Care Quality Commission

Inspection Evidence Table

Staverton Surgery (1-550865493)

Inspection date: 9 January 2020

Date of data download: 09 January 2020

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Requires Improvement

The practice is rated Requires Improvement for providing safe services because:

- **Staff vaccination was not maintained in line with Public Health England (PHE) guidelines.**
- **There were gaps in systems to assess, monitor and manage risks to patient safety.**
- **Appropriate standards of cleanliness and hygiene were not always met.**
- **Clinical data was not always managed securely according to guidance.**
- **The systems for the appropriate and safe use of medicines was not always operating effectively.**
- **The practice did not have an effective system to learn and make improvements when things went wrong.**

Safety systems and processes

The systems, practices and processes to keep people safe and safeguarded from abuse required monitoring.

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.	Partial
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.	Partial

Safeguarding	Y/N/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
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial

Explanation of any answers and additional evidence:

- Safeguarding systems and processes were not operating effectively in relation to identifying vulnerable patients. The safeguarding policies in place did not contain sufficient information, such as the names of the designated safeguarding leads; however, the safeguarding leads were identified on laminated sheets which were available in each clinical room.
- The safeguarding policies did not provide sufficient information relating to Female Genitalia Mutilation (FGM).
- The practice told us staff had attended an FGM education session and further training was provided as part of the bluestream training module.
- The Out of Hours service had access to relevant safeguarding information through shared care records and Co-ordinate my Care (CMC) care plans.
- There were no regular discussions with community midwives, health visitors and school nurses; however, they could be contacted by phone if required.

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.	N
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:

- The staff immunisation programme was not implemented as per Public Health England (PHE) guidelines. There were gaps in all staff immunisation records such as measles, mumps, rubella, typhoid, diphtheria and chicken pox despite a recent confirmed measles case at the practice.
- The practice told us there was a system in place to ensure the registration of clinical staff. For example, the registration of nursing staff was checked annually at appraisal.
- The practice told us the registration of clinical pharmacists working at the practice as well as across other local practices was checked by the federation responsible for their employment.

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: March 2019	Y
There was a record of equipment calibration. Date of last calibration: November 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: 23 December 2019	Y
There was a log of fire drills. Date of last drill: 16 September 2019	Y
There was a record of fire alarm checks. Date of last check: 3 January 2020	Y
There was a record of fire training for staff. Date of last training: adhoc	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 28 November 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

- We saw evidence the fire risk assessment actions were completed. For example, the local fire and rescue service was made aware of the presence of hazardous materials stored at the practice. The recommended fixed electrical installation inspection was booked for 18 January 2020.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 21 November 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 28 November 2019	Y

Explanation of any answers and additional evidence:

- We saw evidence showing the practice had acted on the health and safety risk assessment recommended actions, such as installing an alarm in the patient toilets.
- Although we saw evidence of secured loop cords around the practice, we also saw unsecured blind loop cords in the upstairs waiting room. The practice told us this would be disposed of.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 26 September 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
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.	N

Explanation of any answers and additional evidence:

- Not all areas of the infection control actions were completed. For example, the infection control audit recommended installing soap and alcohol dispensers; however, this was not in place at the time of inspection.
- The infection control audit had also identified that waste was not segregated correctly and a waste management audit was to be carried out every three months; however, the waste management audit was overdue as the last one had been carried out on 25 September 2019. The practice provided evidence after the inspection to show an audit had been carried out on 10 January 2020.
- We observed there were no purple lidded bins for cytotoxic waste and there were no sanitary bins in all the practice toilets.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
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:

- Staff provided cover for each other and regular locums covered for the GPs. They used an instant messaging phone application system to communicate and provide staff cover at short notice.
- We reviewed the practice record of staff training and identified it had not been updated to show all staff had completed sepsis training. The practice provided evidence this training had been completed after the inspection.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment; however, monitoring was required.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
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:

- The practice was registered with the Information Commissioners Office (ICO) and there was an information governance policy in place. Staff knew how to manage secure data; however, monitoring was required to ensure this was being implemented effectively. On the day of inspection, we observed one clinician's room had been left open and steps had not been taken to secure clinical data.
- The system for summarising new patient notes listed 44% of new patient notes had been summarised. The practice told us this was carried out on an adhoc basis and a trained staff member would attend the practice when required to summarise the records.

Appropriate and safe use of medicines

The systems for the appropriate and safe use of medicines was not always operating effectively.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.51	0.59	0.87	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	12.6%	10.0%	8.5%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	7.99	5.89	5.60	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.37	1.06	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 review of their prescribing practice non-medical prescribers, and there was regular supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- The practice had overall low antibiotic prescribing; however, they had a higher than average list size of patients with cystic fibrosis which affected the prescribing of broad-spectrum antibiotics. We saw evidence that two of the GP partners attended antimicrobial courses and the practice told us they were advised to prescribe longer seven-day courses for treating urinary tract infections, instead of shorter three-day courses.
- The practice did not store diclofenac (analgesia), morphine (for severe pain) and naloxone (for drug overdose) at the practice. We saw evidence of a risk assessment carried out to determine the range of medicines held.
- There was a policy in place for prescribing high-risk medicines. However, documentation for lithium monitoring required improvement. For example, when we reviewed one patient record, we found there had been a gap of six months between monitoring. Following the inspection the practice provided evidence to show the patient had received reminders to attend their appointment but this had not been clearly recorded when reviewed on inspection. The practice escalation process for patients not attending for monitoring was also unclear. For example, it was not clear what the process was for patients who had not responded to invitations for monitoring.
- There were no concerns found in relation to warfarin prescribing.
- There was no evidence of arrangements for raising concerns around controlled drugs with the NHS England Controlled Drugs Accountable Officer.

