Care Quality Commission

Inspection Evidence Table

The Lordship Lane Surgery (1-537675048)

Inspection date: 11 February 2020

Date of data download: 28 January 2020

Overall rating: Requires Improvement

The practice is rated as requires improvement overall due to concerns identified around the management of medicines including one high risk medicine and prescriptions, risks associated with legionella, systems to monitor professional registrations, below average uptake of childhood immunisation and cancer screening and above levels average exception reporting for some conditions.

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

Safe Rating: Requires Improvement

The practice is rated as requires improvement for providing safe services as two patients prescribed one high risk medicine had not received appropriate monitoring in line with guidelines and there was no documented rational for continuing to prescribe this medicine in absence of monitoring. In addition, there was no system for logging prescriptions when they were delivered to the surgery. Appropriate action had not been taken to mitigate risks associated with legionella.

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.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y

Safeguarding	Y/N/Partial
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
Explanation of any answers and additional evidence: We found that the practice's child safeguarding policy was not immediately accessible on some computers due to a computer upgrade a week prior to our inspection which the practice had identified resulted in some files not transferring across to all machines.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Explanation of any answers and additional evidence: A review of staff files showed that registration with the relevant professional body was checked at the time of staff appointment but there was no system to check this periodically thereafter. The practice manager provided evidence after the inspection that the professional registrations of all clinical staff at the surgery had subsequently been checked. Only one member of staff was recruited since our last inspection. We found that the practice had completed relevant checks including DSB checks and had retained the staff member's resume. However, the practice had taken one reference and not two as stated in their recruitment policy.	

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: 17/12/19	Y
There was a record of equipment calibration. Date of last calibration: 5/12/19	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: 8/5/19	Y
There was a log of fire drills. Date of last drill: 26/9/19	Y
There was a record of fire alarm checks. Date of last check: 20/1/2020	Y
There was a record of fire training for staff. Date of last training: various dates	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 8/5/20	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: The practice's fire risk assessment was completed internally by the practice manager. The practice had a legionella risk assessment completed in March 2018 which expired in March 2020. The risk assessment identified that the practice's shower outlet provided a low risk of legionella and recommended that the practice undertake periodic temperature monitoring to ensure that temperatures were not within the range that legionella bacteria could survive. We found that the practice was undertaking regular temperature monitoring but that temperatures recorded were within range were legionella could survive and the practice had not taken action in response to these readings.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 10/9/19	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/9/19	Y
Explanation of any answers and additional evidence: The practice's health and safety risk assessment which included an assessment of risks associated with the premises was completed by the practice manager.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 11/6/19	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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:	

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.	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	Y

deliver safe care and treatment.	
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:

All test results were reviewed by a clinical member of staff.

Although most of the records reviewed during the inspection followed current guidelines; the treatment of two patients prescribed one high risk medicine deviated from current guidelines as medicines had continued to be prescribed for these patient's in absence of appropriate monitoring. Additionally there was no justification for continuing to prescribe this medicine in absence of these checks noted in either patient's record.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation in most respects. However, the practice had not undertaken required monitoring for patients prescribed high risk medicine and prescriptions were not being logged when delivered to the practice. We also found that the practice had not completed a formal audit of controlled drug prescribing.

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)	0.57	0.57	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)	8.8%	7.0%	8.5%	No statistical variation
Average daily quantity per item for	6.00	5.14	5.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)				
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)	1.47	1.47	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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels	Y

Medicines management	Y/N/Partial
and expiry dates.	
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 stored prescription stationary securely and there was a system for tracking the serial numbers of prescriptions when they were issued to consulting rooms. However, the practice did not record serial numbers of prescription stationary upon receipt.

We reviewed the records of 10 patients on various high risk medicines. There were no concerns with eight of these records. However, we found concerns in respect of two patients prescribed one high risk medicine.

The practice's high risk drugs monitoring policy stated that patients prescribed this high risk medicine should have their thyroid function, levels of medication and renal function checked every six months. The policy stated that in absence of the patient completing these tests the practice would give the patient one month beyond the required test date to attend for testing before they may consider refusing to prescribe the medication.

The practice had participated in a prescribing safety audit which included a review the proportion of patients who had tests to measure the level of this medicine in their blood. The audit showed that there had not been appropriate checking for two patients on both at the time of the first data collection on 6 June 2019 and then on the second data collection on 3 January 2020. The audit stated that there was a "true risk as blood tests were due".

