice with their children to receive the immunisations. In two cases, the parents had declined the immunisations for their children and this was appropriately documented.

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. The practice had 2,055 patients eligible to receive an NHS health check. Of those, 578 had been invited for, and 292 had received a health check in the past 12 months.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	77.8%	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)	74.5%	69.9%	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)	57.8%	55.3%	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)	90.9%	75.6%	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)	52.9%	51.6%	51.9%	No statistical variation

Any additional evidence or comments

There was evidence to suggest the practice encouraged its relevant patients to engage with nationally run and managed screening programmes.

Public Health England data for the year April 2017 to March 2018 showed the practice was below the national 80% target for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period. We looked at the practice's own unverified

data. This showed that at the time of our inspection, 82% (2,292) of eligible patients were screened adequately within a specified period.

We spoke with practice staff about their efforts to achieve 80% attainment (the threshold set for the National Health Service Cervical Screening Programme to be effective). We found the practice operated a comprehensive reminder system for patients who did not attend for their cervical screening test. They demonstrated how they encouraged uptake of the screening programme, for example, by ensuring a female sample taker was available. In addition to female GPs, there were three female nurses available to complete cervical screening.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

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 medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- GPs at the practice had completed training in mental capacity and Deprivation of Liberty Safeguards (DoLS).

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)	92.7%	90.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	11.3% (7)	7.8%	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)	87.7%	89.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.1% (5)	6.8%	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)	84.7%	84.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.3% (5)	4.6%	6.6%	N/A

Monitoring care and treatment

The practice had a 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)	553.9	539.9	537.5
Overall QOF score (as a percentage of maximum)	99.1%	96.6%	96.2%
Overall QOF exception reporting (all domains)	6.6%	5.2%	5.8%

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

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

We looked at the details of three clinical audits completed over the past two years. These were full cycle (repeated) audits or part of a full cycle programme (scheduled to be repeated) where the data was analysed and clinically discussed, and the practice approach was reviewed and modified as a result when necessary. Findings were used by the practice to improve services.

The practice completed an audit to check adults prescribed a type of corticosteroid (used to treat a wide range of health problems) on a long-term basis had the appropriate monitoring checks completed at the recommended timescales. The initial audit showed that none of the identified patients had all the appropriate monitoring checks completed. The practice took action and implemented changes to ensure all the identified patients were appropriately monitored. At the time of the second (repeat) audit, all the identified patients were monitored in accordance with recommendations.

An audit was completed to ensure patients prescribed a type of medicine used in the treatment of osteoporosis for more than five years had the medicine temporarily stopped (known as a medicine holiday) when appropriate to do so. As a result of the audit, the practice introduced a system of review, an alert protocol and a care template for these patients and reduced the number of patients on the medicine for more than five years by 37.5%.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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.	N/A
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:

Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included role-specific training and updating for relevant staff and the use of an e-learning facility. We saw some non-clinical staff were not recorded as having completed safeguarding training and the infection control lead had not completed any relevant training for that role beyond the essential training completed by all staff.

GPs had one afternoon each month and nurses had one hour every Wednesday as protected learning and meeting time and all staff had twice-yearly protected learning sessions as part of Clinical Commissioning Group target days.

At the time of our inspection, all but four staff had received an appraisal in the last 12 months. All these staff were scheduled to receive an appraisal by the end of October 2019.

The healthcare assistant (HCA) at the practice was employed after April 2015. The Care Certificate didn't form part of their induction. They had completed a level two diploma in health and social care. Following our inspection, the HCA enrolled to complete the Care Certificate at the earliest opportunity.

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 three 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: Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings to discuss the needs of complex patients, including those with end of life care needs, took place monthly. These patients' care plans were routinely reviewed and updated.	

Helping patients to live healthier lives

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

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

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)	92.6%	94.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (18)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: We saw the process for seeking consent was well adhered to and examples of documented informed patient consent for recent procedures completed at the practice were available.	

Well-led Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

At the time of our inspection, the provider partnership was stable and staff turnaround was minimal. There were no planned changes to the partnership, so no succession planning was necessary.

In response to increased demands on primary care, the practice had joined a recently created Primary Care Network (PCN) and was embracing new ways of working as part of this wider network. Plans included employing a clinical pharmacist through the PCN. One of the practice's GPs was the clinical director of the PCN with one day each week allocated to this role.

Vision and strategy

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

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

Explanation of any answers and additional evidence:

The practice developed a three-year written strategic plan in 2016. A subsequent action plan was developed for the practice by an external contracted service in 2017. A monthly partners meeting was used to monitor the strategic direction of the practice throughout the year, including any evolving needs or areas of focus. Some of the main areas of strategic focus for the practice throughout 2019 were strengthening its business planning, increasing the patient list size and the significance of Primary Care Networks (PCNs) in how GP practices operate moving forwards.