Track record on safety and lessons learned and improvements made

The practice did not have an effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
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.	Partial
Number of events recorded in last 12 months:	6
Number of events that required action:	6

Explanation of any answers and additional evidence:

- Not all significant events were recorded. For example, a recent confirmed measles case at the practice had not been recorded as a significant event. It was not clear what action had been taken, such as ensuring staff immunity.
- There were regular clinical and whole practice meetings held by the practice. However, there was no evidence effective sharing of lessons as not all meeting were minuted.
- At the time of inspection, the practice was trialling a new system for recording meetings.

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

Event	Specific action taken
Security alarm not set up by the cleaning staff.	Practice stated the close down process had not been adhered to. Relevant discussions held with staff concerned and records updated to include all action taken.
Water damage to part of building ceiling	All staff informed and repair works completed.

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 examples of actions taken on recent alerts for example, regarding carbimazole. The practice were able to demonstrate that they had reviewed all eligible patients and action had been taken where necessary.

Effective Rating:Requires Improvement

The practice is rated as requires improvement for providing effective services because:

- **The processes to keep clinicians up to date with current evidence-based practice were not effective.**

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. However, further monitoring was required.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
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:

- There was no formal system to keep clinicians up to date with current evidence-based guidelines. For example, the practice told us they were not subscribed to the National Institute of Clinical Excellence (NICE) guidelines. There was no evidence provided to show how the latest guidelines were disseminated to clinicians.
- The practice carried out e-consults and there was a policy in place.

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) (01/10/2018 to 30/09/2019) (NHSBSA)	0.73	0.40	0.74	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.
- Complex patients were referred to the Complex Patient Management Group (CPMG) and received support from the multi-disciplinary team.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

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

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had inhouse ECG monitoring, spirometry and International Normalised Ration (INR) (used to check for clotting problems) testing by finger prick.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan. We saw some patients did not have a recorded personalised care plan. The practice told us this would have been discussed verbally with the patients.

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 (01/04/2018 to 31/03/2019) (QOF)	79.7%	76.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	2.7% (11)	10.8%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	75.4%	78.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	3.5% (14)	7.6%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	82.6%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.2% (21)	7.9%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	80.6%	78.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.5% (9)	2.5%	7.4%	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 (01/04/2018 to 31/03/2019) (QOF)	90.9%	92.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	19.1% (13)	6.9%	11.2%	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 (01/04/2018 to 31/03/2019) (QOF)	80.7%	82.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.0% (18)	3.9%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	85.5%	86.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	7.8% (7)	9.1%	5.9%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice has met the minimum 90% target for all childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. For example, diabetic patients were referred to the diabetic antenatal hospital clinic at the same time as the antenatal obstetric clinic to ensure they are seen quicker.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	106	114	93.0%	Met 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)	108	119	90.8%	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)	110	119	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)	109	119	91.6%	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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice is rated requires improvement for working age people as the cervical screening uptake was significantly below the target.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order relevant repeat medication without the need to attend the surgery.
- Patients could book e-consults and telephone consultations with the GP.
- The practice hosted the local hub service on Monday to Saturday.

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). (31/03/2019 to 30/06/2019) (Public Health England)	58.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	58.9%	60.4%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	43.3%	43.3%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	66.7%	75.0%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	50.0%	53.8%	53.8%	No statistical variation

Any additional evidence or comments

- The practice was aware of the low cervical screening performance and stated this was due to patient demographics which included transient patients who declined screening. The practice also told us there was no nurse in post for one year and a new nurse had not been trained to carry out cervical screening. We saw evidence the nurse had now completed their cervical screening training and supervised practice six months prior.
- They carried out a text message campaign to invite patients for screening appointments on Saturdays.
- Cervical screening appointments were also offered via the hub service during the evenings and weekends between 9am and 3am.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition

according to the recommended schedule.

- The practice demonstrated they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes. They provided care for one residential care home for patients with severe learning disabilities.

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 advice given by nurse.
- 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.
- The practice was a dementia friendly practice. All staff had received dementia training in the last 12 months. The practice worked together with Dementia Care Kilburn to redesign the reception and improve lighting.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Patients could self-refer to the IAPT counselling sessions held inhouse.

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 (01/04/2018 to 31/03/2019) (QOF)	92.7%	90.3%	89.4%	No statistical variation
Exception rate (number of exceptions).	3.1% (4)	6.6%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	89.4%	91.1%	90.2%	No statistical variation

Exception rate (number of exceptions).	3.1% (4)	5.8%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	79.6%	84.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.5%	6.7%	N/A

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	534.8	536.2	539.2
Overall QOF score (as a percentage of maximum)	95.7%	96.0%	96.7%
Overall QOF exception reporting (all domains)	3.2%	5.7%	5.9%

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

- We saw evidence of quality improvements such as audits; however, there was not always a clear audit strategy.

Effective staffing

The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y

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

- There was no healthcare assistant employed at the practice.
- There was no formal assessment of the competence of staff employed in advanced clinical practice such as the Advanced Nurse Practitioner (ANP), locum GPs and the clinical pharmacists. There was no evidence provided of peer reviews.

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 (01/04/2018 to 31/03/2019) (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

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 (01/04/2018 to 31/03/2019) (QOF)	96.4%	95.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (6)	0.5%	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: • The practice demonstrated an understanding of legislation when considering consent and decision making.	

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.