One patient had not had monitoring completed since 12 March 2019 and their last prescription was issued on 30 January 2020. The monitoring completed on 12 March 2019 did not include an assessment of the patient's renal or thyroid function and their renal and thyroid function was last checked in July 2018. There was evidence that staff at the practice had attempted to contact the patient to get them to undergo complete testing without success. The practice had continued to prescribe this medicine in absence of monitoring and there was no documented clinical justification for doing so. The last prescription was issued 30 January 2020.

The second patient last had blood monitoring completed in June 2019. The patient was last issued a prescription in 20 January 2020. Prior to this issue the practice had attempted to contact the patient in October 2019. Staff at the practice told us that 6 monthly monitoring was appropriate for this patient as their condition was stable. However, this rationale was not documented in the clinical record.

The GP partner told us that they had continued to prescribe for these patients as they considered the potential risks associated with stopping the medication outweighed the risks of adverse reactions as they considered the patients to be stable. However, this was not documented in either patient's records. Both patients had medication reviews completed and blood forms issued on 3 February 2020.

Medicines management	Y/N/Partial
Although we were told that the federation pharmacist, who attended the surgery once a week, assisted with the monitoring of controlled drugs prescribing there was no formal controlled drug prescribing audit which reviewed the appropriateness of prescribing. However, we did see examples where the practice had placed alerts in patient records which advised clinicians not to prescribe certain medicines for particular patients. The practice undertook an audit in February 2020 to review of the proportion of patients being prescribed disease modifying anti-rheumatic drugs (DMARDS) who had shared care agreements in place. The results showed that out of 28 patients who required a shared care agreement; 23 of these patients did not have one. The recommendations of the audit were to contact secondary care to put shared care agreements in place. The practice provided documentation after our inspection which indicated that agreements were already in place prior to our inspection.	

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:	3
Number of events that required action:	3
Explanation of any answers and additional evidence:	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Patient delay in receiving a referral	The practice updated their processes so that patients would be sent a text message with referral information.
EMIS records system down	The practice activated their business continuity plan however they could not access the practice's appointment book due to the IT problems. Reception staff now print a copy of all appointments for the day at the start of each shift.

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 evidence of alerts being discussed in practice meetings and action taken in response to safety alerts.	

Effective Rating: Requires Improvement

The practice is rated as inadequate for children families and young people due to low uptake of childhood immunisations, requires improvement for working age people due to below average uptake of various screening programmes and requires improvement for people experiencing poor mental health due to high levels of exception reporting for patients with depression. As a result, the practice is rated requires improvement for effective overall.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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:	

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)	0.15	0.34	0.74	Significant Variation (positive)

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.
- 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.
- Patients over 75 years of age and all had a named GP and health checks were offered to patients over 75 years of age.
- The practice provided holistic health assessments for patients in this age cohort, both at the practice and at home.
- The practice also had register of unplanned admissions to secondary care, with alerts to offer priority appointments if required.
- The practice provided a choice of appointments and home visits are also made available for housebound patients.
- The practice had monthly meetings with the community district nurse team and matron to discuss housebound patients, patients on their caseload and frequent A&E attenders where necessary.

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.
- 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.

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)	85.5%	76.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.4% (17)	7.7%	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)	86.1%	80.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	5.4% (17)	5.9%	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)	86.5%	84.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.4% (17)	7.1%	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)	98.1%	75.3%	75.9%	Significant Variation (positive)
Exception rate (number of exceptions).	5.8% (10)	1.9%	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)	93.8%	91.0%	89.6%	No statistical variation
Exception rate (number of exceptions).	3.0% (1)	5.6%	11.2%	N/A

Indicator	Practice	CCG	England	England

		average	average	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)	98.0%	83.1%	83.0%	Significant Variation (positive)
Exception rate (number of exceptions).	2.4% (10)	3.0%	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)	100.0%	90.8%	91.1%	Variation (positive)
Exception rate (number of exceptions).	34.8% (8)	6.2%	5.9%	N/A

Any additional evidence or comments

The practice attributed their above average scoring in respect of indicators related to hypertension and asthma to optimising patient care with the support of consultants during virtual clinics. In addition, the practice said that they had a good recall system in place and that reception and administrative staff were proactive in encouraging attendance. One of the reception staff had also been trained to take blood pressure readings.

The practice said that their above average rate of exception reporting for the atrial fibrillation indicator was due to two reasons. Firstly, the practice had a number of patients from a local refugee service registered and that these patients had a rapid turnover which impacted the practice's exception reporting. Additionally, the practice said they had a relatively low elderly population with this condition and that excepting reporting only eight patients had created an above average rate of exception reporting.