During our inspection, we found that some of the staff we spoke with were less familiar with the practice's vision and strategic focus than others. Some staff told us they felt the practice's approach was more business oriented than in the past.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: During our inspection, we found the practice did not have access to a Freedom to Speak Up Guardian and staff were not aware of any local initiatives. Senior staff we spoke with told us they'd investigate this provision following our inspection. At the time of our inspection, some staff had completed equality and diversity training. Most staff were yet to complete the training.	

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

Source	Feedback
Staff interviews.	The staff we spoke with said there was an open culture within the practice and they had the opportunity to raise and discuss any issues directly with other staff or at meetings and felt confident in doing so and supported if they did. They told us they felt respected, valued and well supported and knew who to go to in the practice with any concerns. They said they felt their well-being was a priority for the practice. This was despite what some felt was an increasingly business oriented approach at the practice. Staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by the practice.

Governance arrangements

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

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

Explanation of any answers and additional evidence:

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This was demonstrated by such things as the availability of and adherence to practice specific policies. There was a clear protocol in place for how decisions were agreed and a regular schedule of meetings at the practice for individual staff groups, multi-disciplinary teams and all staff to attend supported this.

There were named members of staff in lead roles. There were nominated GP leads for safeguarding, medicines management/prescribing and patients with learning disabilities and diabetes among others. There were also nurse-led clinics for patients with diabetes. We saw there was a clear staffing structure and found that staff understood their roles and responsibilities and those of others.

Managing risks, issues and performance

In most cases, there were clear and effective processes for managing risks, issues and performance.

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

Explanation of any answers and additional evidence:

We identified some concerns during our inspection. For example, those in relation to the appropriate authorisation of Patient Group Directions (PGDs), a staff vaccination programme that was not yet fully completed, some gaps in the completion of safeguarding training by non-clinical staff, and the infection control lead not completing appropriate training for the role beyond the essential training completed by all staff, among others. Senior staff at the practice assured us they would act to ensure any issues were resolved.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: We found the practice used accurate and reliable data and indicators to understand and monitor the performance of the practice. There was a programme of clinical and internal audit which was used to monitor quality and to make improvements.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	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 staff we spoke with said they were encouraged to actively participate in practice life and share their views. An open culture among staff and management supported this.

We saw there were various methods available for patients to express their views and leave feedback about their experiences including an online comments and suggestions facility and an active Patient Participation Group (PPG). Senior staff we spoke with told us the online comments facility wasn't used by patients.

The Patient Participation Group (PPG) met quarterly. We saw there was a dedicated PPG patient information area in the waiting area and the practice's website promoted the PPG and its work and encouraged patients to participate. The PPG had been actively involved in developing and reviewing a patient survey on access in May/June 2019 and 134 responses were received. As a result of the survey the practice was committed to introducing a new telephone queuing system by the end of 2019.

The practice had an effective system in place for handling complaints and concerns. Information was available to help patients understand the complaints system. A complaints notice was displayed in the waiting area and a leaflet detailing the complaints process was available from reception. The full complaints procedure was available on the practice's website. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care or patient experience.

Feedback from Patient Participation Group.

Feedback
From our Patient Participation Group (PPG) interview, we found they were positive about the services provided at the practice and how the relevant staff responded to suggestions made and issues raised. They had confidence in the staff team. Although still an active meeting group, the PPG had no chairperson and there was some concern the group may lack direction. They felt the practice was supportive of the group, with some room for the practice to be more creative in how they utilised the PPG.

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.	Y
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

One of the GP partners had recently developed and introduced a wide range of comprehensive clinical templates for use at the practice to promote the effective care and treatment of patients with a range of long-term conditions, mental health issues, dementia and end of life care needs among others. The local clinical commissioning group (CCG) was investigating introducing these templates in practices throughout the area.

The same GP partner was proactive in providing health information and education events for patients. There had been three cardiac prehabilitation (prehab) education events held at the practice for the relevant patients throughout 2019. (Cardiac prehab is a term used to describe a range of preventative interventions for patients at risk of cardiac issues).

Another GP partner was credited with taking a lead role in establishing a latent tuberculosis (TB) testing service. The service was piloted at the practice in 2017/2018 and due to its success had been introduced across the locality with 530 tests completed and 57 people diagnosed and treated for latent TB. (A person has latent TB if they are infected with the TB bacteria but do not have signs of active TB disease and do not feel ill).

The practice was in the early stages of participating in a Primary Care Network (PCN). (A Primary Care Network is a group of practices working together to provide more coordinated and integrated healthcare to patients). As part of this, the participating practices were identifying areas of focus to assist in improving and diversifying the delivery of patient care.

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.