The practice rate of exception reporting for patients with heart failure was 35.3% compared with 5.7% locally and 8.2% nationally. Staff at the practice said that this was due to a significant proportion of their patients with this condition spending significant periods of time outside of the UK.

Families, children and young people Population group rating: inadequate

Findings

- The practice had not met the minimum 90% target for four childhood immunisation uptake indicators. The practice was not aware of the figures below and disputed their validity. The practice said that they measured outcomes against immunisation targets using payment information data.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	53	70	75.7%	Below 80% uptake
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)	41	61	67.2%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	42	61	68.9%	Below 80% uptake
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)	43	61	70.5%	Below 80% uptake

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

Any additional evidence or comments
The practice provided unverified data from open Exeter which showed that the practice had achieved 90% for childhood immunisation targets. The practice said that they had faced challenges in achieving childhood immunisation targets, particularly that anti-vaccination sentiment had increased. In response one staff member had attended a conference hosted by a technology company to obtain information on strategies to combat anti-vaccination sentiment. The practice had a system of call and recall for parents who did not bring their children in for their required vaccinations; sending letters and texts messages in addition to providing information on the benefits of vaccines both online and in the practice waiting area. The practice registered patients who resided in accommodation for refugees. Although this population had a high turnover, the practice did not believe that this had negatively impacted on their immunisation targets. The practice said that there was not a high patient turnover among the rest of their population.

Working age people (including those

Population group rating: requires

recently retired and students) **improvement**

Findings

- 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. However, the uptake of cervical screening was significantly below the national target and rates of bowel and breast cancer screening were comparatively low when compared to other practices nationally.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery including via a telephone app.
- The practice provided late evening surgeries with GPs and nurses. Patients could also be seen at the local extended access service which provided appointments seven days a week from 8 am to 8 pm.
- The practice offered telephone consultations.

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)	61.5%	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)**	54.6%	62.4%	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)**	40.8%	43.4%	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)**	87.5%	71.3%	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%	52.6%	53.8%	No statistical variation

Any additional evidence or comments

The practice said that they had found it challenging to meet cervical screening targets as there was a reluctance among different populations, including religious groups, to having this procedure. In an effort to improve performance against this target the practice had increased the number of sessions available with a female GP and the practice nurses. They had also displayed posters in the waiting area and regularly text patients who were due for screening in an effort to encourage attendance.

The practice said that they would promote breast screening opportunistically.

The practice has completed a quality improvement initiative to improve the uptake of bowel screening. The practice identified 74 patients who had not attended for screening. Discussions were held with 46 of these patients and counselling offered on the benefits of screening. Thirty patients indicated that they would be willing to participate in screening and nine patients returned screening kits with samples. The practice identified that a number of patients did not have completed contact information on file and the practice found it difficult to follow up all patients identified.

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 that they had a system to identify people who misused substances.
- We saw examples of the care of vulnerable patients being regularly being discussed and having their care reviewed in multidisciplinary forums.
- The practice registered patients at a home for asylum seekers which had 160 beds and approximate turnover of 30 patients per day. They supported a local secondary care service in providing care for these patients. We were told that the transient nature of this population impacted on performance against targets and contributed to above average levels of exception reporting.
- There was a domestic violence refuge in the practice's catchment area and the practice provided support to those who resided there.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The practice had high levels of achievement against QOF targets for patients with severe mental illness and dementia. The practice attributed their high achievement to good care planning supported by the community nursing team. However, the practice had overall exception reporting rates of 13.3% for dementia compared with the local and national average of just above 9% and exception reporting rate for patients with depression of 86.9% compared with 24.2% locally and 22.5% nationally. The practice attributed these above average exception reporting rates to two factors . Firstly, the practice said that a high proportion of patients who registered with the local refugee hostel suffered from severe mental illness but due to the high turnover of these patients;

follow up was often not possible. Secondly the practice said that above average exception reporting could possibly be the result of a coding issue and said that they would consider providing training for GPs to reduce this figure.

- The practice had not followed best practice guidance for two patients prescribed one high risk medicine.
- 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.
- All staff had received dementia training in the last 12 months. One of the GPs had a specialist interest in mental health.
- The practice had a register of patients experiencing poor mental health and reviewed these patients annually. The practice directed patient to local mental health support services.
- The practice had a register of patients with dementia and provided support as necessary. The practice used the local Memory Clinic for patients with memory concerns, for timely assessment and diagnosis, leading to a full management plan.

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)	91.4%	90.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	3.3% (2)	7.5%	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)	98.2%	90.9%	90.2%	Tending towards variation (positive)
Exception rate (number of exceptions).	5.0% (3)	6.7%	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)	100.0%	82.5%	83.6%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	3.9%	6.7%	N/A

Any additional evidence or comments

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However we saw that

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	514.0	545.3	539.2
Overall QOF score (as a percentage of maximum)	93.5%	97.6%	96.7%
Overall QOF exception reporting (all domains)	6.4%	4.6%	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

The practice had completed an audit of drug safety prescribing against 13 indicators. The standard of the audit looked at reducing patient harm for three specific indicators and three of any of the indicators. The audit compared the number of patients who were at risk in June 2019 and then in January 2020. The audit target was 100% for both standards. The practice achieved 67% for the first standard and 100% for the second. A third cycle of the audit was due to be complete in March 2020. However this audit highlighted an area of risk that had not been addressed at the time of our inspection.

The practice undertook an audit in February 2020 to review of the proportion of patients being prescribed disease modifying anti-rheumatic drugs (DMARDS) who had shared care agreements in place. The results showed that out of 28 patients who required a shared care agreement; 23 of these patients did not have one in place. The recommendations of the audit were to contact secondary care to put shared care agreements in place. The practice provided documentation after our inspection which indicated that agreements were put in place prior to our inspection.

The practice had participated in a prescribing incentive scheme audit. The results from January 2020 showed that the practice had achieved maximum points against eight of the 10 indicators including a reduction in antibiotic prescribing.

The practice had also undertaken prescribing audits related to the prescribing of direct oral anticoagulants

(DOACs) and Non-steroidal anti-inflammatory drugs (NSAIDs). The reviews looked at whether those taking these medicines were also prescribed proton pump inhibitors to reduce acid reflux. In respect of patients prescribed DOACs; the proportion of patients who were not being prescribed a proton pump inhibitor reduced at the second cycle review from six patients to four and the number of patients over 65 who were taking NSAIDs who were not prescribed this medication reduced from 11 to eight.

Any additional evidence or comments

Effective staffing

The practice was able to demonstrate that staff had the clinical skills, knowledge and experience to carry out their roles however some required training had not been completed by some members of staff.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

We review the training files of four staff members and asked to see clinical updates completed by the medical staff. Staff were completing regular clinical updates and all staff had completed basic life support, fire, infection control training and the correct level of safeguarding training. However, we found two staff members who had not completed information governance training, one staff member who had not completed mental capacity act training and two members of clinical staff had not completed equality and diversity training.

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
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

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

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,	87.5%	94.8%	95.0%	Variation (negative)

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)				
Exception rate (number of exceptions).	1.5% (12)	0.5%	0.8%	N/A

Any additional evidence or comments
The practice told us that they had an action plan to address this. The practice would use a text messaging service to reach out to patients whose smoking status had not been recorded. This would enable patients to respond with their smoking status by text. The practice said that the for 2019/20 QOF year they had contacted 72 patients and still had 12 patients yet to respond. Their current performance for this target was 81% with several weeks of the QOF year remaining.

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: One clinical staff member whose training file we reviewed had not completed Mental Capacity Act training. However, we spoke with clinical staff on inspection who had good knowledge of issues related to consent and capacity and we saw examples of appropriate decision making in this regard from reviewing patient records.	

Well-led Rating: Requires Improvement

The practice is rated as requires improvement for providing a service that is well led due to deficiencies in governance which resulted in risk associated with the premises not being addressed and a lack of systems to undertake ongoing checks of professional registrations. Gaps in governance also resulted in oversight in respect of certain aspects of medicines management and failure to respond to an audit which highlighted risk in this area. There had also been limited action taken to review and improve performance against some national targets and reduce high rates of exception reporting.

Leadership capacity and capability

Although there was evidence of compassionate, inclusive and effective leadership at all levels there was a lack of understanding around some areas of risk and although actions to address risk around high risk medicines were highlighted by an audit; the practice had not taken proactive action to address these.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
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:

Although leadership had a good awareness of most aspects of the organisation; there were some areas where there was a lack of effective monitoring and oversight including certain aspects of medicines management and risks associated with the premises which adversely impacted on the quality of service provided.

One of the partners was the director of the local GP federation. Practice representatives attended monthly primary care network (PCN) meetings.

Neither of the partners or the practice manager were near retirement age and therefore the practice told us succession planning had not been considered necessary at the time of this inspection. The practice said that they found it increasingly challenging to continue to provide care due to the increase of work being moved into primary care from secondary care coupled with a lack of sufficient funding and resources. The practice was also aware of possible issues arising from the continually changing healthcare landscape. However, staff said that they planned to address these challenges through increased collaborative working and use of information technology. For example, the local primary care network had recently recruited a social prescriber who could reduce the number of clinical appointments used to address social issues.

Vision and strategy

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

sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a clear vision to provide a high standard of care for patients. All staff we spoke said that they were committed to this vision. The practice felt that one of their strengths was that they had a stable workforce who worked well together as a team. Consequently, the practice did not employ any locums which enabled them to provide continuity for patients.	

Culture

The practice had an inclusive and supportive culture.

	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
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: We saw examples of regular staff meetings where significant events were discussed, and action plans were put in place. The practice involved staff in discussions around incidents and all staff felt able to raise concerns and believed that these would be considered and acted upon.	

Two of the four staff whose training files we reviewed had not completed equality and diversity training.

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

Source	Feedback
Staff interviews	Both clinical and non-clinical staff that we spoke with during the course of the inspection said that they enjoyed working at the practice. They said that senior staff were supportive and offered them appropriate training and development opportunities.
Training & appraisals	We saw that staff had access to training and development opportunities.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support governance and management in most areas. However, there were areas of the practice's governance framework that needed to be improved in order to mitigate risk.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The governance systems in place to ensure all patients prescribed high risk medicines were appropriately monitored was not effective in respect of one high risk medicine. There was no system in place to periodically monitor professional registrations of clinical staff. Governance arrangements for monitoring risks associated with the premises were not sufficient as the practice had not taken adequate action to mitigate potential risks associated with legionella.	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing some risks and below average performance. There was evidence of clinical audits and plans for major incidents.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y

There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

The practice had effective systems for identifying and managing risk in most regards. However, we found two patients prescribed one high risk medicine who were not having appropriate monitoring completed in line with current legislation and guidance. The practice had participated in an audit which highlighted this but had continued to prescribe this medicine in absence of appropriate monitoring having been completed and there was no clinical justification for doing so documented in the patient's record.

Risks associated with legionella had also not been adequately addressed.

Appropriate and accurate information

The practice did not always use information effectively.

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

Explanation of any answers and additional evidence:

The practice used internal information and dashboards provided by the local GP federation to oversee performance against targets. The practice had recently upgraded their IT infrastructure and they hoped to further utilise IT to have better oversight of performance and improve the patient experience.

We were told that high exception reporting rates were due to a number of factors including coding issues, the turnover of patients registered from a local refugee centre and patients being abroad for significant proportions of the year. However, in some instances there was limited evidence to back up these explanations and action plans to address these issues were limited.

The practice was not aware of the Child Health Information Service (CHIS) data for childhood immunisation. CHIS which sets targets in line with the World Health Organisation. CHIS data focuses on not only if a child is immunised but whether they have been immunised within the optimum time period. The practice referred to Open Exeter data which relates to general coverage. The practice's Open Exeter data showed that they were achieving 90% of immunisation coverage whereas the CHIS data

showed that performance was below World Health Organisation Targets.

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: Staff told us that they felt engaged and well supported and were aware of, and active participants in, the practice's vision and values. Patient's we spoke with said that they felt listened to and encouraged to make suggestions for improvements. Twenty five of the 27 completed CQC comment cards were positive about the service provided by the practice; saying that care was of a high standard and easily accessible.	

Feedback from Patient Participation Group.

Feedback
We spoke with two members of the PPG during our inspection. Both members were positive about the care that they received from the practice. They said that there was a large and active PPG membership. The PPG met every six months and was attended by members of the senior clinical and management team. The PPG members said that they were regularly asked for suggestions and provided an example where the practice had addressed an issue with prescriptions on the basis of their feedback.

Any additional evidence

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation. However, the practice was always not sufficiently proactive to ensure timely improvements were made.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial

Explanation of any answers and additional evidence:

The practice had undertaken several audits which focused on improving the quality of care. Several of these were two cycle which demonstrated some quality improvement. However there appeared to be limited action taken in response to the high risk medicine audit. Despite the audit flagging two patient's prescribed one high risk medicine who did not have their levels recorded as being at true risk; the practice continued to issue prescriptions for two patients who had not had the appropriate monitoring completed. There was no explanation of why the practice had continued to prescribe in absence of monitoring having been completed documented in the patient's record.

Examples of continuous learning and improvement

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.